A HOMELESS GIRL CONTEMPLATES DROWNING HERSELF

Suicidal ideation and its correlates are common among homeless adolescents.

(Kidd, 2006)

CHAPTER – 1: INTRODUCTION
SYNOPSIS

Introductory chapter highlights on the concept of suicide, with special focus on suicide ideation, relevant risk and resilient variables and the objectives of the current study under the following titles:

1. CONCEPT OF SUICIDE
   
   I MEANING OF SUICIDE
   
   II TERMS FOR SUICIDAL BEHAVIOR
   
   III DEFINITIONS OF SUICIDE
       A Suicide
       B Para suicide
       C Suicide Ideation
       D Suicide Plan
       E Suicide Attempt
   
   IV CHARACTERISTICS OF SUICIDE
   
   V DIMENSIONS OF SUICIDE
   
   VI PSYCHOLOGICAL CONCEPT OF SUICIDE

2 SUICIDAL IDEATION: A SEED OF SUICIDE

3 RISK AND RESILIENT FACTORS

4 OBJECTIVES OF THE PRESENT STUDY
CHAPTER 1

INTRODUCTION

“Whoever kills himself becomes abhisapta (guilty of mortal sin)”.  

(Vashistha)

Almost every other day the news from media carry an account of suicide committed by one person or the other. Some from rich or some from poor families; some from educated families and some from illiterate families commit suicide. Some are politicians, some are industrialists, some are stars, some are scientists, some are teachers, some are students, some are labourers, some are farmers etc. In this way suicide is prevailing in all strata of the society. Some hang themselves, some jump from multi-storey building, some jump into water, some jump in front of fast running train, some burn themselves, some consume poison, some swallow sleeping pills and some end their lives by shooting firearms.

Suicide is as old as history of humanity. The history is replete with suicidal behavior. In other words, suicide is a worldwide phenomenon that can also be observed among great personalities of the world. Cleopatra (30 BC), Queen of Egypt committed suicide by inducing a snake to bite her. Adolf Hitler (1945); Austrian-born, Nazi Germany dictator committed suicide by shooting himself in the mouth to avoid capture by the Soviet military in his Fuhrer bunker in Berlin. His wife also committed suicide with him by ingesting cyanide. Freud persuaded his doctor and friend Max Schur to help him commit suicide to get relief from cancer. He took morphine on 22nd September, 1939 that resulted in Freud’s death on 23rd September, 1939. Heroic suicide, for the greater good of others, is also observed in history. For instance, in the 1960s, Quaker Norman Morrison committed suicide by self-immolation to protest the United States involvement in the Vietnam War. Similar events were reported during the Cold War in Eastern Europe, such as the deaths of Ryszard Siwiec and later of Jan Palach and Jan Zajíc following the Soviet invasion of Czechoslovakia, or Romas Kalanta’s self-immolation in the main street of Kaunas, Lithuania in 1972. During the infamous 1981 hunger strikes, led by Bobby Sands, which resulted in 10 deaths.

Thus, suicide is a world-wide phenomenon. Suicide has been troublesome because it is the only mode of death that depends specifically on a psychological motivation; that is, the death results from a conscious invitation of activities by the decedent that were intended to bring about his own demise. According to WHO suicide is one of the five major causes of death in the western countries. In the year 2000 an estimated 815,000 people died from suicide around the world. This represents an annual global mortality incidence of about 14.5 per 100,000 population (WHO 2002).

The suicide is studied by sociologists and psychologists, though generally it is considered a part of criminology, as an attempt to commit suicide was until recently a crime under section 309 of IPC. On 27th April 1994, the Supreme Court in a historic judgment struck down as unconstitutional section 309 of the Indian Penal Code which makes “attempted suicide” a punishable offence. The court observed that this section was violative of Art. 21 of the constitution which deals with the fundamental right of life and personal liberty.
CONCEPT OF SUICIDE

In fact, suicidology suffers from adequate concept of suicide in the literature. Therefore, the concept of suicide is here illustrated from dictionary meaning to psychological concept of suicide.

I MEANING OF SUICIDE: The investigation into the meaning of any word reflects the history and nature of phenomenon of any act, how it exists in society. The word suicide is of relatively recent vintage. It does not appear in the Bible nor in the famous pamphlet by John Donne (1644) on Self-Homicide.

A Hindi Meaning: Since the Vedic period the act of suicide has been referred in India in terms of Aatamaghatak, Atamhan or Atmahatya, that means self-killer or killing of self. In the Arthasastra, Kautilya prescribes very brutal punishment for those who commit Aatmahatya. (cf. Arthashastram).

B English Meaning: The Dictionary meaning of suicide is to kill oneself intentionally i.e. self-murder. Oxford Dictionary of Psychology (2009) states that the term “suicide” was first used in England in 1651 and derived from the modern Latin Word “suicidium” which in turn stems from the Latin Pronoun for “self” and verb “to kill”. One possible derivation is the word “Suist”, meaning a selfish man and “Suicism” meaning selfishness.

II TERMS FOR SUICIDAL BEHAVIOUR: In the literature, very many terms are used to explain different dimensions of suicidal behavior. For more holistic understanding of the concept of suicide, various key terms and concepts frequently used in the literature are here being discussed. Suicidology, the scientific study of suicide and suicide prevention, includes not only completed suicide and non-fatal attempted suicide but also partial self-destruction, suicidal gestures and ideation, parasuicide, deliberate self-harm, self-mutilation, and a panorama of related self-destructive behaviours (Maris, 1992).

Majority of the terms are related to suicidality revolve around Self Destructive Behaviour (SDB). It is important to distinguish between self-destructive behavior, attempted suicide (deliberate self-harm) and suicide. In fact, probably the majority of
self-destructive actions are partial, chronic, long-term and even unconscious. Perhaps, the larger group of self-destructive behaviors is what Farberow (1980) has labeled Indirect Self-Destructive Behaviors (ISDB), which he defined as behavior in which there is neither suicidal intention nor awareness or expectation of any suicidal outcome. O’Carroll, Berman, Maris, Moscicki, Tanney, & Silverman (1996) proposed a standard nomenclature, offering descriptive terminology, that falls into two broad categories:

A Instrumental behavior (that is, zero intent to die with other motivation such as help seeking, punishing others, or attention seeking).

B Suicidal acts (that is, intent to die).

The terms “suicide”, “suicidal”, “suicidal behavior”, “attempted suicide”, “para-suicide”, “suicidal intent”, “suicide ideation”, “completed suicide” and “deliberate self-harm” (or deliberate self-injury) are used inconsistently and interchangeably in the literature of suicidology. (Santa, Mina, & Gallop, 1998).

The terms suicide, attempt, self-harming behavior, and para-suicide are used commonly and sometimes interchangeably in the suicide literature (Santa, Mina, & Gallop, 1998). Additionally, the terms are not applied uniformly in research and practice (Kidd, 2003).

III DEFINITIONS OF SUICIDE: Suicidology, the study of suicide, has been confused and stagnated because of the lack of adequate standard definitions for suicidal behavior (Kidd, 2003). O’Carroll et al. (1996) proposed a nomenclature for suicide-related behavior in an attempt to solve this dilemma.

A Suicide: Suicide is defined as “the act of intentionally ending one’s own life” (Nock et al., 2008). O’Carroll et al. (1996) defined Suicide as ‘death from injury, poisoning, or suffocation where there is evidence (either exploit or impolite) that the injury was self-inflicted and that the decedent intended to kill himself/herself.

B Parasuicide: Parasuicide which refers to individuals engaging in self-harming acts without the explicit intent to end their lives but rather attract attention from significant others (Moore, 2000). Moreover, nonfatal suicidal thoughts and
behaviours can be categorized into three levels, increasing in severity: suicide ideation, suicide plan, and suicide attempt (Nock et al., 2008).

C Suicide Ideation: Suicide Ideation refers to “thoughts of engaging in behaviour intended to end one’s life” (Nock et al., 2008). O’Carroll et al. (1996) defined suicidal ideation as ‘any self-reported thoughts of engaging in suicide-related behavior’. Suicidal ideation which refers to the experience of thoughts, ruminations or fantasies about committing suicide or verbalising threats to commit suicide (Reynolds, 1988).

D Suicide Plan: Suicide plan is included in suicide ideation and it is a blueprint of final act. A suicide plan highlights on When, Where and How of a suicidal behavior. In other words, a suicide planning is a part of decision making when an individual decides about Time, Place and Mode of Suicide. A Suicide Plan is “the formulation of a specific method through which one intends to die” (Nock et al., 2008).

E. Suicide Attempt: Attempted suicide is described as acts where the intention is to bring about death, however the victim was unsuccessful (Schlebusch, 2005). In a suicide attempt individual seriously acts upon on his decision about ending his life. According to O’Carroll et al. (1996), it is not necessary for injuries to have occurred in order for this behavior to be classified as a suicide attempt. Therefore, a suicide attempt can be classified into two categories:

i Suicide Attempt with Injuries: A suicide attempt is defined as “the engagement in potentially self-injurious behaviour in which there is at least some intent to die” (Nock et al., 2008). According to O’Carroll et al. (1996) definition for suicide attempt includes the intent to kill oneself but the outcome of this potentially self-injurious behavior must be nonfatal. They also used the terms suicidal act and suicide-related behaviour to incorporate both suicide and suicide attempt.

ii “Suicide Attempt without Injuries” is defined as a potentially self-injurious behavior with a non-fatal outcome for which there is evidence (either implicit or
explicit) that the person intended at some level to kill him-or herself (O’Carroll, et al., 1996). These operational definitions are similar but not identical.

**IV CHARACTERISTICS OF SUICIDE**: From a cognitive behavioural therapy (CBT) perspective, suicide is consistent with a person’s thought processes. Although each suicide, like the person who commits it, is unique. Even though, Shniedman (1987) has proposed some common characteristics of suicidal behavior which illustrate fundamental factors of concept of suicide. These characteristics are:

A **Situational** aspect of suicide is – *Stimulus* (unendurable psychological pain)

B **Conative** aspect of suicide is – *Purpose* (to seek solution)

C **Affective** aspect of suicide is – *Emotion* (hopelessness / helplessness)

D **Cognitive** aspect of suicide is – *Cognitive state* (constriction: blocking of ideas)

E **Relational** aspect of suicide is – *Interpersonal act* (Communication of intention)

F **Serial** aspect of suicide is – *Consistency* (lifelong coping patterns)

**V DIMENSIONS OF A DEFINITION OF SUICIDE**: When one considered the many different conceptual treatments of suicide, it becomes reasonably clear that there are several fundamentally independent but related dimensions that are included in different combinations and to varying degrees in most if not all, of the definitions.

A The initiations of an act that leads to the death of the initiator.
B The willing or an act that leads to the death of the willer.
C The willing of self-destruction.
D The loss of will.

These dimensions are not entirely “pure”, some of them do overlap. But, they also seem to cover most of the important dimensions of meanings found in formal definitions of suicide in the Eastern World. They do not, however, completely cover
such definitions. It is possible to give at least three other dimensions that have been given in formal definitions:

A The degree of central integration of the decisions of an actor who decides to initiate an action that leads to the death of the actor.

B The degree of firmness or persistibility of the decision (or willing) to initiate an act that leads to the death of the initiator.

C The degree of effectiveness of the actions initiated by the actor in producing his own death.

Halbwachs’ (1930) definition, for example includes the dimension of intention as necessary (though not sufficient). The justification for this definition lies in the conception of the self or the individual’s being as essentially volitional. The argument has generally been vague, but the fundamental line of reasoning seems simple enough. Suicide is synonymous with “the destruction of the self by the self” The self is the willing or volitional factor of mind (body); therefore, suicide is synonymous with “the destruction of the will by the will (or the intentional destruction of one’s self).

VI PSYCHOLOGICAL CONCEPT OF SUICIDE : In the historical perspective, it can be stressed that the contemporary study of suicide began around the turn of the 20th century with the contributions of two major streams of thought: sociological and psychological. :

In 1897, Durkheim examined society’s effects on individual behaviour and posited that suicide was the result of society’s influences and control over the individual. In his book “Le Suicide” Durkheim formulated four types of suicide. The first, the ‘altruistic’ suicide was a result of society’s expectations of the individual. An example of this would be Hara-kiri, where the society’s customs dictate that the honorable action for the individual is to end one’s own life. The second is egoistic suicide. In the United States, the most frequent form of suicide is the ‘egoistic’ type where the individual has poor social support and poor ties to society. An example of this type is the older man without children who is recently divorced. The third category of suicide according to Durkheim’s theory is the ‘anomic’ suicide, where the individual’s relationship to society is suddenly shattered, such as when a person unexpectedly loses a job (Schneidman, 1979). Fourth type is ‘fatalistic’ suicide, applied to those persons whom economic growth and unemployment is too much.
A Psychological enquiry about suicide was first started by Freud, while Durkheim conceptualized the explanation of suicide in terms of societies’ influences on the individual. The first psychological explanation to suicide came from Freud (1917), who stated that self-hated seen in depression originated in anger towards a love object. This anger in the individual turned back on himself. He was firmly of the view that there would be no suicide without an earlier repressed desire to kill someone else. Freud postulated that the reasons for suicide were intra psychic. He theorized that suicide represents unconscious hostility aimed at the interjected (ambivalently viewed) love object. For Freud suicide was viewed as “murder in the 180th degree” (Schneidman, 1979). Other psychoanalysts have extended Freud’s perspective, for example, Karl Menninger (Kreitman, 1976) delineated the psychodynamics of hostility, postulating that the hostile drive in suicide had three components: (1) the wish to kill; (2) the wish to be killed; and (3) the wish to die (Schneidman ES, 1979).

In contemporary psychology, the suicide is also conceptualized in terms of steps leading to suicide, the process of suicide and as a continuum of suicidal behavior.

**A Steps Leading to Suicide** Suicidal behaviour psychologically follows predictable steps along a continuum towards completed suicide. The steps leading to a completed suicide include experiencing distress, suicidal ideation, suicidal planning and suicide attempts.

*The first step is experiencing emotional distress which*( lays the groundwork for all manner of suicidality. Emotional distress could entail any form of transition, difficulty or element that causes an individual upset. Examples might include: (a) a loss of event, (b) relationship problems, (c) drug use, (d) medical illness, (e) chronic pain, (f) mental illness, (g) substance abuse and (h) poor self-image or other dysphonic thought states (Irwin, La Gory, Ritchey, & Fitzpatrick, 2008).

*The second step is suicidal ideation or thoughts of suicide, which is considered a precondition for suicidal plans and suicide attempts* (Kessler et al., 1999). Most people who commit suicide move through each of these steps in a linear
fashion, going from distress to ideation to planning to actual attempts. Though some skip the planning step and go straight from ideation to attempting in an impulsive manner (Kessler et al., 1999). The following Stepwise Suicide Model explains the nature of phenomenon of suicide.

**MODEL I**

**THE STEPWISE SUICIDE MODEL**

Heikkinen, Hillevi, & Lonnquist (1993)

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**B The Process of Suicide**: In psychology, suicide is also conceptualized as a longitudinal process that goes through emotional, cognitive and behavioral steps before resulting in the loss of life. The process of suicide includes thought, plan (time, place, and method) attempt and suicide. It emphasizes on the role of biopsychosocial risk factors which contribute in the process of suicide. The following model of process of suicide by Vílhelmsdóttir, R., Kristjánsdóttir G., and Sveinbjarnardóttir, E. (1998) also elaborates the concept of suicide.
The Continuum of Suicidal Behaviour: Most of the psychologists agree to view suicide as a continuum from suicide ideation to completed suicide. It may also be important to keep in mind that suicidal behaviour and ideas are complex and may best be explained along a continuum of suicidality. One possible Continuum of Suicidality (Maris et al. 2000) is illustrated in the following figure.
### MODEL III
THE CONTINUUM OF SUICIDA BEHAVIOUR  
(Maris et al., 2000)

<table>
<thead>
<tr>
<th>Lowest -</th>
<th>Totally Non suicidal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diffuse risky lifestyle</td>
<td></td>
</tr>
<tr>
<td>Suicide Ideation (fleeting)</td>
<td></td>
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<tr>
<td>Suicide Ideation (Chronic)</td>
<td></td>
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<tr>
<td>Suicide like gestures</td>
<td></td>
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<tr>
<td>Suicide plan (Vague, Nonlethal)</td>
<td></td>
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<tr>
<td>Suicide Plan (Specific, lethal)</td>
<td></td>
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<tr>
<td>Suicide attempt (low-lethality)</td>
<td></td>
</tr>
<tr>
<td>Suicide attempt (high-lethality)</td>
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</tbody>
</table>

| Highest + | Completed Suicide |

Various terms for suicidal behavior are frequently used in the literature. **Suicidal behaviour can be viewed as an umbrella term which incorporates varying degrees of self-destructive or self-harming acts, which result from emotional distress (Schlebusch, 2005; Rutter, 1995).** Suicidal behaviour can further be divided into fatal and non-fatal suicide behaviour. The term completed or fatal suicide is used when the victim’s intent was to bring an end to his/her life and ultimately achieved this (Schlebusch, 2005). Non-fatal suicidal behaviour include three concepts namely: Attempted suicide is described as acts where the intention is to bring about death, however the victim was unsuccessful (Schlebusch, 2005). Parasuicide which refers to individuals engaging in self-harming acts without the explicit intent to end their lives but rather attract attention from significant others (Moore, 2000). Suicidal ideation which refers to the experience of thoughts, ruminations or fantasies about committing suicide or verbalising threats to commit suicide (Reynolds, 1988).
2. SUICIDAL IDEATION: A SEED OF SUICIDE

Suicidal ideation is the first link or lowest level of suicidal behavior. Suicidal ideation describes thoughts, fantasies, ideas or images related to committing suicide. This term is also referred to suicidal thinking. Thoughts of suicide can range from fleeting thoughts of suicide to making actual plans to end their life. Strictly speaking, suicidal ideation means wanting to take one's own life or thinking about suicide without actually making plans to commit suicide. However, the term suicidal ideation is often used to refer to having the intent to commit suicide, including planning how it will be done. Suicidal ideation is more common than suicide attempts or completed suicide.

Suicidal ideation refers to “thoughts of engaging in behaviour intended to end one’s life” (Nock et al., 2008). Suicide is viewed as an act in which the victim’s intent or aim was to die and this intended goal is achieved, while suicidal ideation is described as thoughts that people have about ending their own lives (Schlebusch, 2005). O’Carroll et al. (1996) defined suicidal ideation as ‘any self-reported thoughts of engaging in suicide-related behavior’. Suicidal ideation which refers to the experience of thoughts, ruminations or fantasies about committing suicide or verbalising threats to commit suicide (Reynolds, 1988). Many measures of suicidal ideation among adolescents confirm to the definition proposed by O’Carroll et al. (1996) and others include thoughts of death (Goldston, 2000). Some researchers use a broader definition of suicidal ideation that incorporates thoughts of death. For instance, Lewinsohn, Rohde, and Seeley (1996) define suicidal ideation as ‘thoughts or wishes to be dead or to kill oneself’

The following Stress and Coping Model of Suicidal Ideation (Moos & Schaefer, 1993) illustrates key factors of the nature and process of suicide ideation:
In the stress and coping model (Moos & Schaefer, 1993), suicidal ideation is considered the health outcome. (Panel 5). The personal system (panel 1) includes hope, self-esteem, and demographic factors as individual factors contributing towards suicidal ideation. The contextual influences (panel 2) such as financial stress, home environment and relationships within the adolescent’s domain were considered as environmental stressors and resources. The phase of human development (panel 3) focuses on the development of adolescents. The cognitive component (panel 4) is focused on coping strategies employed by adolescents in managing their challenging situations.
The nature of suicidal ideation is also viewed in terms of being either passive or active. Active suicidal ideation is when an adolescent experiences persistent thoughts of suicide and continues to feel hopeless. When the ideation is active, an adolescent begins to take steps to carry out a suicide attempt. Passive ideation about suicide includes experiencing vague ideas about committing suicide. Passive ideation is viewed as a possible way to end their pain, but usually no action is taken.

For example: Isha, age 18, feels very sad when her best friend moves away and she experiences a deep sense of loneliness and insecurity. One night she finds herself thinking about suicide as a way to end the painful feelings she is having. She pictures herself taking a bottle of pills and drifting into a deep sleep she will not wake up from. When she wakes up the next day her suicidal ideation has changed, she knows it’s an option but is feeling better and decides to call a friend she hasn’t spoken to in a while.

The severity of suicidal ideation lies in its persistence or temporary stability. Domènech-Llaberia, Canals, and Fernández-Ballart (1992) observed that 27% of girls and 18.4% of boys maintained these ideas at a 3-year follow-up. It seems reasonable to assume from the data that the children, in whom suicidal ideation persists, have a greater probability of developing more serious suicidal behavior when they reach adolescence. Suicidal ideation is a symptom of depression, but many children who meet all the diagnostic criteria of depression do not manifest it. Likewise, not all individuals with suicidal ideation suffer from depression. Carlson and Cantwell’s (1982) research clearly identified three groups of children: children who suffer from depression and suicidal ideation, children who suffer from depression but do not present suicidal ideation, and children with suicidal ideation who do not suffer from depression.

However, there seems to be a close relationship between depression and suicidal ideation. One theory has attempted to explain the peak in suicidal ideation (Kovacs, Goldston, & Gatsonis, 1993). This theory suggests that during early and mid-adolescence the number of distressing situations children encounter grows, but their number of response choices is small and largely based on observation of others’ distress responses. With few options to choose from, there is an increased likelihood
that any one response will be chosen. Therefore, among early and middle adolescents exposed to another’s suicidal behavior there is an increased likelihood of suicidality in response to distressing situations. The theory further suggests that suicidal ideation declines following its mid-adolescent peak, even among those exposed to others’ suicidality, because with age and experience adolescents develop a larger number of distress responses. As the number of choices for responding to distress increases, the chance of choosing any one response decreases.

One line of research with strong potential for improving our understanding of adolescent suicidal ideation views suicidality developmentally, examining age-related trends in suicidal thoughts, plans, or attempts. For example, empirical evidence indicates that, when assessed from early adolescence through young adulthood, suicidal ideation rates increase during early adolescence, reaching a peak during mid-adolescence at approximately the age of 14–15 years, and decline thereafter (Kessler et al., 1999). Most theories examining adolescent suicide begin with recognition of the importance of previous attempts and psychiatric diagnoses, primarily depressive disorders and anxiety. However, though the majority of suicide victims and attempters have a psychiatric diagnosis, this condition, though necessary, is not sufficient to explain suicidal behavior (Brent & Mann, 2003). Adolescent suicide is a difficult event to predict with an acceptable degree of accuracy. Many factors impact this decision, some related to individual characteristics, some to more distant, environmental factors. Risk factors are categorized into a number of domains, social and educational disadvantage, adverse events in the family and in childhood, psychopathology, personal vulnerabilities, stressful life events, and cultural and contextual factors (Martin, Richardson, Bergen, Roeger, & Allison, 2005).

King, Ruchkin, and Schwab-Stone (2003), discussing a “continuum of self destructiveness” in adolescence consider psychiatric diagnoses, including mood, substance abuse, disruptive and anxiety disorders. Damage to significant relationships may undermine coping skills, increasing the likelihood of stressful life events and emotional crises. They identify a third dimension when they suggest that some of these associations co-occur because of negative environmental influences, peers, family, neighborhood, and in interaction with the adolescent’s personality or temperament, these factors promote impulsivity, risk taking, and “thwart
development of coping skills and cognitive and moral development” A critical component in a number of theoretical perspectives about adolescent suicide (King et al., 2003) is recognition that impulsivity is an important contributor to adolescent suicide.

Predictions of suicidal behavior is based on suicide ideation approach that appears to be limited on several accounts. First, environmental model has demonstrated numerous environmental correlates of suicidal behavior. It has little practical utility in the assessment of the individual interacting with such factors. Second, model has in general demonstrated equivocal findings, with little utility in the assessment of the suicidal individual as well as his or her environmental interactions. (Bonner & Rich, 1987). It is important to note that the prediction of suicide is somewhat different from the assessment of suicide risk. Suicide prediction refers to the foretelling of whether suicide will or will not occur at some future time, often many months, based on the presence or absence of a specific number of defined factors, within definable limits of statistical probability. Suicide risk assessment, a clinical activity, refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail. From time to time confused clinicians conclude that because suicide cannot be predicted, clinical risk assessment is a clinical pursuit, and that one might as well toss a coin. Risk assessment done in a systematic, disciplined way is a reasoned and inductive process. It is a necessary exercise in estimating probability over short periods. But the fact remains that suicide prediction is beyond our reach.

In fact, suicidal ideation is a medical term which was observed from the patients of psychiatric disorders and attempted suicide. Although most patients with suicidal ideation do not ultimately commit suicide, the extent of suicidal ideation must be determined, including the presence of a suicide plan and the patient's means to commit suicide. An algorithm for the evaluation of suicidal patients explains the key components of suicide ideation. Following algorithm highlights on the key factors of suicide ideation that include the patient's suicide plan, access to lethal means, social support and judgment:
**MODEL V**

AN EVALUATIONAL MODEL FOR PATIENTS WITH SUICIDAL IDEATION

( Gliatto, M F & Rai, A K., 1999 )

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Suicidal Ideation

Patient expresses suicidal ideation

- Patient has a suicide plan
  - Patient does not have suicidal intent or plan
  - Patient has access to lethal means, has poor social support and poor judgment
    - Patient does not have access to lethal means, has good social support and good judgment
      - Is able to make a contract for safety
        - Hospitalize
        - Evaluate for psychiatric disorders or stressors
          - Treat with antidepressants, refer for alcohol rehabilitation, and individual and/or family therapy
            - Patient does not respond optimally
              - Refer to psychiatric consultant

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**CONCLUSION** Although suicidal ideation appears the least serious of all suicidal behaviour, it must not be assumed that suicidal acts are necessarily insidious starting from suicidal ideation and progressing to more life threatening behaviour. Some researches have indicated that no specific sequence exists in that your first suicide attempt may very well be a fatal suicide (Sehlebusch, 2005). **Adolescent Suicide Ideation is defined as serious, distressing thoughts about killing oneself.** Reasons for the increase and subsequent decline in suicidality from *early to late adolescence remain* speculative. Across different methodologies and measures, several studies now report a peak in *ideation rates at age 13-15 years* (Kessler et al., 1999). One line of research with strong potential for improving our understanding views suicidality developmentally, examining age related trends in suicidal thoughts, plans, or attempts.
3 RISK AND RESILIENT FACTORS

A predominant focus in contemporary suicidology has been the identification of risk and protective factors that influence suicide-related behavior (Rogers, 2001). This focus has revealed various biological, psychological, sociological, and cultural variables as contributors to the ultimate goal of suicide (Welch, 2001). Risk factors are defined as conditions that occur before a particular problem and are associated with an increased probability of experiencing that problem (Berman & Jobes, 1993). Protective factors are circumstances that increase the probability of achieving positive outcomes (Schoon, 2006).

There are well-established factors for those who are at risk of suicide. Gilliland and James (1997) suggest that the individual should be treated as high-risk if four to five or more of the factors are manifested. Common risk factors supposedly include life stress, self-esteem, alcohol use, depression, hopelessness/pessimism, frequent pain, drug addiction, recent trauma, radical changes in moods, psychosis, sexual abuse, loss, family disturbance, illness, abuse, intense negative emotions. Protective factors that may mitigate the risks of suicide include religiosity, maternal coping strategies, environmental factors and positive social support (Evans et al. 2004). Further examination of the protective factors associated with suicidal ideation could lead to interventions that prevent suicidal behaviors (Chioqueta & Stiles 2007). Following risk and resilient factors are the parts of the current study.

1 DEPRESSION AS A RISK FACTOR The primary motivation for suicide is depression. Depression has been identified as a strong and consistent correlate of adolescent suicidal behaviors. Depressive tendency refers to an emotional state characterized by exaggerated feelings of sadness, dejection, worthlessness, hopelessness, psychomotor retardation, sleep disturbance (insomnia or hypersomnia), fatigue, anorexia, constipation, reduced libido or suicidal ideation, to an extent which is inappropriate or out of proportion to reality (American Psychiatric Association, 1994).

Several theories have expounded different etiological factors of adolescent depression. Western theories propose that cognitions are central to mood, that depression is a frequent concomitant of suicidal ideation and behavior and that hopelessness is the most proximal variable to depression and suicidality (Abramson et
Studies in different cultures suggest that depression in specific and psychopathology in general increase the risk for suicide (Gili-Planas, Roca-Bennasar, Ferrer-Perez, & Bernardo-Arroyo, 2001).

The prevalence of depression has been reported to be almost twice as high in HIV-positive than in HIV-negative persons (Schlebusch L & Vawda N., 2010). Studies in Africa have reported high rates of depressive symptoms and suicidal behaviour in HIV-infected persons, (Antelman G, Kaaya S, Wei R, et al., 2007), with the lifetime prevalence for depression ranging from 22% to 45% in this population (Schlebusch L & Vawda N., 2010). A positive HIV diagnosis may be viewed by some as a negative life event resulting in, among others, marital problems, financial problems, stigmatisation by family, friends and community, fear of disclosure of a positive HIV test result, problems in accessing health care, and other difficulties (Schlebusch, L., 2005).

Liu (2006) examined whether severity of depression reduces or intensifies the relationship between friends’ suicide attempt and adolescent’s own attempt to commit suicide, and whether there are gender differences in this interrelationship. Using logistic regression and data from a nationally representative sample of adolescents studied at 2 point in time, this study yielded significant findings. First, friends’ suicide attempt and adolescent depression each predicts adolescent’s own attempt to commit suicide, and these effects are similar for both boys and girls. Second, highly depressed adolescents are less likely than low or non-depressed adolescents to attempt suicide when their friends attempt suicide, and this relationship reduces the relationship between friends’ suicidal attempt and adolescent’s own attempt but this effect is not statistically significant.

Sareen et al. (2005) recently examined this issue in an analysis of data from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). They found that, after controlling for co-occurring disorders and socio demographic factors, the presence of any anxiety disorder was associated with both suicidal ideation [odds ratio (OR) 2.32, 95% confidence interval (CI) 1.31–4.11] and suicide attempts (OR 3.64, 95% CI 1.70–7.83). They also reported that the presence of an anxiety disorder in combination with major depression (MD) increased the likelihood of suicide attempt.
apparent associations between anxiety disorder and suicidality reflect the effects of nonobserved.

Experimental evidence from the two reports on effectiveness of treatments for depression to alleviate also suicidal ideation at least among elderly depressive symptom exists, although these studies cannot inform whether this alleviation is related to depressive symptoms per se, or the role of underlying hopelessness (Bruce et al., 2004; Szanto et al., 2003). Antidepressants have been found to increase the risk of suicidal ideation or attempt (suicidality), although not of suicide, in youths (Hammad, T.A., Laughren, T. & Racoosin, J., 2006).

In particular, mood disorders such as depression, have emerged as one of the strongest predictors of suicidal behaviour (Kim, H.S. & Kim, H.S., 2005). Depression is a long-established risk factor for suicide (Yen, Shea, Pagno, Sanislow & Grilo, 2003), and mood disorders are most frequently associated with suicide and suicide ideation and discussed as risk factors for the presence of suicidality (Chioqueta & Stiles, 2003). The majority of the studies that evaluate the relation of psychiatric disorders to suicide report major depression as the most significant diagnosis related to suicide (Chioqueta & Stiles 2003).

More recently, Kuo et al. (2004) pointed out that the failure to find a significant association between depression and new incident of suicidal ideation might arise because suicidal ideation or suicidal attempt is one of the diagnostic criteria for depression, not because depression is not associated with suicidal ideation. Two recent studies have documented the actual effectiveness of treatments for depression in reducing suicidal ideation among elderly patients with depression (Bruce et al., 2004). Both depressive symptoms and hopelessness have a strong and consistent association with suicidal ideation (Sokero et al., 2003), and they are plausible and theoretically coherent risk factors for suicidal behavior.

There is equivocal evidence that suicidal adolescents experience more stressful life events as compare to the non suicidal counter parts (Overholser, 2003). All the students with depressive symptoms, regardless of whether or not they manifested suicidal ideation, also perceived that their family environment did not
encourage free expression of feelings. Therefore, although this feature has been traditionally associated with suicidal behavior (Groholt et al., 2000). In some cases, suicidal ideation may occur in absence of depression or depressive symptomatology. There is higher risk of suicide during adolescence (Ventura, S.J.; & Bachrach C.A. 2000).

II HOPELESSNESS AS A RISK FACTOR: Snyder (2002) has defined hope as an individual’s thoughts about his or her goals and perceptions of his or her ability to engage in goal-directed behaviour. Hope theory, as introduced by C.R. Snyder (2000), seeks to systematically explain the concept of hope. He argued that people’s trait hope levels are influenced by early childhood experiences with a parent or other guardian. Researchers have argued that hope may be a better predictor of suicide risk than hopelessness (Grewal & Porter, 2007). As Grewal and Porter (2007) suggested, it is important to determine if suicidal ideation is more highly associated with a lack of hope or a presence of hopelessness.

Hopelessness is defined as the "expectation that negative events will occur or that positive events will not occur" added to a sense of helplessness or powerlessness regarding one's ability to change the impending outcome (Abela, Gagnon, & Auerbach, 2007). Hopelessness is defined as a motivational/cognitive state (Velting, 1999). Clinical factors such as depression, hopelessness, and poor problem-solving skills have been identified as significant contributors to suicide and suicidal behaviours (Boyd & Foley, 2009). Hopelessness has been identified as a strong predictor of suicide even among different cultures (Zeyrek et al., 2009). Of all the symptoms of depression, hopelessness and suicidal ideation are characterized by some of the most negative global self-referent cognitions (Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003). The significant correlations between hopelessness, depression and suicidal ideation are important markers. The association between hopelessness, depression and suicide has been well documented (Schlebusch L, 2005). Multiple attempters report more symptoms of hopelessness, depression, and anger than single attempters after a suicide attempt [Forman et al., 2004]. Hopelessness is significantly associated with lack of fluency for positive events while there are usually no relations with fluency for negative events (O’Connor, 2003).
Shahar et al., (2006) examined despite voluminous research on the role of hopelessness and depression in suicidality, a systematic examination of various causal models pertaining to these variables. Structural Equation Modeling (SEM) analyses revealed synchronous, but not longitudinal associations between hopelessness, depressive symptoms and suicidal ideation. The differential activation model suggests that it is not the resting level of hopeless/suicidal cognitions that is important in rendering someone vulnerable to future suicidal crises. Rather, it is the ease with which these patterns of thinking can be activated that is important. Hopelessness is significantly associated with lack of fluency for positive events while there are usually no relations with fluency for negative events (O’Connor, 2003).

According to the Attention Mediated Hopelessness theory (MacCoon, Abramson, Mezulis, Hankin, & Alloy, 2005) when individuals experience a discrepancy between a desired and actual outcome (e.g. a negative life event) their attention shifts to this inconsistency in order to resolve or reduce it. MacCoon et al. (2006) further theorized that individuals who are cognitively vulnerable to depression are less likely to generate successful resolutions to this discrepancy and are, therefore, unable to redirect their attention and become trapped in a recursive self-regulatory cycle. This prolonged and recursive attention to the discrepancy is equivalent to rumination. Finally, this ruminative cycle is expected to increase hopelessness, which eventually leads to depression and specific symptoms such as suicidal ideation. Although hopelessness has been extensively studied in adults, the relationship between hopelessness and adolescent extensively studied in adults, the relationship between hopelessness and adolescent suicidal ideation has only recently received attention in the literature (Thompson et al., 2005). Hopelessness theorists such as Alloy et al. (2000) included symptoms of hopelessness depression (e.g., sad affect, concentration problems, thoughts of suicide) that are in line with primary symptoms.

Recent work examining the relationship between hopelessness and suicidal ideation among adolescents receiving inpatient treatment services has produced several contradictory findings. Bergen et al., (2003) reported that hopelessness is fully mediated by suicide risk and has no independent association with suicide attempts. Indeed, the link between hopelessness and suicide is powerful and well established, such that it is a key risk factor for suicidality (O’Connor & Sheehy, 2001).
Much evidence exists implicating depression and hopelessness as key factors in the prediction of suicidal thoughts, intent, actions, and eventual suicide among adolescent, general adult, elderly, and psychiatric populations (Brown, Beck, Steer, & Grisham, 2000).

III PSYCHOTICISM AS A RISK FACTOR: The trait psychoticism is characterized by tough-mindedness, empirical findings have demonstrated that psychoticism has considerable degree of association with suicidal behaviour (Kerby, 2003). Eysenck’s dimensional model of personality proposes individual differences in personality. In addition to extraversion (E) and neuroticism (N) there was a third major dimension of personality that was called psychoticism (P) The third dimension is expressed on the continuum from tender mindedness, through tough-mindedness, to psychotic disorder. Studies have also reported that psychoticism is significantly related to suicide (Kerby, 2003).

Francis and Williams (2009) demonstrated that previous studies have generally linked high levels of paranormal belief with higher psychoticism scores (tough-mindedness) and lower lie-scale scores (lower social conformity). Hills and Francis (2005) demonstrated that previous studies have generally linked high levels of suicidal ideation with higher psychoticism scores, higher neuroticism scores and lower extraversion scores. Suicide attempters have been demonstrated to show higher introversion (Brezo et al., 2007) and higher psychoticism as compared to non-attempters (Roy, 1995).

Schenider et al. (2006) in their review of studies found that suicide risk was associated with all the three clusters of personality disorders. Suicide risk is strongly associated with and determined by personality disorders because personality disorders, by definition, involve chronic interpersonal difficulties and poor coping strategies (Schneider et al., 2006). Suicide risk in borderline personality disorder is attributed to impulsive aggression and affective instability; and in antisocial personality disorder to negative emotionality and low constraint (Verona, et al., 2001). Amongst those with a psychosis-spectrum disorder, as many as a quarter report current suicidal ideation (Kontaxakis et al., 2004) and around half report a history of suicide attempts (Tarrier, Barrowclough, Andrews, & Gregg, 2004).
Research on suicidal behavior has demonstrated that suicide risk co-occurs with numerous factors like impulsivity (Maser, et al., 2002), childhood adversity (Joiner et al., 2006), and hopelessness (Van Heeringen et al., 2003). A recent and comprehensive review of the literature suggests that a dimensional approach of impulsivity in psychiatric disorders may be more appropriate than a categorical approach (Moeller et al. 2001). There appears a relationship between suicide attempts and the impulsivity. Attempt impulsivity appeared to be inversely associated with attempt lethality (Baca-Garcia et al. 2001).

Verdoux Liraud, Gonsales, et al., (2001) designed a study to assess the baseline characteristics associated with a greater risk of suicidal behaviour (suicide and parasuicide) over the 2 years following a first admission for psychosis, and the associations between suicidality and outcome. First admitted subjects with psychosis (n=65) were assessed at 6-monthly intervals over a 2-year follow-up period. Over this period, 11.3% of the patients displayed suicidal behaviour. Baseline predictors of suicidal behaviour were a lifetime history of Para suicide before first admission, lower positive and negative symptom scale, positive sub scores and a longer duration of first admission. Subjects with suicidal behaviour presented with a longer duration of psychotic symptoms (OR = 1.1, 95% CI: 1.02-1.2) and a greater risk of being readmitted (OR = 4.6, 95% CI: 1.1-19.1). Subjects with substance misuse over the follow-up period were seven times (95% CI 1.3-3.9) more likely to engage in suicidal behaviour. Subjects with a previous history of Para suicide, with a deteriorating clinical course, or with substance misuse are at increased risk of suicidal behaviour in the 2 years after the onset of first psychotic episode. Amongst individuals with non-affective psychosis, hopelessness has emerged as one of the most reliable and consistent clinical predictors of suicidal thoughts and behaviours (Pompili et al., 2009).

**IV SOCIAL SUPPORT AS A RESILIENT FACTOR**: Social support is defined as either positive or negative socio-emotional exchanges between an individual and their network of family members and peers. Positive ties are critical in coping with crises, life transitions, and deleterious environments (Crosnoe and Needham 2004). Social support refers to information or actions (real or potential) that
lead individuals to believe that they are cared for, valued, or in a position to receive help from others when they need it (Heller, 1979). Social support has been conceptualized as a coping resource that affects the extent to which a situation is appraised as stressful (Lazarus & Folkman, 1984) and enables a person under stress to change the situation, to change the meaning of the situation, or to change his or her emotional reactions to the situation (Thoits, 1986).

Across many definitions of social support, the benefits of social support extend well beyond reducing suicide risk to lower morbidity and mortality (House, Landis, & Umberson, 1988). Numerous studies have demonstrated that social support promotes good mental health, including the reduction of suicidal thoughts and wishes (Hovey, 2000). Research has shown that positive social support is a protective factor and discord within the family is correlated with increased suicide rates (Gururaj et al. 2004).

There is also some evidence that protective factors within the family, including caring and support, may increase resilience and buffer adverse environmental influences (Meadows et al. 2005) and hospital-based adolescents (Donald et al. 2006). Protective factors that may mitigate the risks of suicide include religiosity, maternal coping strategies, southern residence, environmental factors and positive social support (Evans et al. 2004). A supportive and healthy social network seems to be a protective factor against suicidal ideation (Westefeld et al., 2000). Indeed, the perception of positive social support has been found to be inversely related to suicidal ideation, even when both the effects of depression and hopelessness are controlled (Chioqueta & Stiles, 2003).

Adolescence Risk for Suicide and Negative Social Exchanges with Family and their Peers Some studies have shown that various types of adolescent emotional and behavioural problems tend to be correlated with a negative perception of family, school and peer group relationships. This has led to the widely accepted notion that negatively perceived social exchanges unfavorably affects adolescent well-being and that a negatively perceived peer network, more so than a negatively perceived family network, is related to adolescent malfunction (Garnefski & Doets 2000).
The negative exchanges from peers were not associated with suicide ideation, especially in light of the current dialogue on the stresses caused by such phenomenon as peer bullying (Delfabbro et al. 2006). Previous research has usually focused on positive social support. The findings also highlight the importance of negative social exchanges from family members, as well as the buffering effect associated with positive social exchanges from peers. Moreover, although mood disorder episodes were the largest single predictor of suicide ideation in the model, negative social exchanges from family were a close second. The finding of a positive association between mood disorders and suicide risk are well established (Beautrais 2003).

The positive exchanges with peers were inversely associated with suicide ideation. The positive social support from peers was strongly associated with lower suicide ideation in older adolescents. Thompson et al. (2000) found positive effects on perceived family support, depression, and suicide risk behaviors in a longitudinal intervention that included peer group and teacher support. There are numerous investigations of the effects of poor health, depression, and social support on suicidal ideation. Many investigations have examined these risk factors independently of one another (Hovey, 2000). Others have found that family support and cohesive families protected college students from suicidal ideation and depression (Harris & Molock, 2000). Both positive and negative exchanges are experienced with family and peers. There are a number of things that parents can do to increase the chance that their efforts to help their adolescents succeed in dealing with health risks such as suicide (Steinberg and Duncan 2002).

V LOCUS OF CONTROL AS A RESILIENT FACTOR: Locus of control is defined as a generalized expectancy of internal or external control of reinforcement (Rotter, 1966). Locus of control is the ability to apply control over outcomes which can influence the extent to which frustration results in aggression. The internally controlled individual believes that reinforcement is attributable to his/her own ability or efforts. The externally controlled individual believes that reinforcement is attributable to fate, chance, or some powerful external force.

The most studies have supported a relationship between an external locus of control and increased suicide risk in adolescents (Beautrais, Joyce, & Mulder, 1999). Explorations of locus of control as it relates to suicide has sought to illuminate the
difference in risk between individuals who tend to view their behaviors as impacting the world (De Wilde, Kienhorst, Diekstra, & Wolters, 1993). According to Osterman & Bjorkqvist (1999), internal locus of control is composed of dependent events mostly related to one’s permanent characteristics. On the other hand, external locus of control is related to the feeling that outcomes are a result of fate, luck, chance, or in control of others.

**Internal locus of control** has been found as a protective factor against suicidal behaviour (Donald et al., 2006) but the lack of consistency in replicating the relationship between a high internal locus of control and low suicidal tendencies has lead to this relationship remaining a debatable issue (Graffeo & Silvestri, 2006). Persons with a strong sense of coherence perceive their world as ordered and consistent and are able to manage stressful situations effectively and find meaning in life (Antonovsky & Sagy, 2001). Research conducted on adolescents and young adults found a significantly negative relationship between a sense of coherence and suicidal behaviour (Rothmann & Van Rensburg, 2002).

**External locus of control** has been found to be associated with higher levels of suicidal risk (Evans, Owens, & Marsh, 2005). External individuals use fewer problem-solving methods when dealing with stress (Liu, Kurita, Uchiyama, Okawa, Liu, & Ma, 2000), and problem solving deficits have been found to be characteristics of suicidals (Pollock & Williams, 2004).

Evans, Owens, & Marsh (2005) made an attempt to understand possible relationships between environmental factors, locus of control, and suicide risk among adolescents. The data derived from school surveys of eight-grade students conducted in 1998 and 1999 in Arizona, California, Nevada, and Wyoming. Results revealed that higher levels of suicide risk were associated with a more external locus of control orientation. Relationships between suicide risk and several environmental factors and preferences also were found. Personality traits such as whether one has a sense of coherence, the position of the locus of control, and neuroticism were found to have a significant influence on the increased risk of suicidal behaviour (McDevitt & Ormrod, 2004). In a cross-sectional study of 13 year olds, logistic regression was used to
examine a model of perceived academic performance, self-esteem and LOC onto suicidality (Richardson, Bergen, Martin, Roeger, & Allison, 2004).

Pinzon Perez, and Perez (2001) surveyed 10th graders from 32 Colombian public schools to examine gender, perceived academic performance, type of school, and their relationships to depression and suicide. Significant differences in perceived academic performance scores were found between those reporting suicidal thoughts and attempts and those who did not. Few other studies into the relationship between perceived academic performance and suicide risk exist, and only two studies to date have investigated perceived academic performance, self-esteem and LOC together (though not in association with suicide. *The individuals who have external locus of control (chance) and who less often use problem-focused coping skills are more prone to attempt suicide.* (Liu, et al., 2000).

Keeping in view what has been said in the preceding studies, the current study intends to investigate “Interplay of Among Risk Factors And Resilient Factors For Suicidal Ideation in Adolescents of Haryana.”

4. OBJECTIVES OF THE CURRENT STUDY

The study started with the following objectives:

1. TO EXAMINE THE ROLE OF HOPELESSNESS IN SUICIDAL IDEATION
2. TO EXAMINE THE ROLE OF PSYCHOTICISM IN SUICIDAL IDEATION
3. TO EXAMINE THE ROLE OF SOCIAL SUPPORT IN SUICIDAL IDEATION
4. TO EXAMINE THE ROLE OF LOCUS OF CONTROL IN SUICIDAL IDEATION
5. TO EXAMINE THE MODERATING ROLE OF SOCIAL SUPPORT IN THE RELATIONSHIP OF HOPELESSNESS AND PSYCHOTICISM IN SUICIDAL IDEATION.
6. TO EXAMINE THE MODERATING ROLE OF LOCUS OF CONTROL IN THE RELATIONSHIP OF HOPELESSNESS AND PSYCHOTICISM IN SUICIDAL IDEATION.