



SHORT COMMUNICATION

Psychological well-being and depressive symptoms in individuals who have lost a family member by suicide

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Abstract

Background and objectives: The impact of death by suicide represents an important public health issue. The current study reports data relating depressive symptoms and psychological well-being to exposure to suicide in the family.

Methods: A final Portuguese community sample of 266 participants answered a protocol presented on a Google platform. Two groups were defined: a suicide exposure group ($n = 45$) and a control group ($n = 210$) who responded to the *Échelle de Mesure des Manifestations du Bien-Être Psychologique* (Psychological Well-being Manifestation Measure Scale) and to the *Center for Epidemiologic Studies* Scale to assess psychological well-being and depressive symptoms, respectively.

Results: Groups differ significantly on psychological well-being, even when contorting for unemployment and having physical disease, differed on depressive symptoms and tended to differ on depressive symptoms when contorting for unemployment and chronic physical disease.

Conclusion: Based on results, we suggest that therapeutic interventions should focus not only on reducing depressive symptoms in exposed individuals, but as well as promoting well-being. Limitations include the size of the sample and the cross-sectional nature of the design.

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The impact of death by suicide represents an important public health issue.¹ Loss by suicide requires more time to grieve than other types of bereavement² and exposure to

suicide results in a number of adverse consequences, namely distress and the increased likelihood of one's own suicide.³ There is some evidence relating exposure to suicide in the family and depression,^{4,5} but little data has been reported looking at suicide exposure in relation to low positive emotions and low levels of psychological well-being⁶. The absence of psychopathological symptoms, namely depressive symptoms does imply well-being. In fact mental health is not the opposite, or simply the absence of

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psychopathology. In Portugal, Santos, Campos and Tavares⁷ examined whether several indicators of distress, namely depression, related to suicidal ideation in individuals exposed to suicide in the family and just one study⁸ compared a group of individuals exposed to family suicide with a control group, demonstrating that those college students in the exposure group presented significantly higher levels of depressive symptoms than the controls. No study has looked into whether exposed individuals presented lower levels of psychological well-being. The current study aimed to contribute to the understanding of the effect of being exposed to a suicide in the family and reports data relating depressive symptoms and psychological well-being to exposure to suicide in the family.

Materials and methods

A final Portuguese community sample of 266 participants (205, 80.4% women) answered a protocol presented on a Google platform. It related to psychological variables, thoughts about death, and risky behaviors. Participants were not compensated for their participation. Participant mean age was 35.89 years ($SD = 12.42$, Median = 32.00) and ranged from 18 to 64. Only nine participants were students, and mean years of education was 13.95 ($SD = 2.57$, Median = 15.00), ranging from 6 to 19. Fifty-two (20.4%) were unemployed. Twenty-seven (10.6%) of the participants had received a psychiatric diagnosis (44.4% with a depressive disorder, 29.6% with an anxiety disorder 22.2% with a mixed anxiety and depressive disorder, and 3.7% with another diagnosis) and 53 (20.8%) had been diagnosed with a chronic physical disease.

Individuals provided informed consent on the first page of the online protocol and then were asked to click “continue” and received a brief socio-demographic and several clinical questionnaires including the Psychological Well-being Manifestation Measure Scale and the Center for Epidemiologic Studies Depression Scale. All participants were provided with telephone numbers of available mental health services. Participation was voluntary and anonymous and could be discontinued at any time. Three individuals were excluded because they reported residing outside of Portugal.

Participants were also asked if any family member had died by suicide and, if so, information was requested about the family member, when, what suicide method was used, and the degree of impact (using a 1-minimal impact to 5-high impact scale). Sixty-nine participants answered yes, however ten of these reported a date for the suicide that was before the participant’s birth, and another 11 failed to report any date. Consequently, we defined a suicide exposure group ($n = 48$) as those individuals who had lost a family member by suicide during their lifetime with an impact different than minimal in addition to a control group ($n = 210$). The 11 individuals who did not report the date of the suicide were eliminated from the analysis. Of the 48 members of the exposed group, 15 were grandchildren of the deceased, one was a brother, one was a great grandchild; four were children; two were daughters; eighteen were cousins; thirteen were nieces or nephews; one was a father-in-law; and

three reported other kinship. For ten exposed individuals (22.2%), two or more family members had died from suicide. Hanging was the most frequent method (approximately 40%) followed by intoxication (approximately 24%), using medication, a drug or poison. Mean time since the suicide was 16.64 years ($SD = 10.89$).

Participants responded to the *Échelle de Mesure des Manifestations du Bien-Être Psychologique* (Psychological Well-being Manifestation Measure Scale),⁹ a 25-item five-point Likert scale (1-never to 5-always), originally developed in Canada, that assesses manifestations of well-being in the previous month. Examples of items are: “I felt confident”; “I felt good, at peace with myself.” The Cronbach alpha of the original version of the questionnaire was .93. In the Portuguese adaptation,¹⁰ used in the present study, a Cronbach alpha of .93 was also obtained. In the present study Cronbach alpha was .97.

Participants also responded to the *Center for Epidemiologic Studies Depression Scale - CES-D*¹¹ is a 20-item measure that assessed the frequency of depressive symptoms in the week prior the assessment. Items (e.g., “I felt depressed”) are answered on 4-point Likert scales from 0 - “Never or very rarely - less than 1 day” to 3 - “Very frequently or always - 5-7 days”). Radloff¹¹ reported scale score coefficient alphas of .85 and .90 for community and clinical samples, respectively. In the Portuguese version¹² internal consistency coefficient alpha values have ranged from .85 to .92 in various samples. In the current study, the coefficient alpha was .91.

Results

Table 1 presents descriptive results as a function of group membership (suicide exposure or control) for the socio-demographic variables of age, gender, years of education, unemployment and marital status, and whether participants had a psychiatric diagnosis and/or chronic physical disease. Descriptive statistics by group for psychological well-being and depressive symptoms are also displayed. For all variables, suicide exposed and control groups were compared, using t tests, ANOVA or χ^2 tests. Each group’s psychological well-being and depressive symptoms were also compared, controlling for other relevant variables using ANCOVA.

As displayed in Table 1 suicide exposed individuals did not differ from controls regarding age, gender, years of education, marital status, or having a psychiatric diagnosis. However, the groups did differ significantly on psychological well-being ($t = 2.83$, $p < 0.01$; $F = 6.59$, $p < 0.05$; partial $\eta^2 = 0.03$) even when controlling for unemployment and having chronic physical disease ($F = 5.28$, $p < 0.05$; partial $\eta^2 = 0.02$). Groups also differed regarding depressive symptoms ($t = 2.24$, $p < .05$; $F = 4.17$, $p < .05$; partial $\eta^2 = 0.02$) and tended to differ when controlling for unemployment and chronic physical disease ($F = 3.31$, $p < 0.10$; partial $\eta^2 = 0.01$).

Discussion

Results demonstrated that exposed individuals not only presented significantly higher levels of depressive

Table 1 Descriptive and inferential statistics for control ($n = 210$) and suicide exposed ($n = 48$) groups.

Variables		<i>n</i>	%	Mean (SD)	<i>n</i>	%	Mean (SD)	<i>t</i> / χ^2
<i>Socio-demographic and clinical variables</i>		Control Group			Exposed Group			
Age in years				35.79 (12.36)			36.33 (12.85)	0.27
Gender	<i>Female</i>	167	80.7%		38	79.2%		0.06
	<i>Male</i>	40	19.3%		10	20.8%		
Years of education				14.06 (2.21)			13.45 (2.78)	1.41
Unemployed	<i>No</i>	171	82.6%		32	66.6%		6.10 *
	<i>Yes</i>	36	17.4%		16	33.3%		
Marital status	<i>Not married or living together</i>	127	62.4%		30	62.5%		0.02
	<i>Married or living together</i>	90	38.6%		18	37.5%		
Having a chronic physical disease	<i>No</i>	170	82.1%		32	66.6%		5.66 *
	<i>Yes</i>	37	17.9%		16	33.3%		
Having had a psychiatric diagnosis	<i>No</i>	186	89.9%		42	87.5%		0.23
	<i>Yes</i>	21	10.1%		6	12.5%		
Psychological well-being				87.74 (21.05)			79.11 (19.97)	2.57 *
Depressive symptoms				20.70 (10.61)			24.77 (12.91)	2.30 *

Note. * $p < .05$.

symptoms, confirming previous results, but also reported lower levels of psychological well-being, suggesting that therapeutic interventions should focus on reducing depressive symptoms in exposed individuals, as well as promoting well-being. Often, an excessive focus on psychopathology neglects important dimensions of the individual, such as well-being.¹³ Stigma related to death by suicide may be one of the factors that impact survivors' well-being.⁶ Suicide prevention programs should include strategies targeting broad-based populations aiming to reduce the stigma associated to death by suicide.

The primary limitation of the present study was the size of the sample and the cross-sectional nature of the design. Particularly, the group of participants whose family member died before his/her birth was too small (just 10 participants) to be compared to individuals exposed during life time and to the control group. Secondly, we relied solely on self-report measures to assess depressive symptoms and psychological well-being. Also, the obtained effect sizes were small. Finally, it should be noted that the Google platform does not reregister individuals that start responding but discontinue their participation before the end of the protocol.

Ethical considerations

Authors declare that the research meet all the guidelines of the Portuguese Psychologists Board

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Declaration of competing interest

Authors declare no conflict of interest.

References

1. Andriessen K, Krysinska K, Grad O. Preface. In: Andriessen K, Krysinska K, Grad O, eds. *Postvention in Action: The International Handbook of Suicide Bereavement Support* (pp. xv-xviii), Göttingen, Germany: Hogrefe; 2017.
2. Bellini SM, Ricci F, Migliorati M, et al. Survivors of suicide: a research on the consequences of a loss for suicide. *Eur Psychiatry*. 2016;33:323–4.
3. Jordan JR, McIntosh JL. Suicide bereavement: why study survivors of suicide loss? In: Jordan JR, McIntosh JL, eds. *Grief after Suicide: Understanding the Consequences and Caring for the Survivors*, New York, NY: Routledge; 2011:3–17.
4. Kessing L, Agerbo E, Mortensen P. Does the impact of major stressful life events on the risk of developing depression change throughout life? *Psychol Med*. 2003;33:1177–84.
5. Li N, Zhang J. Influencing factors for depression among Chinese suicide survivors. *Psychiatry Res*. 2010;178:97–100.
6. Corrigan PW, Shhehan L, Maya A, et al. Insight into the stigma of suicide loss survivors: factor analyses of family

- stereotypes, prejudices, and discriminations. *Arch Suicide Res.* 2018;22:57–66.
7. Santos S, Campos RC, Tavares S. Suicidal ideation and distress in family members bereaved by suicide in Portugal. *Death Stud.* 2015;39:332–41.
 8. Campos RC, Holden R, Spinola J, Marques D, Santos S. Exposure to suicide in the family: suicidal ideation and unmet interpersonal needs in young adults who have lost a family member by suicide. *J Nerv Ment Dis.* 2020;208:201–7.
 9. Massé R, Poulin C, Dassa C, Lambert J, Bélair S, Battaglini A. Élaboration et validation d'un outil de mesure du bien-être psychologique: L'É.M.M.B.E.P. *Revue Canadienne de Santé Publique.* 1998;89:352–7.
 10. Monteiro S, Tavares J, Pereira A. Adaptação portuguesa da Escala de Medida de Manifestação de Bem-estar Psicológico com estudantes universitários portugueses. *Psicologia Saúde & Doenças.* 2012;13:66–77.
 11. Radloff LS. The CES-D scale: a self-report depression scale for research in the general population. *Appl Psychol Meas.* 1977;1:385–401.
 12. Gonçalves B, Fagulha T. The Portuguese version of the Center for Epidemiologic Studies Depression Scale (CES-D). *Eur J Psychol Assess.* 2004;20:339–48.
 13. Seligman M, Steen TA, Park N, Peterson C. Positive psychology progress: empirical validation of interventions. *Am Psychol.* 2005;60:410–21.