Family functioning of suicide attempters*

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Family factors are important in suicidal behavior. Available research so for indicates that family functioning is considerably disturbed in individuals who have attempted suicide. The purpose of this study was to compare suicide attempted, depressed without a suicide attempt and normal individuals as well as their families with regard to family functioning. Family Assessment Device(FAD) was utilized in this study. The results showed that perception of family functioning was significantly disturbed in suicide attempted individuals as compared to those in depressed and normal controls. When the families in three groups were compared no statistically significant difference was found. On the other hand when a similar comparison was carried out between suicide attempters, dépressives and normals in regard to their family members it was found that in suicide attempted group there were significant findings in problem solving, communication, affective responsiveness and in general functioning subscales. In the depressive group without suicide attempts there were significant findings in affective responsivenes, behavior control and in general functioning subscales, in normal controls such a finding was not encountered. [Turk J Med Res 1994; 12(1): 34-42]

Key Words: Family functioning, Suicide, Depression.

Research on the family's role in suicide is of major interest as shown in recent studies. Studies looking at familial factors have tended in general to explore genetic associations, losses and non specific family stresses (1-4). They suggested that suicide attempts are related to disturbed home environment. Families of suicide attempters have been described as having difficulties with communication, problem solving, marital role and adjustment (4-8).

These families may be characterized as having an inflexible family system. Inability to accept necessary changes, role conflicts of family members, lack of communication and intense hostile interacitons occur in these families (1,9-12). Suicidal subjects, adolescent or adult, perceive their family functioning negatively. They report not only poorer familial relationships but receiving less support and affection from the family members as well (5,6,13-15). In a study investigating family functionig of suicide attempted adolescents using Family Assessment Device, suicide attempters perception of his/her family were worse than normal adolescents on problem solving and communication dimensions (17). Authors in this study focused on suicide attempters perception of their family functioning but recent studies indicate that suicidal behaviour is commonly associated with a discrepancy between the suicide attempters' perception and the perception held by other family members (18).

Depressive illness continues to be associated with high rates of suicide. It is also clear that depression is associated with significant degree of family dysfunction (18-22). Keitner et al compared the family functioning of suicide-attempting and non-suicidal depressed group. The results showed that suicide-attempted group perceived their family functioning more negatively than non-suicidal depressed group. A discrepancy between the perception of the suicidal group and their families were found. They also reported that non-suicidal depressed patients had a more positive view concerning their family functioning than the rest of their family members (18).

The purpose of this study was to investigate the family functioning of suicidal, non-suicidal depressive

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and normal control families. We searched the answers to following questions:

1. Are there differences in family functioning between suicide-attempters, non-suicidal depressives and normal-control individuals groups?

2. Are there differences in family functioning between the families of suicide attempters, depressives and nonmal individuals?

3. Are there differences in family functioning within the individual families. Are the perception of family functioning of suicid-attempted, depressed and normal members different from the other family members.

MATERIALS AND METHODS

Subjects: The study sample consisted of 62 suicidel-attempters, 35 non-suicidal depressives, 38 normal control subjects and their 189 family members. Sociodemographic variables are given in Table 1.

Suicide-Attempters (n=62): Subjects in this group were referred to Crisis Intervention Center from the Emergency Service of Medical School of Ankara University. All of the subjects had no psychotic symptoms and their Bech Depression Inventory scores were 17 and over. There were 44 (71%) women and 18 (29%) men. Mean of their age were X=22.2 (SD=7.65) and average years of education were X-8.69 (SD=3.44). In regard to marital status 37 (59.7%) were single, 24 (38.7%) married and 1 (1.6%) divorced. Forty-six (74.2%) subjects were from nuclear. 11 (17.7%) from extended and 5 (8.1%) subjects were a member of a broken home. Position of the suicide attempters in the families were; 20 wives, 4 husbands and 38 children of 62 had one or more past attempts and 5 subjects had a suicide attempted member in their families.

Families of suicide attempters (n=85): Family members who participated in the study includes 17 husband, 3 wives, 22 mothers and 17 fathers, 21 brothers or sisters and 5 others. Mean of age and education were 34.20 years (SD=11.35), 7.76 (SD=3.83) years respectively. Average number of family members were 4.66 (SD=1.67).

Non-Suicidal Depressives (NSD, n=34): This group consisted of patients from the Outpatient Service of Psychiatry Clinic of Medical School of Ankara University. Patients who met the criterias below were admitted to the study: (1)-DSM III-R criteria for mild or moderate major depression, (2)- A total score of 17 and over from the Beck Depression Inventory. Assessment of suicide potential by the clinician revealed that their suicide potential were low. As with the suicide group, they had no psychotic symptoms. There were 22 (62.9%) women and 13 (37.1%) men in this group. Mean of their age were 33.53 (SD=12.04) and average years of education were 10.70 (SD=4.4.6). There were 15 (42.9%) single, 18 (51.4%) married and 2 (5.7%) divorced patients in the group. Percentage of the subjects who were the member of a nuclear family were high (n=32, 94.2%). Position of the non-suicidal depressives were 13 wives, 6 husbands and 16 children.

Families of depressed patients (n=54): Family members who agreed to participate in this study were 13 husbands, 3 wives, 11 brothers or sisters, 6 children, 8 mothers and 9 fathers. Mean age and education were 38.04 (SD-11.07) and 10.64 (SD=4.30) years respectively. Average number of family members were 3.60 (SD=1.50).

Normal-Control Subjects (NC, n=38): The members of this group were chosen from the non-clinical families in a university community. Mean of age 20.05 (SD=4.98) and education were 11.47 (2.57) years respectively. There were 29 (76.3%) women and 9 (23.7%) men in the group. Percentage of the single individuals were high (32, 84.2%). In regard to family structure, 5 (13.2%) were from a broken home, 29 (76.3%) from nuclear and 4 (10.5%) were member of an extended family. There were 5 wives, 1 husband and 32 children.

Families of normal controls (NCF n=50): 1 wife, 5 husbands, 24 mothers, 17 fathers and 7 brothers or sisters of the subjects participated in this study. Families had neither past psychotic illness nor acute medical problems. Mean of age were 41.46 (SD=6.65) and education were 9.74 (SD=4.85) years respectively. Average number of family members were 4.1 (SD-1.37).

Univariate analyses of variance indicated that there were significant differences between the groups on age (F: 2.133=27.23 p<.001) and education years (F: 2.133=8.27 p<.001) but there did not exists any differences between the sexes. Non-suicidal depressive subjects were older than control and suicide attempters. Also the mean education years of suicide attempters were lower than normal and depressed groups. Groups were similar in marital and family status.

Assessment of Family Functioning

Family functioning were assessed by using the Family Assessment Device (FAD). FAD is a 60 item self-report questionnaire which asks family members to rate how well each item describes their family functioning on a four point scale (23,24). It is based on the Mc Master Model of Family Functioning and measures six dimensions as well as overall level of family functioning. The seven subscales Include, Problem Solving, Communication (CM), Roles (RL), Affective Responsiveness (AR), Affective Involment (AI), Behaviour Control (BC) and General Functioning (GF). FAD can be administered to individuals over the age of 12. The highest score which can be taken from the questionnarie is 4. Higher scores reflect worse functioning. Family scores can be computed using the average of all family members (24).

Table 1. Sociodemographic characteristics of suicide atempters, non-suicidal depressives, normal control group and their families.

Groups n=135	Gender Male n (%)	Gender Female n (%)	Age $\bar{X}$ (SD)	Education years $\bar{X}$ (SD)	Maital Status Single n (%)	Maital Status Married n (%)	Maital Status Divorced n (%)	Number of family members $\bar{X}$ (SD)
Suicide Attemters n=62	18 (29)	44 (71)	22.2 (7.65)	8.69 (3.44)	37 (59.7)	24 (38.7)	1 (1.61)	4.66 (1.67)
Non. S. Depressives n=34	13 (37.1)	22 (62.9)	33.53 (12.04)	10.70 (4.46)	15 (42.9)	18 (51.4)	2 (5.7)	3.6 (1.50)
N.Control n=38	9	29	20.05	11.47	31	6	—	4.1

Family Status			Roles in Groups				Families	
Nuclear n (%)	Extended n (%)	Separeted n (%)	Wife n (%)	Husband n (%)	Child n (%)	Past Scuide Attempt n (%)	Age n (SD)	Education X (SD)
46 (74.2)	11 (17.7)	5-, (8.1)	20 (32.2)	4 (6.5)	38 (61.3)	19 (30.6)	85 34.20 (11.35.)	7.76 (3.83)
5 32 (94.2)	1 (2.9)	1 (2.9)	13 (37.1)	6 (17.1)	16 (45.8)		54 , 38.04 (11.07)	10.64 (4.30)
29 (76.3)	4 (10.5)	5 (13.2)	5 (13.1)	1 (2.6)	32 . (84.3)	—	50 41.46 (6.65)	9.74 (4.85)

The psychometric properties of the FAD have been described in previous publications (23,24). Published data suggest that FAD subscales have adequate internal consistency (.72-).(92), adequate test-retest reliability (.66-) (.76) and a moderate correlations with other measures of family functioning and low correlation with social desirability (.06-.19). FAD has also been found to differentiate between families rated as healthy or unhealthy by experienced clinicians for each dimensions. It has been used in several previous studies investigating family functioning of psychiatric patients. Specifically family functioning of depressed patients (18-22).

FAD has been adapted to Turkish Culture by Bulut Test-retes reliability coefficients of 7 subscales of FAD ranges from .62 to .90 and internal consistency coefficients for PS-CM, RL, AR, AI, BC and GF are .80, .71, .42, .59, .38, .86 respectively. Turkish version of FAD has been found to have adequate internal consistency and test retest reliability (25).

Concurrent validity of Turkish version of FAD were tested with Marital Satisfaction Questionnaire. Correlation coefficient between the General Functioning Subscale and Marital Satisfaction Questionnaire was .66. Bulut examined the construct validity of FAD by comparing divorced couples with couples who had

Table 2. FAD mean scores of suicide attempters non-suicidal depressives and control groups

	N	X	SD	F (df=2.133)	P
Problem Solving (PS)					
Suicide Attempters	62	2.45	.81		
Non-Suicidal Depressives	35	2.18	.83		
Normal Control	38	1.83	.67	7.55	.0008
Communication (CM)					
Suicide Attempters	62	2.38	.65		
Non-suicidal Depressives	35	2.08	.61		
Normal Control	38	1.81	.53	10.58	.0001
Roles (RL)					
Suicide Attempters	62	2.25	.51		
Non-Suicidal Depressives	35	2.16	.65		
Normal Control	38	1.83	.43	7.48	.0008
Affective Responsiveness (AR)					
Suicide Attempters	62	2.48	.85		
Non-Suicidal Depressives	35	2.14	.77		
Normal Control	38	1.86	.65	7.77	.0006
Affective Involvement (AI)					
Suicide Attempters	62	2.35	.52		
Non-Suicidal Depressives	35	2.22	.57		
Normal Control	38	1.93	.39	8.39	.0004
Behavior Control (BC)					
Suicide Attempters	62	2.08	.58		
Non-Suicidal Depressives	35	2.10	.58		
Normal Control	38	1.71	.48	6.20	.002
General Functioning (GF)					
Suicide Attempter	62	2.35	.75		
Non-Suicidal Depressives	35	2.08	.66		
Normal Control	38	1.68	.56	11.60	.000

minimum marital distress (25) differentiated the two groups on all dimensions. Besides for construct validity, families with or without a psychiatric patient were compared. Families who had a psychiatric patient had higher scores on 7 scales of FAD and the mean scores of these families were statistically significant. So the Turkish version of FAD is a reliable and valid instrument for assessing family functioning.

Suicide-attempters, non-suicide depressives groups and their family members over the age of 12 administered the FAD in a week after their application. Whole family scores were computed using the average of all reporting family members by excluding the scores of the diagnostic groups from the calculation of the family means, family-only scores and including these scores to the family means whole-family scores were computed. Comparisons were made between suicide-attempters, non suicidal depressives and normal control groups and their families on whole family, family-only FAD scores using analyses of variance (ANOVA) techniques. The perception of suicide-attempted, non suicidal and normal member of the families were compared with perception of their family members by using paired t test in all subscales. Age and education years were covaried between the groups on FAD dimensions bu using covariance analyses. All analyses were performed by using the SPSS program.

RESULTS

Univariate analyses of variance were used to compare suicidal-attempted, non-suicidal depressed and control subjects scores on all dimensions of FAD as well as to compare the scores of their families. Mean scores and F values of each dimension of FAD concerning the suicide-attempted, non-suicidal and control groups are shown in Table 2.

On each dimension of FAD, significant differences were observed between the suicide attempters, non-suicidal depressives and control groups by using ANOVA. Univaritae variance analyses on PS, F (2,133)=7.55, CM, F (2,133)=10.58, RL, F (.133)=7.48, AR, F (2,133)=7.77, AI, F (2,133)=8.38 and GF (2,133)=11.60 of FAD were significant at the p<001) level and BC, F (2,133)=6.20 were significant at the p<0.01 level. Mean comparisons using the Tukey test at the p<.05 level were then employed to examine specific differences between the groups. These comparisons indicated that suicide attempted group had higher mean scores than normal group on all of the FAD scores. Non-suicidal depressive group's mean

Table 3. Whole-family meanFAD scores: suicide attempters, non-suicidal depressives and normal control groups

	N	X	SD	F (df-2.133)	P
Problem Solving (PS)					
Suicide Attempters	62	2.20	.57		
Non-Suicidal Depressives	35	2.01	.61		
Normal Control	38	1.71	.49	9.07	.0001
Communication (CM)					
Suicide Attempters	62	2.21	.52		
Non-suicidal Depressives	35	1.98	.50		
Normal Control	38	1.81	.52	7.49	.0008
Roles (RL)					
Suicide Attempters	62	2.18	.40		
Non-Suicidal Depressives	35	2.06	.46		
Normal Control	38	1.85	.42	6.79	.001
Affective Responsiveness (AR)					
Suicide Attempters	62	2.22	.59		
Non-Suicidal Depressives	35	1.97	.55		
Normal Control	38	1.78	.54	7.28	.0001
Affective Involvement (AI)					
Suicide Attempters	62	2.31	.34		
Non-Suicidal Depressives	35	2.15	.45		
Normal Control	38	1.95	.40	10.26	.0001
Behavior Control (BC)					
Suicide Attempters	62	2.02	.44		
Non-Suicidal Depressives	35	1.93	.37		
Normal Control	38	1.73	.38	5.98	.003
General Functioning (GF)					
Suicide Attempter	62	2.16	.55		
Non-Suicidal Depressives	35	1.92	.50		
Normal Control	38	1.65	.48	11.38	.000

scores were different from normals on RL, AI, BC and GF. The two diagnostic groups reported that their family functioning were worse than normal group. Finally suicide attempted and non-suicidal group didn't differ from each other on any measure.

When whole family (including the patient) FAD scores were compared on each dimension of FAD between the families, ANOVAS were significant at P<.001 level on PS, F (2.133)=9.07, CM, F (2.133)=7.49 RL F (2.133)=6.79 RL F (2.133)= 6.79 P<001 AR, F (2.133)=7.28, GF, F (2.133)=11.38, AI, F(2.133)=10.26 at the P<.01 level on BC, F (2.133)=5.98 dimensions. Whole-family mean scores of suicide attempters were higher with respect to the normal whole-family mean scores. Although the non-suicidal whole family FAD scores were higher than normal families the differences between the two families were insignificant (see Table III).

Family-only FAD scores were compared between the 3 families again by using analysis of variance (see Table IV). Results of the ANOVAS indicated that there were significant differences between the families on family-only scores were inconsistent when age and education were covaried. Significant differences on PS, RL and GF dimensions were non-significant when age and education were adjusted which points out the effectiveness of these variables on the so called scales.

The perception of family functioning among the suicide'attempters, non-suicidal depressives and control subjects with the rest of their family members were compared be using paired-t test (see TABLE V). On each dimension of FAD, mean scores of control subjects and their family members were insignificant (p<.005). However in the non-suicidal depressive group on AR (t=2.36, p.05), BC (t=2.33, p<0.05) and GF (t=2.57, p<0.1) subscales there were significant perception differences between the patient and rest of the family members. In these dimensions non-suicidal depressed group reported poorer functioning than their family members. Similarly suicide attempters when compared to his/her family members perceived poorer functioning on overall functioning (t=2.65, p<.001). Besides there were significant differences on PS (t=3.42, p<.001) and CM (t=2.54, p<.01) dimensions of FAD between the suicide attempted group and their respective family members. Mean differences on RL, AI and BC were not significant in comparisons within the suicide-attempters' family.

DISCUSSION

Family factors are important in increasing the vulnerability to suicidal behaviour. Self-destructive behaviour is associated with aspects of family dysfunction.

Table 4. Family -only men FED scores: suicide attempters, non-suicidal depressives and normal control groups

			SD	(df=2.133)	
Problem Solving (PS)					
Suicide Attempters	62	2.03	.70		
Non-Suicidal Depressives	35	1.95	.62		
Normal Control	38	1.64	.55	4.37	.or
Communication (CM)					
Suicide Attempters	62	2.12	.68		
Non-Suicidal Depressives	35	1.95	.54		
Normal Control	38	1.83	.64	2.58	.079
Roles (RL)					
Suicide Attempters	62	2.14	.53		
Non-Suicidal Depressives	35	1.96	.49		
Normal Control	38	1.86	.47	4.00	.02*
Affective Responsiveness (AR)					
Suicide Attempters	62	2.04	.74		
Non-Suicidal Depressives	35	1.86	.57		
Normal Control	38	1.72	.62	2.69	.07
Affective Involvement (Al)					
Suicide Attempters	62	2.30	.47		
Non-Suicidal Depressives	35	2.11	.53		
Normal Control	38	1.97	.52	5.59	.004
Behavior Control (BC)					
Suicide Attempters	62	1.98	.58		
Non-Suicidal Depressives	35	1.82	.44		
Normal Control	38	1.76	.38	2.53	0.83
General Functioning (GF)					
Suicide Attempter	62	2.04	.70		
Non-Suicidal Depressives	35	1.83	.54		
Normal Control	38	1.64	.52	5.08	.007*

* Nonsignificant when age and aducation were covaried.

The results of this study indicated that suicide-attempters' family (whole-family) perceived poorer functioning on all dimensions of FAD than normal (19). However there was no diffrences between families of suicide-attempters compared to non-suicidals which is in agreement with our results. Also Keitner in the above mentioned study found that using whole family scores non-suicidal families perception of their family differed from control families. This finding is inconsistent with the finding of this study in which there were no significant differences between families of non-suicidal depressives and normals.

In Keitner et al study the sample consisted of in-patients diagnosed as major depression but in our study depressed patients were outpatients diagnosed as mild or moderate major depression (19). Inconsistent results between the two studies can be due to cultural differences.

Previous studies and the present study of family functioning using FAD showed that mean scores of FAD dimensions were lower than American Scores (26,27). Bulut in reliability and validity studies of Turkish FAD pointed out that Turkish families with a psychiatric patient had lower scores than American families and this was due to cultural differences or life style of our families (26). Moreover in the present study mean scores of families on FAD dimensions were not high as in the Miller et al, and Keitner et al studies (19,22).

Whole family scores of suicide attempters were similar to their suicidal member indicating dysfunction on several dimensions in respect to normals. Although the family-only scores were higher than normals and non-suicidal groups only on Al there were significant differences betweeen the families when family only scores were compared and adjusted for age and education. Therefore the significant differences on whole family scores between the normal and suicide attempters' family may be the result of higher scores of the suicide attempted member.

Suicide attempters were from large and crowded families and their educaiton level were low in respect to normal families. Families reported that within the family they show only minimal interest and concern for each other. This may be the characteristics of families from lower educational levels. In these families interest, care and supportive behaviors family members invest on each other is restricted.

Table 5. t Values of mean FAD scores of suicide attempters, non-suicidal depressives, normal conrol members vs other family members.

	FAD SCALES						
Groups	P.S	CM	RL	A.R	A.I	B.C	G.F
SAvs Fam.Mem.	t=3.41 ***	132.54**	NS	t=3.39"*	NS	NS	t=2.65"
N.D.S. vs. Fam.Mem.	NS	NS	NS.	t=2.36*	NS	t=2.33*	t=2.57**
N.C. vs. Fam.Mem.	NS	NS	NS	NS	NS	NS	NS

p<05,"p<01,"p<001
P.S.: Problem Solving **CM:** Communication **RL:** Roles **AR:** Affective Responsiveness **AI:** Affective Involvement
B.C.: Behavior Control G.F: General Functioning NS: Nonsignificant

Stressful home environment of suicide attempters has repeatedly been emphasized in the literature. Lack of communication, problem solving difficulties, lack of support and empathy as well as intense hostile interactions and role conflicts of family members are. the characteristics of such families (1,6,9,11,12,16,17).

In this study suicide-attempted group perceived their family members as being unloving, rejecting and nonsupportive. They also reported that there was lack of communication, problem solving difficulties as well as problem in maintenance of the family's standards and boundaries. Eğilmez et al in the study on suicide-attempted adolescents reported that home environment of suicide attempters were chaotic and they were more often physically abused for maintaining discipline (5). De Wilde et al also stresses the importance of adolescents experiencing turmoil in childhood and not stabilizing in adolescence (28). These studies points out the long-term dysfunctioning of suicide attempters families. Dysfunctional families may lead the individual to isolation, loneliness and to suicidal behaviour. 19 of 62 subject in suicide attempted group had a past attempt. This may be due to using as a way-out of their destructive relational patterns of feeling lack of support to help them out of their depressed state.

Seriousness of suicidal intent is strongly associated with negative expectancies and negative attitude toward the future than with depression (29). Suicide attempters' distorted cognitions may lead the subject to view his/her family functioning more negatively which may reflect a sense of hopelessness and helplessness particularly about the interpersonal relations which has been the strongest predictor of suicidal behavior (30).

Results of present study can not differentiate out whether the suicide attempt of a family member which is **a** life threatening behavior and not approved in Turkish society because of religious beliefs threw the family into crisis or were these families dysfunctional for a long time? These questions can only be addressed over time by looking at families after the treatment of the suicidal member.

As with the suicide-attempted, non-suicidal group reported poorer functioning on AI, BC and GF than normals. Comparisons with their families pointed out that non-suicidal depressives perceived worse functioning on AR, BC and GF than their other family members. In contrast to the patient, families did not perceive dysfunction on any dimension compared to normals and suicide attempters families. Observed differences may be due to the cognitive distortions of non-suicidal group which is effective in perception of family functioning. In Miller and Norman study, patients with high distoriton showed persistent depressive conginitions after clinical improvement (31).

Non-suicidal depressives, family-only scores on several dimensions were below the cut-off point which is 2 in FAD. So families' perception of their functioning were in the healthy range but families may manifest unhealthy functioning in one or more areas. Whether this findings is due to cultural differences or due to the misperception of the families, cannot be answered by this study so further studies with larger samples of depressed families is needed.

Patients in non-suicidal group were in the acute episode and this may have affected their scores. If a member of a Turkish family has an illness whether physical or psychiatric, family members usually get together in times of emergency but this may have been considered as over protectiveness.

There are studies investigating the association between family functioning and the course of depressive illness, as well as with recovery and relapse of an illness (19-22). Family functioning during the acute episode was found to be associated with recovery. Ac-

cording to the results of these studies recovery was associated with older age at onset of depression, being male, lower level, of family dysfunction and average premorbid family functioning (21). Although family functioning was not associated with speed of recovery, positive changes in family functioning during the course of illness were associated with faster recovery times. Stressful, unsupportive social environment have been found consistently to be associated with higher rates of relapse (8). The findings of these studies points out the importance of the association with family functioning and the course of depressive illness. It is clear that further research which assesses family functioning during the acute episode and after remission will be necessary to address the issue.

Finally in this study suicide attempters and their families perceived their family functioning worse than normals. Suicidal behaviour is not determined by one variable Needless to add, factors other than family functioning must be taken into consideration but family functioning may help to identify those most at risk for suicide together with other variables. In clinical assessment family factors, especially family functioning must be taken into consideration and clinicians should consider family therapy for suicide attempters.

Aile işlevi, intihar girişimi ve depresyon

İntihar davranışında aile ve aile işlevi önemli bir faktördür. Çalışmalar intihar girişiminde bulunan bireylerin aile işlevlerinn oldukça bozuk olduğuna işaret etmektedir. Bu çalışma intihar girişiminde bulunan, girişimi olmayan depresif ve normal bireyleri, aynı zamanda ailelerini aile işlevleri açısından karşılaştırmaktadır. Aile Değerlendirme Ölçeğinin kullanıldığı çalışmada, intihar girişimi grubu, aile işlevlerini gerek depresif gerekse normal gruptan daha bozuk algılamaktadır. Üç grubun aileleri karşılaştırıldığında, aileler arası anlamlı bir farklılık bulunamamıştır. İntihar girişimi olan ve olmayan depresif ve normal bireyler diğer aile üyeleri ile karşılaştırıldığında intihar girşimi grubunda problem çözme, iletişim duygusal tepki verme ve genel fonksiyonlar alt testinde işlevleri bozuk algılamaktadır. Normal grupta ise diğer aile üyeleri karşılaştırıldığında alt testler açısından anlamlı bir farklılık saptanamamıştır. [Turk J Med Res 1994; 12(1):34-42]

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