

## CHARACTERISTICS OF SUICIDE VICTIMS WHO HAD VERBALLY COMMUNICATED SUICIDAL FEELINGS TO THEIR FAMILY MEMBERS

Antonios Paraschakis<sup>1</sup>, Ioannis Michopoulos<sup>2</sup>, Christos Christodoulou<sup>2</sup>,  
Filippos Koutsaftis<sup>3</sup> & Athanassios Douzenis<sup>2</sup>

<sup>1</sup>Psychiatric Hospital of Attica "Dafni", Athens, Greece

<sup>2</sup>Second Department of Psychiatry, Athens University Medical School, "Attikon" General Hospital, Athens, Greece

<sup>3</sup>Athens Department of Forensic Medicine, Athens, Greece

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### SUMMARY

**Background:** Verbal expression of suicidal feelings has rarely been investigated in the literature, particularly regarding individuals who died by suicide.

**Subjects and methods:** We retrospectively collected data on the suicide cases of the period November 2007-October 2009 from the Athens Greater Area and completed psychological autopsy questionnaires after phone interviews with their family members. The specific question was: "Has your relative expressed to you his/her deep suffering or the intention to end his/her life at any time during the six months prior to the suicide?"

**Results:** Data were collected for 248 individuals who died by suicide out of a total of 335. 121 of them (48.8%) had verbally communicated their intention to die -or their profound suffering- to their family members. Suicide communicators were older ( $p<0.001$ ), less educated ( $p=0.04$ ), more frequently divorced or separated and less often single ( $p<0.01$ ) than non-communicators. They had more often positive psychiatric history ( $p=0.004$ ) and were less physically well ( $p=0.005$ ), in comparison to non-communicators. Differences regarding sex, nationality, previous attempts, suicide note-leaving, completed suicide method and hospitalization either for physical illness or psychiatric disorder the year prior to the suicide were not statistically significant among the two groups. Considered that we interviewed only one relative for every case, the actual number of suicide communicators would be probably higher; the suicidal feelings could have been disclosed to another relative instead.

**Conclusions:** This is the first time that a similar study was carried out in Greece. We found that approximately half of the individuals who died by suicide in our sample had been (verbal) suicide communicators. The latter seem to present distinct characteristics. These findings, coupled with the observation that the relatives are keen observers of the suicidal feelings of their loved ones, could provide new insights to future suicide prevention efforts.

**Key words:** suicide communicators - verbal suicide communication - psychological autopsy

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### INTRODUCTION

Every year approximately 800,000 people die by suicide –nearly 1.4% of the total amount of deaths in the world (World Health Organization 2014). Annually, more people die by suicide than in all the armed conflicts worldwide (Wasserman 2009). Suicide was the 15th leading cause of death for 2012, whereas for individuals aged 15-29 years old it was the second one (WHO 2014). The annual cost of suicides is expected to amount to 2.4% of the global burden of disease for the year 2020 (Bertolote & Fleischmann 2009).

Communication of suicidal intent is an event that often precedes suicidal behavior (Robins et al. 1959, Barraclough et al. 1974, Kovacs et al. 1976, Wolk-Wasserman 1986, Isometsa et al. 1994, Handwerk et al. 1998, Zhou & Jia 2012). Nevertheless, few of the studies on this subject are focused on individual who died by suicide and not on suicide attempters. In fact, only Robins et al. (1959), Isometsa et al. 1994, De Leo & Klieve (2007), De Leo et al. (2012), Zhou & Jia (2012) have focused on suicide completers. However, De Leo and

Klieve referred exclusively to patients with schizophrenia, Isometsa et al. to those with major depression, De Leo et al. compared Indigenous to non-Indigenous populations in Australia, and Zhou and Jia examined only young individuals who died by suicide. Therefore, studies on the characteristics of suicide communicators that consequently die by suicide, regardless of age, ethnicity, or disorder suffered have been scarce in the literature.

The aim of our study was to investigate the characteristics of individuals who died by suicide and had verbally communicated their intention to die or their deep desperation –from now on both considered as "suicidal feelings"- to their loved ones prior to their death. We have also compared them to the respective of the individuals who weren't referred to have disclosed such feelings to their family members.

Data for our study were provided by the first psychological autopsy study that was ever carried out in Greece. Articles from this study have already been published (Paraschakis et al. 2013, Paraschakis et al. 2014). None of them though focused on the characteristics of the individuals that had verbally commu-

nicated their suicidal feelings to their relatives the few months prior to their suicide. Furthermore, it was interesting to investigate how often were the suicidal feelings expressed by individuals who died by suicide to their family members in a rather conservative society, as the Greek one is generally considered.

## SUBJECTS AND METHODS

We retrospectively collected data for the suicide cases for a 2-year period (November 2007 until October 2009) from the Athens Department of Forensic Medicine (ADFM). The ADFM, the largest, by far, of its kind in Greece, covers an area where nearly 35% of the country's approximately 11 million population live.

Data were collected from the forensic records of the suicide cases and from the completion of a psychological autopsy questionnaire after phone interview with a family member of the deceased as well as from eventual police reports or suicide notes.

The psychological autopsy method is viewed as a rather direct method for creating a profile of the individual who died by suicide as well as of the act itself (Shneidman 1981). It is based on the information gathered from the forensic records of the individuals who died by suicide -including suicide notes and police reports-, and also from data collected from interviews with their family members (Isometsa 2001, Pouliot & De Leo 2006). The interviews commonly take place within a certain time window after the loss – usually more than 2 months, but less than a year (Hawton et al. 1998, Isometsa 2001).

The psychological autopsy questionnaire we have used included numerous parameters that, according to the relevant literature, have been related to the suicide act: socio-demographic, history of psychiatric disorder(s), drug abuse, physical illness(-es), hospitalization in a medical or psychiatric ward the year prior to the suicide, history of previous attempts, completed suicide's method, suicidal communication prior to death and note-leaving (Cavanagh et al. 2003, Chiu et al. 2004, Snider et al. 2006).

We completed each questionnaire after phone interview with a deceased's family member. Information were gathered by parents, spouses, children, brothers and sisters, cousins and, albeit rarely, other acquaintances. The phone interview usually took place between 2 – most often 3 -, and 4 months after the individual's death.

The item "suicidal communication" refers to either the verbal expression of "direct" or "indirect" suicidal communication, using the distinction proposed by Wolk-Wasserman (1986) and by Wasserman et al. (1998). "Direct" communication refers to clearly expressed suicidal intention sometimes with details regarding, for example, method of suicide, while "indirect" indicates a feeling of despair and hopelessness or that life is not worth-living and that there is no escape to one's suffering. The specific question, as included in the

questionnaire, was: "Has your relative expressed to you his/her suffering or the intention to end his/her life at any time during the six months prior to the suicide?"

Permission for our study was granted from the Ethics Committee of "Attikon" General Hospital as well as from the ADFM which provided unconditional access to the forensic records of all suicide cases.

## Statistical Analysis

Statistical analysis was carried out by the Pearson's  $\chi^2$  test for comparison of percentages and the t-test for comparison of means of variables. The level of  $p < 0.05$  was chosen to indicate statistical significance. The Statistical Package for Social Sciences (SPSS) version 16.0 was used for statistical analyses.

## RESULTS

During the 2-year period of our study 335 individuals died by suicide: 250 males (74.7%) and 85 females (25.3%). We conducted phone interviews with the relatives of 256 suicide cases (76.4%); for the rest of the sample a phone number was not available.

We collected data on suicidal communication in 248 cases -in 8 cases the relatives were unwilling to cooperate. Nearly half of them (121 cases or 48.8%) had verbally expressed their suicidal feelings to their relatives the semester prior to the suicide. Suicide communicators were significantly older, less educated, divorced or separated and less often single, in comparison to non-communicators. Suicide communicators more often had positive psychiatric history and suffered from a physical illness. For the remaining parameters the differences among the two groups were not statistically significant.

In Table 1 are shown the differences regarding the sociodemographic characteristics between the two groups. In Table 2 are pictured the respective for the psychiatric and medical history.

**Table 1.** Differences between suicide "communicators" and "non-communicators" regarding their sociodemographic characteristics (n=248)

	Commu nicators	Non-commu nicators	p*
Sex (%)			
Male	72.7	77.2	n.s**
Female	27.3	22.8	
Nationality (%)			
Greek	90.1	92.9	n.s
Other	9.1	7.1	
Family status (%)			
Single	26.7	46.9	
Married	39.2	32.8	0.01
Divorced-Separated	23.3	13.3	
Widowed	10.8	7.0	
Age (years, mean/SD***)	57.5 (17.4)	48.9 (17.9)	<0.001
Education (years, mean/SD)	10.2 (4.2)	11.34 (4.3)	0.04

\* $p < 0.05$ , \*\*n.s: non significant \*\*\*SD: standard deviation

**Table 2.** Differences between suicide “communicators” and “non-communicators” regarding their psychiatric and medical history (n=248)

	Communicators	Non-communicators	p*
History of psychiatric disorder	67.5	49.2	0.004
History of drug-alcohol abuse problem	25.8	17.2	n.s**
Prior suicide attempts	28.6	18.6	n.s
Suicide notes	26.1	24.8	n.s
Physical illness	57.5	39.1	0.005
Hospitalization in a medical ward	27.7	18.6	n.s
Hospitalization in a psychiatric ward	15.0	13.3	n.s
Completed suicide’s method			n.s
Jumping from a height	35.5	34.6	
Hanging	38.8	29.9	
Shooting by a firearm	15.7	18.1	
Self immolation	2.5	3.1	
Poisoning by solid or liquid substances	4.1	2.4	
Cutting	1.6	3.9	
Run over by train	1.6	1.6	
Drowning	0.8	3.1	
Medication overdose	0.0	2.4	

\*p<0.05, \*\*n.s: non significant.

From the qualitative point of view, suicide communicators often used phrases illustrating emphatically their suffering, as relayed to us by the informants. Examples were: “I can’t stand going on like this”, “my life is worthless”, “I am going to end this soon”, “I don’t have the courage to live”, “I want to find peace in dying” “God has forgotten to take me” etc. All these could be considered examples of “indirect” verbal suicidal communication. On the other hand, phrases such as “I don’t want to live anymore; I want to die by suicide”, “I will be hanged one of these days from that tree over there” etc, might be viewed as cases of “direct” suicidal communication.

## DISCUSSION

In our study we found that approximately half of the individuals who died by suicide had communicated their suicidal feelings to a family member. Most likely this number underestimates the real figure because such feelings could have been expressed to another relative instead of the individual interviewed. In the literature, the proportion of verbal suicide communicators in samples of completed suicides ranges from 27.5% to 69% (Robins et al. 1959, Zhou & Jia 2012).

Communicators were older and in worse physical health than non-communicators. This could be attributed to the high psychiatric comorbidity of the group of elderly with physical problems, the main psychiatric disorder being depression (Preville et al. 2005, Harwood et al. 2006). Another hypothesis that could be made is that individuals with comorbidity, given their complex problems, may also be in touch with more people, having more opportunities to express their suffering.

The issue of comorbidity is particularly important considering the fact that seriously depressed elderly patients with physical problems rarely make non-lethal attempts -being their poor physical health a contributing factor to their death (Conwell et al. 2002). Our finding also suggests that suicidal intent is rarely investigated in medical care, an observation already made by other researchers (Isometsa et al. 1995).

Communicators were less educated than non-communicators. We don’t know exactly why this happens and there is no similar finding in the literature to provide possible explanations. We can only speculate that less educated people find difficult to ascribe their suffering to psychological causes and, consequently, rarely turn to mental health professionals to speak about it. Instead, they could possibly prefer to communicate their psychic pain to their family members, perhaps indirectly asking for help or instructions. Finally, another explanation could possibly be that more educated individuals do not communicate their suicidal ideation as part of their plan to die by suicide fearing that their family and friends will respond by insisting on psychiatric consultation (or admission).

Suicide communicators were more frequently divorced or separated and fewer were single in comparison to non-communicators. It could be proposed that singles retain fewer close contacts in comparison to divorced or separated; therefore, they communicate less frequently their psychic suffering. Whether divorced-separated are more communicative and why this is happening could be an interesting topic for further research. Our results differ from those of Robins et al., (1960) and of Zhou and Jia (2012) who found no difference in marital status among the two groups. However, we note that the size of our sample was small; therefore, caution is required in the interpretation of the results.

Significantly more communicators had history of a psychiatric disorder. It is well known that most of the psychiatric disorders related to completed suicide – particularly mood disorders- have a recurrent pattern (Henriksson et al. 1993, Harris & Barraclough 1997, Arsenaault-Lapierre et al. 2004). Therefore, it seems probable that the communicators, having suffered from a recurrence of their psychiatric disorder, were used to this kind of suffering and less hesitant to communicate it to their family members.

An intriguing finding of our study was that, perhaps contrary to what is generally believed, women didn't communicate more frequently than men their suicidal feelings. This finding was also uncovered by Robins et al. (1960) and Zhou & Jia (2012).

Another interesting finding of our survey was that the history of prior attempt(s) was not related to verbal expression of suicidal feelings. This appears to suggest that the history of prior attempt(s) is not a necessary component of suicidal communication and that perhaps only marginally could be related to suicide intent. Our results are in accordance with those of previous studies (Beck et al. 1976, Hawton et al. 1999, Zhou & Jia 2012).

From the suicide prevention perspective our study helps us draw various conclusions. Above all is that individuals who died by suicide have very often verbally communicated their suicidal feelings to a family member. It is the first time that a similar result comes up from a study on suicides in our country. As Robins et al., (1959) have already pointed out, the study of verbal communication between individuals who die by suicide and their family members, has four parameters: who does it, what exactly says, to whom, and how the receiver of the communication reacts to it. We can assume that a reason why this communication sometimes takes place and others does not has to do more with the dynamics of the relationship among the two parties and less with the characteristics of the deceased alone (Wolk-Wasserman 1986). In our study the family members, though initially surprised and distressed by this kind of communication, either didn't pay much attention to what their loved ones were saying or believed that "who says it doesn't do it" or, finally, were ambivalent about how to react. Ambivalence regarding helping or not the suicidal individual has been described as a common reaction in similar cases (Wolk-Wasserman 1986). Consequently, after the suicide, the relatives were often regretful for not having paid much attention to their loved ones' words and for not responding "appropriately". At this point, we should highlight that the relatives aren't to blame for their reaction. It is not easy for a family member to respond efficiently to this kind of communication and advise the suicidal individual (Robins et al. 1960). Furthermore, among the "signal" of future suicide completers -or attempters- there is always the "noise" of those who will never proceed in any suicidal act despite having expressed such feelings. Therefore, it should be acknow-

ledged that the receiver of the communication is found in a particularly distressful position.

It has been described that family members may also show hostility or even express violent wishes against the suicidal individual (Rosenbaum & Richman 1970, Richman 1978). However, we didn't encounter any such reactions in our sample or, at least, they were not referred to us.

We highlight the need for educating non-psychiatrists, mainly general practitioners and internists, regarding the importance of actively searching for suicidal feelings as part of a thorough medical evaluation of their older and more physically frail, in particular, patients. We speculate that if health professionals ask gently, yet explicitly, about them, a considerable proportion of these patients will not hesitate to express them. Furthermore, health professionals who have the care of elderly with physical problems should investigate whether suicidal feelings have been disclosed to the patient's family members too. The former are keen observers of their loved ones' suicidal feelings and could provide valuable insights into their psychic pain.

Our study has various limitations. First of all, there are no standardized tools or homogeneous interpretation of suicidal communication until now. In fact, there have been considerable differences among authors on this subject (Wasserman et al. 2008). Second, it is particularly difficult to define whether suicidal communication reflects a temporary apprehension with death or something more enduring in time (Zhou & Jia 2012). Third, we were not focused on which precise period during the six-month interval prior to the suicide did the communication take place. In fact, rarely the individuals who die by suicide express suicidal feelings during their last days, for numerous reasons –desire not to be discovered, hopelessness, ambivalence regarding the act etc. (Isometsa 2001). Fourth, our study, as occurs with psychological autopsies in general (see Hawton et al. 1998, Pouliot & De Leo 2006), was retrospective in nature with all the misfits of similar endeavors: recall bias, biases due to the cause of death, to the feelings of guilt or shame of the informant or to the former's emotional state.

We were not able to locate a relative's phone number in approximately 25% of the suicide cases. Furthermore, we performed all interviews by phone and with only one relative for every case due to limited resources. Therefore, we may have missed additional information that direct interviews with more family members could have prevented and this is the reason why we grouped together "indirect" and "direct" suicide communication. Investigating in detail these two groups would have benefited from another study design. However, the success of a similar project, implemented for the first time in a country with considerable prejudices regarding mental health, was not, by any means, given.

## CONCLUSIONS

Our study was the first to address the issue of verbal expression of suicide feelings by individuals who died by suicide in Greece, and among the few similar in the literature. We found that suicide cases had very often verbally expressed their suicide feelings to, at least one, family member. Communicators did also present different characteristics in comparison to non-communicators. This information, coupled with the fact that family members are keen observers of the suicidal feelings of their loved ones, could provide valuable insights for future suicide prevention efforts.

It should be pointed out that probably only a minority of suicide communicators will eventually die by suicide. Studies aiming to define this group and to explore the qualitative aspects of verbal suicidal communication are certainly needed. The ultimate goal should be to “communicate” this knowledge to anyone who provides health services in the community. After all, as Friel and Frank (1958) have already pointed out, “a case of suicidal patient could fall into the hands of any physician, regardless of specialty or type of practice”.

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*Correspondence:*

Antonios Paraschakis, MD  
Psychiatric Hospital of Attica "Dafni"  
Ioanninon Street 95, 16674 Glyfada, Attica, Greece  
E-mail: antparaschakis@yahoo.gr