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A Suicidal Family

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The familial incidence of affective illness is well documented. Many studies have shown identical twins to be highly concordant for affective illness (e.g. Price, 1968; Tsuang, 1977). Suicide is strongly linked with affective disorder. However, few cases of both twins committing suicide have been described, and the family reported here, in which several other members also committed suicide by violent means, is thought to be of considerable interest.

The Cases

A, a single man, aged 21 at the time of his death, was one of identical twins. He was a quiet, hard working man with few interests and rarely went out with friends. In 1970 he became increasingly depressed over about three months. He lost interest in things and his appetite and sleep pattern were impaired. Psychiatric help was not sought. He suffered from a detached retina and feared that he might become blind. He shot himself on the day he was due to enter hospital for an operation on his retina.

B, the identical twin of A, was of similar temperament and had shared the same interests. He was first seen by a psychiatrist eleven days after his brother's death, having become severely depressed. He began to express feelings of guilt about his brother's death and to have suicidal ideas and was admitted to a psychiatric hospital. He was treated with chlordiazepoxide and psychotherapy and made a good recovery. He was discharged after a week but readmitted a few weeks later, having again become depressed. On this occasion he received electroconvulsive therapy (ECT) and amitriptyline and recovered well. In 1978, he again became depressed and responded satisfactorily to out-patient ECT and amitriptyline. One year later, in July 1979, he had to be readmitted to hospital with a further depressive episode, again making a good recovery with ECT and amitriptyline. He married in September 1979. In December 1979 he again became very depressed. At about the same time, his father was admitted to a psychiatric hospital because of a depressive illness. One week later, he was found dead by his wife, having shot himself in the chest with his shot-gun.

Mrs C, the mother of A and B, experienced a grief reaction after her son's suicide in 1970. She was then 44. About six months later, she was referred to a psychiatrist and was found to have many symptoms of a true depressive illness, including diurnal variation of mood, impaired energy and concentration, weight loss and feelings of hopelessness. Previously she had been a stable effective person. She responded to out-patient ECT and clomipramine. She relapsed twice during the next two years, responding on each occasion to ECT and clomipramine. She maintained good progress until her second son committed suicide. She is still taking treatment and is on nomifensine and chlordiazepoxide.

Mr C, 54, father of the twins, has been admitted to hospital on three occasions since December 1979 because of a depressive illness. Previously a conscientious man, his depression was characterized by early morning waking, diurnal variation of mood, anorexia, anergia, impaired libido, self-criticism and loss of interest. On the first two occasions, he recovered on tricyclic antidepressants and ECT but soon relapsed. He was readmitted to hospital in April 1980 having cut his wrists and his throat. While on leave, he took an overdose of clomipramine in October 1980. At the present time, he is still a patient in a psychiatric hospital.

Mr and Mrs C have a third son and two daughters, none of whom has as yet shown any evidence of psychiatric disorder. However, it is interesting to note that the elder daughter is married to a man who suffers from a recurrent depressive illness.

Mrs C's father committed suicide by cutting his throat at the age of 73, three years after his wife died.

Mr C's mother, who is 80, suffered from a depressive illness necessitating in-patient treatment at the age of 74. She recovered and remains well.

Mr C's grandfather committed suicide by cutting his throat. It has not been possible to obtain further information about him.

Discussion

Opposing views have been expressed on the possibility of a genetic determination of the impulse to suicide, some against (Shneidman and Farberow, 1961; Kallman, 1953) and others in favour. The most substantial evidence is that of Haberlandt (1967) who, in an excellent review, described 98 dizygotic twin

pairs and 51 monozygotic twin pairs at least one of whom had committed suicide. He found 9 sets of monozygotic twins (18 per cent) who had both committed suicide; in a further five pairs (10 per cent), one had committed and the other had attempted suicide. No concordant dizygotic pairs were found. Haberlandt (1965) noted that the relatives of completed suicides had a higher suicide rate than the general population and this was supported by the evidence of Farberow and Simon (1969).

In this family only male members committed or attempted suicide and all of them chose violent means. One explanation which might at first be considered is that their behaviour was imitative. However, the suicide of the paternal great-grandfather and that of the maternal grandfather involved two people who had never lived together or indeed known one another so that this suggestion is inadequate here. In addition, the fact that the acts of the twins were widely separated in time also makes it seem unlikely. Although the female members showed no suicidal behaviour they did express suicidal ideas when depressed. The impulse to suicide seemed therefore partly determined by the occurrence of depressive illness but this does not plausibly explain such a high incidence of violent suicide in a single family. It therefore seems at least likely that there was a genetic predisposition to violent suicide in this family.

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