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Research report

# A qualitative investigation into the relationships between social factors and suicidal thoughts and acts experienced by people with a bipolar disorder diagnosis

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ABSTRACT

*Background:* The prevalence rate of completed suicide in bipolar disorder is estimated to be as high as 19%. Social factors or influences, such as stigmatisation and family conflict, contribute to the development of suicidal ideation in clinical and non-clinical populations. Yet, there is a lack of studies examining suicidality from a psychosocial perspective in people who experience bipolar disorder.
*Method:* Semi-structured interviews were used to collect qualitative data from 20 participants with bipolar disorder. The interview focused on the effects of social factors upon participants' experiences of suicidality (suicidal thoughts, feelings or behaviours). A thematic analysis was used to understand the data.
*Results:* Social or interpersonal factors which participants identified as protective against suicidality included, 'the impact of suicide on others' and, 'reflecting on positive social experiences'. Social factors which triggered suicidal thoughts included, 'negative social experiences' and, 'not being understood or acknowledged'. Social factors which worsened suicidal thoughts or facilitated suicidal behaviour were, 'feeling burdensome,' and 'reinforcing negative self-appraisals'.
*Limitations:* Some participants had not experienced suicidal thoughts for many years and were recalling experiences which had taken place over ten years ago. The accuracy and reliability of these memories must therefore be taken into consideration when interpreting the results.
*Conclusions:* The themes help to enhance current understanding of the ways in which social factors affect suicidality in people who experience bipolar disorder. These results highlight the importance of considering the social context in which suicidality is experienced and incorporating strategies to buffer against the effects of negative social experiences in psychological interventions which target suicide risk in bipolar disorder.



## 1. Introduction

Suicide accounts for 1.5% of all mortality, making it the 14th leading cause of death worldwide (O'Connor and Nock, 2014). An extensive body of research suggests that suicidal behaviour occurs as the result of a complex interaction between numerous cumulative factors (e.g., Dieserud et al., 2001; O'Connor and Sheehy, 2001; Panagioti et al., 2013; Taylor et al., 2010; Wasserman et al., 2007). Therefore, a biopsychosocial conceptualisation of suicidal behaviour is utilised within many clinical settings (e.g., Hoffman, 2000; King & Merchant, 2008; O'Connor and Nock, 2014; O'Connor and Sheehy, 2000). The influential role of social or interpersonal factors in the development of suicidality (i.e., suicidal thoughts, feelings and behaviours) has been substantially documented within the research literature, in both clinical and non-clinical populations (e.g., Coker et al., 2002; Hawton et al., 2012; Hinduja and Patchin, 2010; Jakupcak et al., 2010). However, the role of such factors within pathways leading to suicidal behaviour is still not fully understood. Previous research focusing upon the role of social factors in suicidal ideation and behaviour has emphasised the impact of characteristics of family relationships, such as the perceived level of family support (e.g., Diamond et al., 2010; Hoagwood et al., 2010) and family conflict (e.g, Legleye et al., 2010; Xing et al., 2010). Characteristics of wider social networks have also been implicated in the formation of suicidal ideation, such as social isolation (e.g., Bearman and Moody, 2004) and peer integration amongst adolescents (e.g., Connor and Rueter, 2006).

Suicide is a cause of death in which psychological factors are directly involved, as the individual ultimately forms a decisive

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intention to end their own life (Johnson et al., 2008; O'Connor and Nock, 2014). It is therefore necessary to consider the individual's psychological state and the influence of social factors upon their mental health or wellbeing and level of suicidality. There are four main contemporary psychological models of suicidality, each of which specifies a role for social factors in the development, maintenance and intensification of suicidal thoughts and behaviours. The Integrated Motivational-Volitional model of Suicidal Behaviour (O'Connor, 2011) implicates social problem solving abilities as a key factor in a person's evolution from suicidal ideation to behaviour. The Cry of Pain model (Williams, 1997; Williams et al., 2005) asserts that perceptions of 'no rescue' are central to both triggering and worsening suicidal ideation and behaviour. Rescue factors can include social support, a lack of which can lead to feelings of entrapment and suicidal ideation as a means of escape from negative life circumstances (Williams et al., 2005). Joiner's (2005) Interpersonal Theory of Suicide hypothesises that a combination of the psychosocial factors of feeling burdensome and perceiving a low level of belongingness within social networks, produce a greater risk of suicidal ideation. Finally, the Schematic Appraisals Model of Suicide (Johnson et al., 2008) posits that negative appraisals of social factors, such as, perceptions of poor social support and social interactions, are involved in pathways leading to the development of suicidality

A mental health diagnosis is a strong predictor of suicidal behaviour and nine out of 10 people who end their life will have experienced clinically significant mental health problems (World Health Organisation, 2012). However, the low specificity of this predictor must be acknowledged, as the great majority of people who experience mental illness do not die by suicide. Individuals who experience bipolar disorder are at a heightened risk of suicide compared to the general population (Clements et al., 2013). There is also clear evidence that social factors, particularly the nature of the family environment, can play a key role in determining the clinical course of bipolar disorder. A prospective follow-up study of participants with a diagnosis of bipolar disorder demonstrated that a critical and hostile family atmosphere, known as high expressed emotion, significantly predicted the rate of relapse into acute mood episodes (Miklowitz et al., 1988). The presence of these family attitudes has been associated with more frequent relapses and worse symptomatic outcomes in a number of studies (Honig et al., 1997; Kim and Miklowitz, 2004; Miklowitz et al., 2000; O'Connell et al. 1991; Yan et al., 2004). Moreover, psychosocial family interventions which focused upon educating family members about bipolar disorder, facilitating better communication, and optimising problem-solving have been associated with better global functioning (Clarkin et al., 1998) in addition to fewer relapses and greater improvements in depressive symptoms (Miklowitz et al., 2000). However, the influence of the immediate social context upon the development of suicidal thoughts remains under-researched in people with bipolar disorder.

The most recent UK based epidemiological study investigating the prevalence rates of suicide in bipolar disorder reported that 1489 people with bipolar disorder ended their own lives between 1996 and 2009, an average of 114 suicides each year (Clements et al., 2013). Despite these high prevalence rates, there are a limited number of studies investigating the relationship between social factors and suicidal behaviour in bipolar disorder. There are a number of studies which report that bipolar disorder is significantly associated with social dysfunction and can have a profound negative effect on social relationships (e.g., Hirschfeld et al., 2003). However, the role of social factors in the development of suicidality within the context of bipolar disorder remains largely under researched. The few studies which have focused upon social factors and suicidality in bipolar disorder have highlighted the significance of adversities during early life, such as childhood physical and sexual abuse (Alvarez et al., 2011; Carballo et al., 2008; Garno et al., 2005; Leverich et al., 2002), a family history of suicidal behaviour (Galfalvy et al., 2006; Leverich et al., 2002; MacKinnon et al., 2005; Pawlak et al., 2013), a family history of mental health problems (Lopez et al., 2001; Pawlak et al., 2013), problems with social relationships (Leverich et al., 2002; Tsai et al., 1999), and stressful life events (Antypa et al., 2013; Azorin et al., 2009).

However, none of the aforementioned studies involved directly asking individuals with past experiences of suicidality and bipolar disorder to identify the socially relevant processes or factors they feel are involved in pathways leading to suicidal thoughts and behaviours. Indeed, family histories of suicidal behaviour and mental health problems may involve maladaptive-dysfunctional social relationships, but this has not been examined directly. Given the lack of specific research targeting social factors in suicidality in individuals who experience bipolar disorder, a practical first step would be to ask people with bipolar disorder which social factors they feel are implicated in the pathways to suicide, as key processes may not have been recognised within the existing research literature.

The aim of the present study was to identify which social factors people who experience bipolar disorder perceived as having triggered, worsened and protected against suicidal thoughts, feelings and behaviours. Qualitative interviews were used to gain an in-depth understanding of participants' subjective experiences of suicidal thoughts, feelings and behaviours.

## 2. Method

### 2.1. Design

This study involved conducting one-to-one semi-structured qualitative interviews with individuals with a diagnosis of bipolar disorder.

### 2.2. Inclusion criteria

A total of 20 participants were recruited based upon the following inclusion criteria:

1. A primary diagnosis of bipolar disorder (I or II) according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV research criteria (First et al., 1997), confirmed by the Structured Clinical Interview for DSM-IV Axis I Disorders, Research Version (SCID; First et al., 1997).
2. Self-reported past experience of suicidal thoughts, feelings and/or behaviours.
3. In contact with a care-coordinator or an equivalent named health professional who could be contacted in the event of suicide-related risk issues.
4. Aged 18–65 years.

### 2.3. Recruitment

This study was given approval by the University of Manchester Ethics Committee and NHS Research Ethics Committee (Ref: 13/NW/0846). Participants were recruited via opportunistic sampling using a number of recruitment methods. Recruitment of participants took place across the North West of England, in collaboration with a range of NHS and non-NHS organisations, such as community mental health teams, primary care services and charitable organisations including Mind and Bipolar UK.

Self-referral to the study was invited via flyers and posters which were placed in areas accessible to potential participants (e.g., local community centres). Advertisements were also placed in local