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Review article

Association between history of suicide attempts and family functioning in bipolar disorder

Mariangeles Berutti [a,*], Rodrigo Silva Dias [a], Vivian Alves Pereira [a], Beny Lafer [a], Fabiano G. Nery [a,b]

[a] Bipolar Disorder Program (PROMAN), Department of Psychiatry, University of São Paulo Medical School, São Paulo, Brazil
[b] Department of Psychiatry & Behavioral Neuroscience, University of Cincinnati College of Medicine, Cincinnati, USA

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ABSTRACT

Objectives: To investigate the association between history of suicide attempts (SA) and family functioning in bipolar disorder (BD) patients.
Methods: Thirty-one BD type I patients with lifetime history of SA, 31 BD type I with no lifetime history of SA, participating in the Outpatient Clinic of the Bipolar Disorder Program at the Institute of Psychiatry of the University of São Paulo Medical School were recruited for this study. We used the Family Assessment Device (FAD) to evaluate family functioning. We compared these two groups on demographic and clinical variables to identify which variables were associated with family functioning impairment. Fifty-one relatives of the same patients were also asked to complete a FAD.
Results: BD patients with SA presented more psychiatric hospitalizations, higher frequency of psychotic symptoms, and higher scores on depressive, manic, and suicidal ideation than BD patients without SA. BD patients with SA presented significantly higher scores in several subscales of the FAD, including Problem Solving ($p=0.042$), Communication ($p=0.009$), Roles ($p=0.006$), and General Functioning ($p=0.025$), when compared with BD patients without SA. Relatives of BD patients with SA presented significantly higher scores in Communication, Roles, Affective Responsiveness, and General Functioning than relatives of BD patients without SA.
Limitations: Cross-sectional study and long time elapsed since last SA.
Conclusion: History of SA in BD is associated with worse family functioning in several domains of FAD, including Problem Solving, Communication, Roles, and General Functioning. As suicide attempts are routinely assessed in clinical practice, these findings may help to identify patients with poorer family functioning and may suggest a role for environmental risk factors in suicidal behavior among BD patients.

Contents

* Correspondence to: Institute & Department of Psychiatry, University of Sao Paulo Medical School, Rua Dr. Ovidio Pires de Campos, 785, Cerqueira Cesar, Sao Paulo, SP 05403-010, Brazil.
E-mail address: angie.berutti@gmail.com (M. Berutti).

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1. Introduction

Bipolar disorder (BD) is a serious, recurrent and highly disabling psychiatric illness. Suicidal behavior is a serious clinical problem in BD. Studies reported that up to 59% of BD patients have suicidal ideation and 25–56% present at least one suicide attempt during lifetime (Abreu et al., 2009). In addition, along with cardiovascular diseases and cancer, suicide is one of the leading causes of mortality among BD patients (Pompili et al., 2013). BD patients have a 20–30 times greater chance of committing suicide than the general population and up to 15% of BD patients commit suicide (Goodwin and Jamison, 2007; Abreu et al., 2009; Pompili et al., 2013). Although it has been hypothesized that suicidal behavior among BD patients is caused by a complex interplay of genetic, neurobiological and environmental factors (Oquendo et al., 2004; Ghaemi et al., 2008; Abreu et al., 2009), little is known about possible modifiable environmental factors that could mitigate or attenuate this complex clinical problem.

BD symptoms interfere significantly with family, social and work relationships (Spalt, 1975; Bauwens et al., 1991; American Psychiatric Association, 2002). Many BD patients and their families report difficulties such as extramarital experiences, promiscuous behavior, and low marital adjustment levels (Spalt, 1975; Bauwens et al., 1991). Divorce rates are higher among BD patients compared with the general population (American Psychiatric Association, 2002). Other problems include violence, propensity to accidents and suicidal behavior, already mentioned (Khalsa et al., 2008). As expected, these individual difficulties related to the BD symptomatology and functional impairment might be associated with significant burden among families of BD patients (Pompili, 2014). Recent studies suggest that there may be a bi-directional relationship between some clinical aspects of BD and family environment or functioning (Ellis et al., 2014; Weinstein et al., 2015). Indeed, mounting evidence suggests that BD patients report worse family functioning when compared with healthy subjects and with patients suffering from other psychiatric disorders (Friedmann et al., 1997, Koyama et al., 2004, Unal et al., 2004, Uebelacker et al., 2006, Townsend et al., 2007).

The impact of suicidal behavior on family environment or functioning (and vice versa) in BD has been poorly investigated. In children and adolescents with BD, suicidal ideation is associated with higher levels of parental expressed emotion, higher family rigidity (Ellis et al., 2014; Weinstein et al., 2015) and lower adaptability (Goldstein et al., 2009) Worse family functioning is associated with suicidal ideation and with history of suicide attempts (SA) (Algorta et al., 2011). Among patients with major depressive disorder (MDD), worse family functioning is associated with history of suicide attempts, particularly in domains such as problem solving and communication (Keitner et al., 1990; McDermut et al., 2001). To the best of our knowledge, no study investigating family functioning and suicidal behavior in adult BD patients has been published. Furthermore, no previous study has evaluated family functioning among relatives of BD patients

The aim of this study was to investigate associations between history of SA and family functioning in BD patients. Our hypothesis was that families of BD patients with history of SA would present worse functioning than families of BD patients without SA. The findings of this study might help clinicians to identify characteristic associated with SA, and to help to plan targeted psychosocial interventions to mitigate suicidal behavior among BD patients.

2. Methods

2.1. Patients

The sample was comprised of 62 BD type I patients. Subjects were recruited from the Outpatient Clinic of the Bipolar Disorder Program at the Institute of Psychiatry of the University of São Paulo Medical School. Patients were recruited by word of mouth, when they attended their regular appointments, after a brief screening was presented to verify whether they met inclusion and exclusion criteria. The local Institutional Ethics Committee approved the study, and all the patients gave voluntary written informed consent before participating in the study.

Inclusion criteria for patients were: age over 18 and a DSM-IV BD I diagnosis, living with at least one first-degree family member (father, mother, siblings, partner). Exclusion criteria were: alcohol or drug abuse during the previous year, pregnancy, living alone, and CNS illnesses including neurological illness, and/or serious medical condition such as hypertension or mellitus diabetes.

To include the family perception of family members other than the patients', and to explore the consistency of responses within the families, for every patient included in the study we invited one relative (patients' caregiver) to complete the Family Functioning Assessment (please see below). Inclusion criteria for relatives had to meet at least three of five criteria established by Pollak and Perlick:As for the inclusion criteria for relatives, they had to meet at least three of five criteria established by Pollak and Perlick: (1) being a spouse or parent; (2) having more frequent contact with the patient than any other caregiver; (3) helping to support the patient financially; (4) being the contact persona available for treatment staff in case of emergency; (5) being involved in the patient's treatment (Pollack and Perlick, 1991) and living with the patients at the time of last SA. Fifty-one relatives completed the FAD assessment. FAD assessment data is shown below and their data are presented here.

2.2. Psychiatric assessments

Diagnostic assessments were all conducted by research-trained, Board-certified psychiatrists, using the Structured Clinical Interview for DSM-IV Disorders (SCID), Patient Version (First, 2002). The 17-item Hamilton Depression Rating Scale (HAMD-17) (Hamilton, 1960) and the Young Mania Rating Scale (YMRS) (Young et al., 1978) were administered to assess the current severity of depressive and manic symptoms, respectively. Demographic and clinical characteristics of the disease, including psychotic symptoms, psychiatric hospitalizations, family history of mood disorders was obtained using the same standardized protocol and information from the SCID. Suicidal behavior, including number of SA, lethality and severity of SA was evaluated using the Columbia Suicide Severity Rating Scale (C-SSRS) (Oquendo and Mann, 2003). Suicidal ideation in the week prior to participating in the study was evaluated using the Beck Scale for Suicide Ideation