FAMILIAL SUICIDE

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SUMMARY

Seven completed suicides in a family of lower socioeconomic status and suburban domicile in Pondicherry are reported. The presence of bipolar affective disorder in the family members and the absence of exogenous factors are illustrated by utilising both family history method and family study method. The details collected formed the basis for the terminology 'familial suicide'. The management of the index case, one of the only three surviving male members of the family, who presented with suicidal ruminations and depressive features, is described.

Key Words: familial suicide, completed suicide.

INTRODUCTION

According to Adam (1985), patients with depression and borderline personality disorder form a high risk group for suicide and active conflict with significant others may not be obvious as a precipitating factor. Kety (1979) found higher incidence of suicide in biologic relatives of adoptees who suffered from depression than in other adopted relatives. Kety also reported that the biologic or adopted relatives of non depressed adoptee controls had lesser frequencies of suicide than the biologic relatives of adoptees who were depressed. There is a genetic component to suicide, but how exactly it operates is not known. Clayton (1985) speculated that certain personality traits, which may be the basis of decisiveness and impulsivity, operating under the effect of depression and excessive uncontrolled drinking, would have made some individuals commit suicide.

Dabbagh (1977) has mentioned among familial suicide potentials, factors which disable the family members, from maintaining as a self satisfying structural unit of the society amidst crises, of internal, interpersonal and social interfamilial nature. These factors include intolerance for separation, preoccupation with death, symbiosis without empathy, crisis intolerance, a pattern of role disturbance and role failure in areas of social, personal functioning.

Certain studies do not suggest a genetic component to suicide: for example, twin studies done by Kallman and Anastasio (1947), illustrated that even if the twins have several similar characteristics like type of personality, cultural setting, social frustration and depressive psychoses, they rarely both commit suicide.

INDEX CASE DETAILS:

A 24 year old man who had no formal schooling, but having good talent in drawing and painting, was brought by his French godfather and enduring well wisher with complaints of severe suicidal ruminations in the month of January 1989 for a consultation with the author. His other symptoms were inactivity, unhappiness, crying spells, tearfulness, mild anxiety, weight loss, loss of appetite, decreased libido and tremors of hands. He had no psychotic features. He had thoughts of committing suicide in the same way as his sister and brothers, did. These thoughts used to terrify him. These problems started 4 1/2 months ago and progressed slowly. Before the onset of these problems he used to draw and paint well and regularly and used to earn his livelihood by this. His studio was reported to have several incomplete drawings and paintings, which had got collected over the preceeding few months. He was of athletic build and his physical health was good. There was no history of past or present suicide attempt. His premorbid personality was of meticulous, religious, godfearing but short tempered nature. During adolescence he had a brief period of homosexual activity about
which he felt guilty during the depressive periods. There was no precipitating factor for his periods of high or low moods, except for the usual inconveniences of life in his environment. His fiancée was very supportive, but his younger sister was possessive, and used to utilise his family ties for getting substantial amount of money from him. This money was often misused by the patient's brother-in-law for drinking. This had produced difference of opinion and occasional quarrels between patient and his fiancée. Patient also had used alcohol intermittently to get rid of his sleeplessness or anxiety due to suicidal rumination, before consulting the author. His past depressive episodes were preceded by two or three month periods of elation.

FAMILY HISTORY

The informants who gave the history were the patient, his foster father, his maternal uncle and his siblings. Patient's paternal and maternal grand fathers and father worked in the cemetery, a profession passed down the generations. There was no history of suicide in both the grand parents' families. The grand parents died of old age and natural illness. The patient's parents committed suicide in their late forties. Patient had five brothers and three sisters of whom three brothers and one sister committed suicide. His brother in law, who was his youngest paternal uncle, also committed suicide. Of the seven suicides, five were performed by hanging, one by burning, and one by consuming poison. The interval between these suicides ranged from 4 to 7 years.

Mr. G. 49 years, father of the patient, had a cordial interpersonal sociofamilial life. He was financially contented with the remuneration he got from his clients for his work in the cemetery. He committed suicide by hanging from one of the trees in the cemetery in the early hours of morning. He had taken alcohol prior to the act, though he was not a regular drinker. He was suffering from depression and guilt feelings prior to the incident. He had previously attempted suicide by the same method at the same site during a period of depression. His suicide note did not speak of any hostility towards anybody or illtreatment by anybody. It just mentioned his lack of interest in life. He had several previous depressive episodes, preceded by periods of elation, for which he never had psychiatric treatment.

Mrs. G. 48 years old mother of the patient, a housemaid, committed suicide by hanging. She had cordial relation with family and friends. She had several periods of elation each lasting for one or two months, followed by depression with agitation, guilt feelings, self blame and hopelessness, which used to last for three of four months. The suicide note mentioned her lack of interest in living. She had not undergone any psychiatric treatment.

Mr. T. 28 year old eldest brother of the patient, a bachelor who assisted his father in the cemetery, committed suicide by hanging. He had a well adjusted premorbid personality but suffered from cycles of elation followed by depression. His suicide note mentioned his lack of interest in life, and his impending marriage. The note did not mention any hostility towards or illtreatment from anybody. It also had no mention of any disgust or disinterest in his work.

Mrs. K. 25 year old married sister, had strained marital relationship. She committed suicide by burning herself with kerosene, after consuming alcohol. She had previously attempted suicide by hanging following family quarrels. She had undergone psychiatric treatment for depression after the suicide attempt. Strained emotional interaction with her husband's family was the content of her suicide note.

Mr. M. 25 year old brother of the patient, a petty shop owner went into depression after a period of single handed extra effort to make money and arrangement for his younger sister's marriage. He committed suicide by hanging after intoxication with alcohol. In the suicide note he had mentioned that he has no interest to live further, now that his personal commitment was over after his sister's marriage. A similar period of depression three years prior to the suicide,
was treated by medication and electroconvulsive therapy.

Mr. N, 26 year old brother-in-law of the patient, a farmer committed suicide by consuming organophosphorous compound along with alcohol. He was a good worker, cordial to colleagues and was a good provider to his family. He had two previous episodes of depression which were treated by a psychiatrist. An interview with his employer confirmed that he had a period of elation and extra enthusiasm to work before the depressive episode. He had mentioned lack of interest in life in his suicide note.

Mr. P, 28 year old brother of the patient, mason engaged to be married, committed suicide by hanging under the effect of alcohol in his own house during the early hours of one morning. He was saved by the index patient during a previous attempt. The index patient was a witness to the gory sight and regretted that he could not save him, the second time. He had undergone treatment for depression before. The suicide note showed that it was a deliberate well planned act as he had sold all his personal belongings and wanted the entire cash to be utilised for his sister’s marriage.

As the patient, and his parents and siblings who committed suicide, had depressive episodes, which were demarcated by a switch to an episode of opposite polarity with normalcy in between, the diagnosis of bipolar affective disorder unspecified (F31.9), according to ICD 10 was made. There were no history suggestive of psychosis in any of the family members and the patient. All available living siblings had no past or present history of mood disorder.

**Similarities in the behaviour of family members who committed suicide:**

All the seven subjects had a depressive episode during or preceding the suicide. All were well planned, silently done with alcohol intake prior to the act. Except for Mr. P’s previous suicide attempt, all were performed in a lonely place. If the patient’s parents committed suicide in their late forties, the siblings and brother-in-law followed suit in the late twenties. All had utilised drastic measures. They chose an occasion when they were alone. None of them had a non-cordial interpersonal relations either in the family or in the society. In fact, Mr. M had conducted his sister’s marriage and Mr. P had collected and kept money for his younger sister’s marriage before committing suicide. All had kept suicidal notes but none gave any warning signal. Patient’s father Mr. G, patient’s siblings Mrs. K. and Mr. P. had attempted suicide, but it was during a previous episode of depression. All had history suggestive of bipolar affective disorder. The only other person who committed suicide outside the patient’s paternal nuclear family was his brother-in-law. But he was his paternal uncle.

**Discussion**

The index patient stood at the highest risk for committing suicide according to the literature and according to the clinical experience of the author. He had not attempted suicide but had suicidal rumination during the depressed phase of his illness. Like Dabbagh’s (1977) index case, he expressed suicidal ideas and sought professional help through his godfather. He was fearful about his own suicidal rumination and his most unusual family history. When he approached the author accompanied by his godfather in 1989, he was single, but now he is married and having fluctuating degrees of cordiality with his wife. Considering his several episodes of elation and depression, sometimes with no normalcy in between, a diagnosis of bipolar affective disorder was made. He was put on carbamazepine, lithium and antidepressant or neuroleptic medication depending upon the presence of depression or elation respectively. After an initial six months’ regularity he became noncompliant to medication. A psycho educational intervention in the patient and family members based on the biopsychosocial and environmental approach (American Psychiatric Association, 1994) made
him compliant to treatment and follow up.

Patient's artistic works are getting exhibited in standard exhibitions organised through his godfather's colleagues in Paris. The news and photographs of these have boosted the morale of the index patient. The interesting factor is that the patient has taken up a profession and developed it single handedly initially, and later with the help of his godfather. This creativity stands out against his family background of cemetery work and the fact that the patient has not undergone any formal schooling.

According to the cerebral laterality theory the right brain is the seat of artistic talents and emotions. When he is depressed, after an initial period of slowness, patient completely refuses to paint. During his euthymic phase he paints remarkably well and in large numbers. Above all, the patient's mind is heavily loaded with bitter experiences of directly seeing his parents and siblings die, right from his 7th year. These aspects are freely expressed by him during his depressive phases either to the author, to the godfather or to his wife.

It appears that the medication with regular reviews, the support from his godfather, and the positive reinforcement of monetary gain from his work have made him remain euthymic consistently over the last one and half years.

A look at the family pedigree (fig 1), illustrates the heredo-familial contribution from both the parents of the patient. Similarities in their suicidal act and lack of exogeneous factors for 6 out of 7 of the completed suicides in the family clearly supports the endogenous nature of the affective disorder which culminated in suicide.

Repetition of the same method, hanging, by majority of the subjects, make them similar to the subjects in Dabbagh's (1977) report, who committed suicide by burning. Patient's father, even if he had a history of suicide attempt, never sought any professional help unlike Ms K, Mr M, Mr N and Mr P. All those who took treatment did not continue to avail of the professional help consistently. A similar nature was seen in the index patient as evidenced by his defaulting on medication in the initial stages of his contact with the author.

The author first obtained information indirectly from the patient (proband), and one of his sisters (family history method). The author had separately interviewed each of the sisters and brothers of the patient and his maternal uncle directly, to corroborate one another's history (fam-
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ily study method). The author is continuing to keep in touch with each of the family members, the patient, his wife and his godfather, with a view to preventing any further untoward incident in this family. Andreasen (1986) pointed out that the family history method is less costly and utilisable for large and comprehensive group of relatives, but has the drawback of under reporting. According to her, family study method is more accurate, but costly.

The time span of 4-7 years between two suicides in this family makes it distinct from a suicidal pact. The well illustrated heredo-familial contribution, the fact that all had bipolar affective disorder, similarity in suicidal act of the subjects and lack of temporal closeness of each of the suicides made the author call this a "familial suicide"

Suicidal risk in primary affective disorder patient is 25 times greater than the risk in general population and 15% of the depressives die by suicide (Guze and Robins, 1970). In the present family all who committed suicide and underwent treatment, had primary affective disorder. Bipolar affective disorder with family history of suicide (Roy, 1985), early parental loss and recurrent psychiatric illness from a very young age (Roy 1985) are the characteristics shared by most of the members of the present family. These factors placed them at increased risk for suicide or attempted suicide. The biologic correlates of the suicidal behaviour may represent only the biologic dysfunction of the underlying psychiatric disorder that was associated with suicide (Roy, 1985). But the Compenhagen study (Roy, 1985) quoting Schulsinger et al, 1979), suggested genetic transmission of suicidal behaviour independent of mental illness. In the present family it is clear that the suicidal behaviour (the idea, the attempt and the completion) was associated with affective disorder in all the subjects.

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