Chapter-V

Discussion
In the present study considering ego functions as underlying personality variable, comparisons were made between a group of attempted suicide subjects and normal subjects. The similarities and the differences between these two groups were evaluated in terms of ego function organizations, specific cognitive styles, experienced number of stressful life events in last one year and depression as well. At the same time attempts have been made to determine how ego functions, stressful life events, cognitive styles and depression predicts suicidal ideations.

As the result of the present study suggests (Table-3) no significant difference exists between male and female with respect to criterion variable (ASIQ) and among 17 predictor variables except in the two ego functions (DF and MC), further analysis were done combining male and female together. Previous studies by various authors yielded ambiguity in gender differences in ego function research. Basu et al. (2002) found that there is no evidence that males and females differ in the adaptive and mal-adaptive ness of ego functions. Bellak et al. (1973) also found no significant difference between sexes. However, Basu et al. (1996) in another study showed that females are superior to male in six ego functions.

From the obtained result and existing literatures, these areas will be discussed in this chapter. The discussion will be presented separately for different variables in different sections. At the end an integration of the findings will be discussed.
5.1 Comparison of ego function profiles between normal and attempted suicide group

The present study suggests that there is significant difference between two groups in terms of ego functions (table-3). The various components of ego functions are discussed separately in the following:

5.1.1 Reality Testing (RT)

From the result it is evident that Reality Testing (RT) is significantly different between normal and attempted suicide groups. RT refers to the accuracy of perception, distinction between percepts and ideas, appropriate interpretation of external events, accuracy of inner reality testing (psychological mindedness and awareness of inner states) and reflective awareness. These qualities are found to be higher in normal group.

This finding is supported by an earlier study by Pfeffer et al. (1995) where relationship between lacks of reality testing or inappropriate perception was found to be associated with suicidal ideation. Role of RT has been explored by various researchers in formation of psychopathology as well.

Though impaired RT essentially assess the presence of psychotic features and detachment from reality, yet impaired RT is also found to be a part of other disorders not necessarily psychotic in nature. One principle component of RT concerns the perceptual and cognitive capacity to distinguish internal from external stimuli. The loss of the capacity is most clearly demonstrated by one of its extreme forms, as in the formation of hallucinations. It is more subtly seen in illusions or other phenomena where the perception of external reality is significantly altered by an internal affective state. A more common yet more subtle form of confusion between internal and external stimuli occurs when contemporary external reality is perceived in terms of the internalized past, as when infantile fantasies or object representations determined the response to a here-and-now situation. Freud (1924) has discussed this loss of reality as a foundation of neurosis.
In a study by Basu (1993) comparing ego functions between patient with schizophrenia, patient with neurosis and normal observed that RT along with 7 other ego functions discriminates among the three groups. The normal scored best in all ego functions over the clinical groups except AR. The neurotic group scored higher than the psychotic group in reality testing. In another study (Basu & Basu, 1996) compared the ego organization of three psychiatric groups namely antisocial personality disorder (ASPD), anxiety disorder (ANX) and paranoid schizophrenia (PAR) with a normal sample. RT has been found to be impaired in all three clinical groups in comparison to normal. The ASPD group was found to be in between the normal and other two groups in terms of ego organizations. But surprisingly the ANX and PAR groups were not adequately discriminable from each other in terms of ego functions.

In a study examining the ego function characteristic in destitute women in comparison to depressed and normal control group RT is found to be impaired in both destitute and depressed group in comparison to normal. Deterioration of this feature in destitute and depressed implies that fantasy activity might replace their accurate intake of reality. In this way that group of people might escape from the pain of the real world.

In a study in the similar line (Basu et al., 2002) implies that RT as an ego functions is impaired in neurosis also.

In the present study as the attempted suicide group is devoid of psychotic features but they showed neurotic features like depression and anxiety, the impairment of RT thus found in the attempted suicide group is in accordance with the previous studies.

Reality testing is considered as a distinct function separate from sense of reality and judgment. Other authors have discussed reality testing as a component of larger function, the ‘relation to reality’ (Beres, 1956; Frosch, 1964). Nevertheless the systematic study of the ego substantiates consideration of reality testing as a separate function on phenomenological grounds.

In the present study a significant negative correlation has been found between RT and suicidal attempt. As it is mainly denotes accuracy of perception and inner reality testing,
this quality decreases when there is an increase in suicidal ideation. Therefore, when one's RT gets impaired he/she think more of attempting suicide.

Impairment of RT in the present study is not of such severity so as to produce psychosis. However the degree to which RT is impaired in this study is probably responsible to produce stress-related disturbances in thinking involving concreteness and failure in logic with some impairment in conceptualization. This may lead to inability to apply problem solving behaviour in adverse situations and may lead to suicidal vulnerability.

5.1.2 Judgment (JD)

Judgment as a component of ego functions found to be significantly different in the 'attempted suicide' group in comparison to normal group. This component is found to be lower in the attempted suicide group as found from lower mean values.

Significant negative correlation between JD and suicidal ideation has been found in the present study, i.e., judgment decreases with an increase in suicidal ideation. Judgment is all about apprehension of the consequences of the intended behaviour, when JD is impaired or disturbed vulnerability towards suicide increases. Poor judgment therefore increases one's risk for thinking about or attempting suicide.

Judgment (JD) refers to probable consequences of intended behaviour, voluntary inhibitional behaviour which has led to some earlier dysfunction and the propriety of behaviour with tuning to reality. In this sense, JD is a 'social' and 'conscious' function involving the ego's capacity to appreciate its interaction with external reality. Impaired JD result in inappropriate behaviour relative to a specific cultural setting.

Judging is a central aspect of all secondary process thinking. Freud considered an impartial passing of judgment to be an aspect of reality testing. Relationships between the two can certainly be found. In practice the behaviour of persons with organic brain syndromes is often described as reflecting 'poor judgment', while similar behaviour in persons suffering from functional psychoses and neuroses is described in terms of poor
'reality testing' (Rapaport et al., 1946). Rapaport hypothesized a close connection between, and overlapping of, reality testing, judgment and reflective awareness.

Reality testing and judgment are related in that good judgment depends upon good reality testing. If any of the major components of RT is not functioning adaptively, JD is likely to be secondarily affected. Despite these relationships and the fact that some aspects of judging (deciding and discriminating) are often used in testing reality, it is useful to evaluate separately from reality testing. This is because anticipation and appropriateness play central role in JD.

Hartmann (1939) held that anticipation is an ego function of great importance in adaptation and we direct our actions by anticipating sequences of events.

The ability to apprehend what is appropriate to a given a situation is one aspect of good judgment. While knowledge and accurate thinking are both required, the more crucial ingredient is an emotional orientation that brings to mind the relevant possibilities from which an appropriate selection and emphasis must be made. Defensive constellations and cognitive style can interfere with appropriateness.

Impairment of JD is characteristics of psychotic states (Yager & Gitlin, 1995). In a comparative study of ego functions (Basu et al., 2002) between three different clinical groups viz., schizophrenia, generalized anxiety disorder and dysthymia, significant difference in JD is found between normal and schizophrenia, normal and anxiety and normal and dysthymia group. However JD is found to be most impaired in schizophrenia group.

In a study (Basu & Basu, 1996) comparing the ego organization of three psychiatric groups namely antisocial personality disorder (ASPD), anxiety disorder (ANX) and paranoid schizophrenia (PAR) with a normal sample, JD has been found to be impaired in all three clinical groups in comparison to normal. The ASPD group was found to be in between the normals and other two groups in terms of ego organizations. ASPD group suffers from the misapprehension of the reality, proneness to impulsive action and lack of empathy and scruple (supported by low JD, DC and RT).
Fonagy (1999) suggested that the capacity for meta-cognitive control, reflective self functioning and mentalization that can help protect against injury to self esteem has not developed in suicidal patients. As such, the person is unable to think and reflect beyond the immediate experience and unable to or impaired in the capacity to reflect and understand the consequences of aggressive and self destructive actions.

Logic, which involves the awareness and understanding of cause and effect relationships, is integrally related to judgment. Although logic is generally an aspect of autonomous functioning and thought process, its relevance to judgment has to do with individual’s capacity to appreciate the external effects of behaviour.

Poor judgment lowered the ability to anticipate the situation. Good judgment depends upon the delay of discharge to allow time for the processes underlying judgment to be exercised. Inability to delay along with poor anticipation leads to poor selection of the appropriate solution from the possible alternatives in a given situation. So it is quite possible that when this function of ego becomes disturbed the person considers suicide as the instant and only solution to his problems rather than to explore positive and better alternatives. Another significant aspect of JD is its role in acting out. Persons with impaired judgment are expected to act out in a socially inappropriate and perhaps harmful way. In presence of a conflicting situation a person with deficient judgment gets involved in self destructive behaviour or commits suicide.

5.1.3 Sense of Reality (SR)

This ego function is central to experiencing of oneself and the world. An attempt to describe the sense of reality requires a consideration of body image, ego boundaries, the concept of self and identity as well as a review of some of its major disruptions such as depersonalization and de-realization. Aspect of self image and more enduring self-representation are seen to play an important role in the sense of reality. Disturbances in the sense of reality are often clinically found to be associated with disruptions in object relations and in synthetic-integrative functioning, where body image, self representations and identity may be disturbed to varying degrees.
Sense of reality of the world and of the self includes - a) the extents to which external events are experience as real and as being embedded in a familiar context, b) the extent to which the body (or parts of it), and its functioning and ones behaviour are experienced as familiar, unobtrusive and belonging to (or emanating from) the individual, c) the degree to which the person has developed individuality, uniqueness and a sense of self and self esteem; and d) the degree to which the persons self representation are separated from his or her object representation.

Another aspect of faulty self-esteem regulation is the lack of a constant cohesive concept of self. The result here is that the persons self esteem are quite mutable because of its dependence on daily experience and the opinion of others (as observed mostly in narcissistic personality disorder).

In a study Basu et al. (2004) explored the role of ego functions in relation to stressful life events and three indices of psychopathology, namely Psychoticism, Anxiety, and Depression among 60 adult patients suffering from schizophrenia. Significant scores on sense of reality and defensive functions are found in depression. Both of these ego functions are concerned with regulation of inner identity and assault from inner stimuli (Bellack et al., 1973). Impairment in SR and DF implies a resignation to the disease state, and rejection of external aid.

In a study examining the ego function of destitute women in comparison to normal control group (Basu & Chakraborthy, 1996) depressed group is found to have lower sense of reality and drive control over normal. SR refers to ones orientation of ones own self in the context of the world at large. Its impairment leads to body image distortion, somatic pre-occupation and delusions as well as vague but overwhelming panic of losing identity.

Disturbance in this area also suggest an overall problem with 'relationship to reality' (Beres, 1956 & Frosh, 1964). Persons give history of responding to stress by regressively loosing ego boundaries with resultant perceptual distortions. In a comparative study of ego functions in three different clinical groups (Schizophrenia, Generalized Anxiety Disorder and Dysthymia) and normal (Basu et al., 2002) SR is found to be impaired in
schizophrenia in comparison with normal. However, in the above mentioned study there is no significant difference in SR between normal and anxiety and normal and dysthymia group.

In a study of criminality and ego psychology (Basu, 2008), Reality Testing and Sense of Reality is significantly impaired in deliberate self harm group in comparison to normal and convicts.

Bellack et al. (1973) found significant differences in all the ego functions between normal and neurotics. Basu (1993) also found difference in SR between normal and neurotics. However, Basu & Basu (1996) found no difference in SR and OR between normal and anxiety group.

A question arises ‘Are sense of reality and reality testing distinct from each other?’

Both of these ego functions deals with the ego’s ability to distinguish internal from external and its awareness of body boundaries. It is clear that the two functions are interrelated. There is in fact, preliminary evidence from factor analysis that reality testing judgment, sense of reality and regulation and control of impulses form a ‘group’ of functions whose strength and weaknesses correlate closely in a particular person (Bellack et al., 1973). And yet one function relates to the way the ego senses and experiences reality whereas the other involves the egos ability to ‘test’ these experiences against fixed internal percepts and ideas of what is real.

Frosch (1964) points out interrelationships of reality testing, sense of reality and relation to reality and underscores clinically useful distinctions between them. “Reality testing” is defined as ‘the ability to arrive at a logical conclusion from a series of observable phenomena’ and “sense of reality” as ‘the sense that phenomena going on around and within are real’. In short, awareness of inner states is most relevant to the sense of reality whereas the accurate appraisal of these is most relevant to reality testing.

Depersonalization, de-realization, déjà vu, and dissociative experiences are all examples of defective sense of reality. Impaired sense of reality leads to propensity for dissociation.
Propensity for dissociation spurs suicide by means of generation of partially dissociated states of mind, some of which evolve into suicidal ones, denial of reality and irreversibility of death, and automatic acting out of suicidal fantasy. Self esteem is related to the sense of reality and is strongly influenced by super ego factors. Greenacre (1958) believes that normal self esteem is dependent upon optimal feedback of a sense of worth. Bibring (1953) introduced the concept of lowered self-esteem as central to depression. This important function of ego is found to be lowered in attempted suicide group as reflected by lower mean value, indicating decreased sense of reality, lower self esteem, poor clarity of boundaries between self and world leading to vulnerability toward suicidal attempt.

5.1.4 Drive Control (DC)

This ego function concerns the person's ability to tolerate anxiety, depression, disappointment, frustration, and the necessity of postponing expected satisfaction. It involves the expression of inner wishes, emotional strivings and urges in a harmonious and modulated manner. Included also is the ability to delay responses to inner promptings for tension discharge or gratification (Moore & Fine, 1968).

As per drive control or DC is concerned, it is supposed to be poor in persons attempting suicide and the present study fully agrees with this supposition. Regulation and control of drives, affects and impulses includes a) the directness of impulse expression (ranging from primitive acting out through neurotic acting out to relatively indirect form of behavioural expression) and b) the effectiveness of delay and control, the degree of frustration tolerance and the extent to which drive derivatives are channeled through ideation, affective expression and manifest behaviour.

Fenichel (1945) pointed out that impulsive actions often involve an attempt to escape from, deny, or reassure oneself against danger, including the danger of depression. In habitually impulsive individuals an oral regulation of self esteem is frequently found; there is strong over-dependence on getting things and on being loved and a tendency to
become depressed when these things are not sufficiently forthcoming. Low frustration tolerance is an important aspect of impulsiveness and poor regulation and control.

Acting out involves impulsive behaviour but is considered to be on higher levels of organization. Formulations related to what later became the concept of acting out were introduced by Freud in *The Psychopathology of Everyday Life* (1901). Fenichel (1945) discussed neurotic acting out in relation to general impulsiveness, addiction, traumatic neuroses and transference in psychoanalytic situations. He found acting out to be closely related to all of these, a pattern of action that unconsciously relieves inner tension through a partial discharge of warded off impulses and in which energies from repressed memories are displaced on to a current situation. A major aim of acting out is the avoidance of un-pleasure rather than the attainment of pleasure.

Though impulsiveness and acting out reflect one side of the regulation and control continuum, there is another side to it: inhibition and over control. Freud (1926) discussed inhibition, defined it as ego function that uses energies available to the ego. An inhibition may involve only a normal restriction of function but it may also take part in pathological symptom formation.

Anxiety and depression are two of the most important affects. Zetzel (1949, 1965) has focused on the capacity to bear them and has shown that such a capacity is necessary for successful ego development and that its failure predisposes to ego defects and vulnerability to psychopathology. In her consideration of the ability to tolerate depression, Zetzel (1965), hypothesizes that such a capacity is necessary for optimal maturation. She maintains that in adult who have not successfully work through the separation there may occur a loss of control, an impairment of reality testing or a greater susceptibility to psychosis or suicide.

In the present study, the two groups showed significant difference in DC which might act as a crucial factor for the clinical group. In a comparative study of ego functions in three different clinical groups (Schizophrenia, Generalized Anxiety Disorder and Dysthymia) and normal groups (Basu et al., 2002), normal when compared to schizophrenia group
shows no significant difference in DC and AF. However, there is significant difference in DC when normals are compared to either anxiety or dysthymia group. DC and TP and DF are more impaired in anxiety group than any other group. Similar result also had been found in another study (Basu et al. 1999).

In a study (Basu et al., 1998) comparing ego profile of diabetics, depressive and normals DC yielded significant difference among the three groups. DC refers to the ability to inhibit impulsive acting out. In the diabetics this control might be loosen due to constant duress. However in a study exploring the cognitive and ego function characteristics of patients with Hemophilia in comparison to normals has found no significant difference in DC (Basu & Bhattacharya 1995).

Impaired regulation of drives is directly related to a tendency towards acting out. In a study conducted to investigate the mental health aspect of creative persons, creative group compared to non creative group scored significantly lower on DC. Creative group is less able to manipulate their social behaviour as indicated from lower OR or DC score.

DC refers to the ability to inhibit impulsive acting out. In the depressed group this control is loosened and the internalized aggression often leads to self mutilation and suicidality (Rowe, 1978).

A significant negative correlation has been found between DC and suicidal attempt in the present study as well. It indicates that with decrease in drive control suicidal risk increases. DC represents regulation and control of impulses in terms of directness of impulse or inner drive expression, so person with poor DC are more likely to think about or attempt suicide. This association between DC and suicidal ideation have been supported by an earlier research study (Pfeffer et al. 1995) which specifically indicated those subjects with poor impulse control, deficit in reality testing and impulsivity characterized by low frustration tolerance, inability to plan for future events and inability to make appropriate decisions when faced with alternatives are more likely to have made suicide attempts or report suicidal ideation.
5.1.5 Object Relations (OR)

The components OR is found to be significantly different between the two groups and it is lower in ‘attempted suicide’ group. According to Bellak (1973) OR refers to the ability to use social resources.

The main components of OR are a) the degree and kind of relatedness to others an investment in them, b) the extent to which present relationships are adaptively or mal-adaptively influenced by, or patterned on, older ones, and serve present, mature aims rather than past immature ones, c) the degree to which the person perceives other has separate entities rather than an extension of himself or herself and d) the extent to which the person can maintain object constancy (i.e., sustain relationships over long periods of time) and tolerate both the physical absence of the object and frustration, anxiety, and hostility related to the object.

Two major aspects of object relation are the ability to form friendly and loving bond of others with a minimum of inappropriate hostility and the ability to sustain relationships over a period of time with little mutual exchange of hostility. Disturbances in OR are reflected in emotional coldness and detachment, inability to fall in love or sustain love, self centeredness, helpless dependency on others, need to dominate others, and perversions (Moore & Fine, 1968).

Object relation is the degree and kind of relatedness, narcissistic attachment or symbiotic object choice. According to the Object Relation approach of studying the ego, the individual with Schizoid trend retreats from objects (Guntrip, 1968). Impairment in this function is therefore is a significant finding in psychosis but not in the Anxiety group (Fairbrain, 1954). The significance of disturbed OR in the psychotic process has been explained in terms of fusion between self and object and perception of object as devouring (Fairbrain, 1952).

A stepwise discriminant analysis was used to choose some ego functions which were useful to discriminate between BPD group and neurosis group (Koga, 1993) OR was found to play a great part in discrimination between the BPD group and the Neurosis
group from the viewpoint of ego function. The object relations in the BPD group are unstable. The patients rely on others excessively or distance themselves from others, and try to control others. They often have a crisis of ‘identity’ and entirely rely on the cognition of themselves by others. Their feelings are easily hurt and they often feel rejected. In the present study, though person with any kind of personality disorder were not included in the sample, but feeling of rejection, and ‘aloneness’ (distance from others) was found as a part of depression in ‘attempted suicide’ group.

OR refers not only to the degree and kind of relatedness to others, but also to enjoys interpersonal relationship and the ability to tolerate separation. Dysfunction in this component of OR is typical characteristic feature in depression and hence the score in OR is significantly lower than the normal. In fact, the score of OR was found to be the lowest among all the EFs of a group of depressives by Schwindle et al. (1984).

In a study by Basu et al. (2004) conducted on ego functions in relation to stressful Life Events and indices of psychopathology in paranoid schizophrenics OR was only ego function which contributed to all indices of psychopathology namely psychoticism, anxiety and depression. OR is the only ego function which was a moderator between scores on stressful life events and psychopathology.

One of the most important adverse life events in case of attempted suicide is interpersonal stress. In study by Sudhir Kumar & Chandrasekaran (2000) on adolescent suicide attempters found that interpersonal problems as the main precipitating factor for suicide attempt. When suicide attempters have problems in their close relationships with family and friends, they may lose important social support which may in turn increase the risk of depression and suicidal behaviour. Impaired OR in this present study may relate to this fact that inability to tolerate interpersonal stress and loss of significant others may contribute to a great extent to develop suicidal psychopathology.

5.1.6 Thought Process (TP)

Thought process refers to a) the adequacy of processes that adaptively guide and sustain thought (attention, concentration, anticipation, concept formation, memory and language)
and b) the extent of relative primary/secondary process influences on thought (degree to which thinking is unrealistic, illogical and/or loose).

In a study (Smith et al., 1991) on eating disorder group scored significantly higher than BPD group in TP with several other EFs. In another finding it was found that Anxiety and Schizophrenia group differs from normal in TP. Basu (1993) observed that anxiety neurosis differed from schizophrenia in terms of RT, OR and TP.

In a comparative study of Ego functions (Basu et al., 2002) TP is found to be impaired in Schizophrenia, Anxiety, and Depression group in comparison to normal. Comparison between Anxiety and Depression group shows that TP is more impaired in anxiety group. TP refers to the degree of adaptiveness as well. Anxiety group is more impaired in functions relating to intra-psychic organization (e.g., TP and DF) while Depression group suffers more on flexibility and self esteem issues (SF and MC).

The role of depression is well known in formation of psychopathology of suicidal behaviour (Beck et al., 1985; Fawcett et al., 1990). A study in ‘Relation of stress and ego function to experienced Depression’ (Basu et al., 1997) highlighted the role of TP in depression. TP is the ability to abstract and think rationally. It is obvious that better this function indicates less amount of depression. It is well known that depressed persons are more susceptible to suicidal behaviour.

The present study revealed significant negative correlation exits between TP and suicidal attempt. It indicates that with decrease in thought process an increase in suicidal risk occurs. Therefore it can be said that development of suicidality is provided by impaired or distortion in thought process. As the basic function of TP is to guide thoughts in a realistic and logical fashion, so disruption in this area probably leads to loosen the association of realistic thoughts and make the person to choose the unrealistic step of attempting suicide rather than to judge the other alternatives.
5.1.7 Adaptive Regression in the Service of the Ego (AR)

There is significant difference in AR among two groups. From the mean value it is seen that the normal group have better function in AR than ‘attempted suicide’ group.

AR plays an important role in daily adaptation. In the broadest sense, creativity the ability to meet life’s demands with other than previously learned solutions is the essence of adaptation. AR is not a quality or a process relevant only to the arts and sciences, in which the end product is a cultural or technical success; it can be observed in more diverse and private sectors of living as well.

The term ‘regression in the service of the ego’ was introduced by Ernst Kris in The Psychology of Caricature (1936). Bellack (1958) suggested that Kris’s regression in the ‘service of the ego’ be further specified as ‘adaptive’ regressions in the service of the ego i.e., ARISE. ARISE has been used to develop an understanding of wit and humour, artistic creativity, productive fantasy and imaginative processes, problem solving, ego building identifications, motherliness, empathic writing and love.

While Kris equates creativity with health, Weissman relates it to pathology. According to Weissman (1969) the fantasies of creative people are modified so that they are more hallucinatory or delusional than the typical fantasies of non-creative people. This unique alteration in fantasies is caused by phenomena that he designate as ‘beyond the reality principle’.

The components of AR includes a) relaxation of perceptual and conceptual acuity and other ego controls with a concomitant increase in awareness of previously preconscious and unconscious contents (first phase of an oscillating process) and b) the induction of new configurations that increase adaptive potentials as a result of creative integrations (second phase of oscillating process).

In a study of ego functions of destitute, depression and normal women (Basu & Chakraborty, 1996) the finding suggests destitute women astonishingly retain a near normal ability of adaptive regression. High adaptive regression scores refer to the
flexibility required for delving deep into fantasy activity and to bring about an adaptive configuration. While this greater flexibility may seems somewhat unexpected among the destitute. Some earlier investigations have indicated that adaptive regression holds a very special position among all ego functions. Like all other functions it may not be directly associated with the mental health aspect (Basu et al., 1995), rather persons with a creative bend of mind retain this ability even along with poor reality orientation (Mukhopadhyay et al., 1992).

The nature of AR is found to be ambiguous as suggested by results of various authors. In a study (Basu & Basu, 1996) all 11 functions of ego was found to be associated with psychoticism and neuroticism except AR, which is defined as the flexibility of the ego to dive in and out of unconscious fantasy world (Kris, 1952). Contrary to the findings of Dahl (1984) and Goldsmith (1984), this study did not observe any association of AR with psychoticism and neuroticism. Similar results is found by Basu (1993) which also failed to show adequate discrimination among the clinical categories of anxiety disorder, psychotics and antisocial personality disorder and also between each of these and normal. So far from the contradictory findings it may be suggested that AR is independent of mental health status of the individual rather it may be associated with ones attitude towards fantasy activity and creativity.

In the present study poor AR in ‘attempted suicide’ group may be attributed to their rigidity or inner ability to look for an alternative (Scher, 1971) and inability to learn to look afresh to problem situations. Rather this group is resigned to their fate and ends life instead of fighting it out. This in tern reflects their poor capacity to adapt with the environment.

5.1.8 Defensive Functioning (DF)

Defensive functioning deals with a) the degree to which defensive components adaptively or mal-adaptively affect ideation and behaviour and b) the extent to which these defences have succeeded or failed (degree of emergence of anxiety, depression and/or other dysphoric affects indicating weakness of defensive operations). In other words DF
has two binary functions that include the extent to which defensive functions are successful in reducing dysphoric effects such as anxiety and depression and the degree to which the defences influence ideation and behaviour adaptively or mal-adaptively.

In a study by Dhar & Basu (2006), DF has been found to contribute along with JD, OR and DC to formation of psychopathology of suicidal ideation.

In another study exploring relation of stress and ego functions to expressed depression, (Basu et al., 1997) DF was found to be only ego function having a moderator status and is found significant only in normal. Probably in the normal, the defensive system is strong enough to prohibit the upsurge of depression. In the clinical samples (depressive disorder) DF is impaired, revealing the pathological pattern underneath. Incapacitating dysphoria has a disruptive effect. Severe depression will result in retardation of thought and associations, as well as a general impairment of cognition.

Defensive functioning is important because good defences minimize anxiety. Excessive anxiety has an obvious disorganizing effect that can lead to attempted suicide.

In Inhibitions, Symptoms, and Anxiety (1926), Freud defined “defences” as the general term for all the techniques used by the ego in dealing with conflicts that may lead to a neurosis and include all processes that protect the ego from instinctual demands. His conceptualization of defence at his time included the idea that a symptom is the result of the failure of a defence against an instinctual drive derivatives, eventuating signal anxiety and subsequent defensive efforts to ward off the unpleasant affect. He specified the main danger situation leading to anxiety to be fear of loss of the object, love, castration and super ego. He also saw that a given individual will use the same form of defence, whatever the id impulse, while the same id impulse is warded off in different ways by different individuals.

While Freud had suggested that a connection exists between certain defences and particular neuroses, Anna Freud showed this connection to be more general and to link the kind of symptom formation, the kind of defence used against instinctual drive and affects. Hartmann (1939) suggested the value of studying conflicts and defences in
relation to the conflict-free ego sphere. He also pointed out the defences, in addition to operating against instinctual drives, can be seen to have an adaptive aspect. Fenichel (1945) classified defences into successful and unsuccessful. The former "bring about cessation of that which is warded off," and the later required a repeating of the warding off process in order to prevent the ego-alien impulse derivatives from erupting into awareness.

Defensive functioning can thus interfere with adaptation in three main ways. Early overuse of various defences can lead to ego distortion, deviation, or defect. Defences can also interfere with other ego functions because of the processes involved. Regressive alteration of ego functions in the service of defence can decrease overall adaptive functioning.

This function of ego has been found to be significantly lower in clinical group. It indicates that the suicidal individuals' poor defensive control leading to poor coping with drives and affects that is producing mal-adaptive responses (suicidal attempt). The mean value is found to be lower in attempted suicide group indicating their poor ability of adaptation to situations.

5.1.9 Stimulus Barrier (SB)

Present study reflects SB is significantly different among two groups. SB is found to be better in normal group as found from greater mean values.

The ego function referred to as SB has two basic components: a receptive and an expressive one. The receptive is the individual’s threshold for sensitivity to and awareness of sensory stimulation. The receptive component includes sensitivity to internal and external stimulation. Examples of internal stimulation include changes in body temperature and visceral and muscular pain, whereas external stimulation includes light, sound, drugs and other forms of inanimate stimuli.
The expressive component relates to how the individual respond to different degrees of stimulation with particular emphasis on whether coping mechanisms are adaptive or maladaptive.

Properly functioning, the stimulus barrier scales down the intensity of external stimuli to a level that the organism can manage. Although described by Freud mainly in the context of trauma, the SB concept was clearly applied by him to all pathological states as well as to normalcy. Freud described the workings of the SB in *Beyond the Pleasure Principle* (1920): ‘the external covering of the apparatus to manage excess stimulation is directed against external stimuli while the next layer is differentiated into an organ for the perception of stimuli’. Later (1940) it was seen as a constitutional precursor of the ego, serving a primitive defence function that foretells the ego’s more elaborate and highly developed protective mechanisms. In later elaboration of Freud’s SB concepts, a number of writers independently came to the conclusion that the inner outer distinction do not hold. Evidence of the organism treating disturbing internal stimuli as though they are external and attempting to deploy the same protective measures against both. Engel (1962) sees a defensive or paradoxical behaviour raising the stimulus barrier among people for whom it is constitutionally low, as leading to defensive withdrawal following attempts to reduce incoming stimuli. According to Goldfarb, (1961) SB can be considered as a component that works for integration of sensory experience.

SB concerns with the individual’s capacity to cope with different level of stimulation and plays a critical role in regulating individual’s stimulus threshold that entails the individual’s ability of modulation and selective attention to stimulation. This screening ability allows the person to positively adapt with his environment by enhancing heightened acuity, and focused concentration.

It has also significant negative correlation with formation of suicidal ideation in ‘attempted suicide’ group, which means improved SB decreases the suicidal thoughts. SB is related with one’s ability to modulate stimulation for positive adaptation with the environment. When this quality is impaired it increases the risk of attempting suicide.
The person gets overwhelmed by the negative / harmful stimulation (problem or stresses) and unable to choose the most effective solution.

Waelder (1960) sees SB as an “active regulator”, also implying an adaptive function. Implicit in the idea of traumatic excitations powerful enough to break through the shield are assumptions that the organism can deal with an onslaught of stimuli by either autoplastic adjustment (making an internal change so as to live with the external conditions without unbearable suffering) or by alloplastic adjustment (bringing about changes in the outer world to eliminate the source of tension).

In attempted suicide group the stimulus barrier function is impaired and taxed by so much stimulation that the person cannot handle the tidal waves (in terms of emergency situations) and as a consequence faces breakdown that comes as the attempt to destroy the self.

5.1.10 Autonomous Functioning (AF)

From the result it is seen that AF has genuine difference between normal and attempted suicide group. The mean value indicate better score in normal group.

The degree of freedom from impairment of apparatus of primary autonomy: attention, concentration, memory, learning, perception, motor function and intention and the degree of freedom from impairment of secondary autonomy: disturbance in habit patterns, learned complex skills, work routines, hobbies and interests (Bellak, 1973) characterize autonomous functioning.

Autonomy refers to the freedom from impairment of these operations by the intrusion of conflict, ideation, affect and/or impulses.

Hartmann introduces his ideas about ego autonomy in *Ego psychology and the Problem of Adaptation* (1939). Two groups of hypothesis are involved and can be discussed separately. These are called primary and secondary autonomy. By primary autonomy Hartmann meant that in addition to the instinctual drives and the impact of external
reality circumstances, ego development has a third basis, which can be referred to as inborn. Specifically, he held that such processes as perception, intention, object comprehension, thinking and language do not depend upon conflict for their genesis or development. Hartmann referred to these aspects of ‘ego constitution’ as ego apparatuses or inherited ego characteristics, and they constitute (along with characteristics that attain secondary autonomy) what he called the conflict-free ego sphere.

Secondary autonomy was seen as on a continuum with the degree of autonomy defined by the extent to which the activity in question is removed from id-ego conflicts, from regressive pressures exerted by id determinants, and from sexualization and aggressivization. In short, the extent to which the manifestation is refractory to regression and instinctualization determines the degree of secondary autonomy.

Rapaport (1958) concluded that autonomy from the id is guaranteed by the apparatuses of primary autonomy (i.e., the constitutionally given apparatuses of reality relatedness). Autonomy from the environment is ultimately guaranteed by the drives. Both autonomies are secondarily guaranteed by cognitive organizations, including ego interests, values, ideals, ego identity and superego influences.

Boorstein (1959) developed a milieu therapeutic approach based on Rapaport’s idea that there is reciprocal relationship between autonomy from the drives, on the one hand, and autonomy from the environment, on the other; and that ego structure require stimulation for their maintenance.

The healthy autonomous ego is capable of a greater or lesser degree of motoric activity in relation to object, to reality orientation, and to instinctual expression. It is capable of establishing an optimal balance between active and passive modes of behaviour and inner degree of ego autonomy. Maximum autonomy can be preserved only when the ego has certain relationships to reality and to drives and that too much or too little contact with the drives or reality decrease ego autonomy. Relationship with AF with regulation and control of drives, affects and impulses has been noted (Bak, 1954; Michaels, 1959). Loss of impulse control affects both primary and secondary autonomous functions of the ego.
Primary and secondary autonomous function represents the ease with which day to day normal activities may be carried out without internal and external disturbances. Therefore, when AF is impaired one becomes more likely to think about or commit suicide.

5.1.11 Synthetic Integrative Functioning (SF)

SF has been found to differ genuinely between two groups. The lower mean value in attempted suicide individual signifies poor SF functions than the normal.

Hartmann (1939) assumed that the synthetic function of the ego is super-ordinate to all the other ego functions. These appears to be supported by Freud’s definition of the major task of the ego as being to reconcile the often conflicting demands of the id, super ego and outside world, since reconciling conflicting trends is a central aspect of the synthetic function.

SF has two specific components. The first is the capacity to integrate potentially discrepant or contradictory experiences which can be behavioural, psychological or both. It can involve thoughts, feelings, actions and perception. Psychological aspects include the ability to integrate 1) apparently divergent self representation, 2) distortions between internally perceived object representations and externally perceived objects, and 3) affects with incongruent ideation or internal perceptions.

The second major component of this function is the ability to interrelate and integrate psychic or behavioural experiences that need not be contradictory. This aspect of the functions facilitates the experiences of connections and continuity, in addition to allowing for planning and organizing operations. Psychologically, it enables the perception of the relationship of past to present, mood to idea, and percept to experiences.

Nunberg’s paper on the SF (1930) illustrated the manifestations of ego’s synthetic capacity in the assimilation of alien elements, both from within and from without, in the mediating between opposing elements, in reconciling opposites, and in setting ‘mental productivity in train’. The functioning of the ego is made more economical by resolving
contradictions in thoughts, feelings, and action. An indiscriminate increase in SF may lead to mental events or contents to be combined or fused in ways that lead to bizarre outcomes. Nunberg argued that a failure in SF is discernable in all mental symptom formation. In the initial stage of events leading to symptom formation, there is a failure to reconcile the claims of conflicting forces. The ensuing symptom which is a compromise between the conflicting claims is then experienced as alien to the ego (in neurotic conditions). In the development of paranoid delusional systems he sees the SF as responsible for the relating together of ideas and events that are irrelevant to one another in order to support a previously generated idea.

SF represents integration of discrepant massages and adaptation to sudden change Miller et al. (1965) see the SF as synthesizing elements into relatively enduring substructures that are sometimes bound together rather rigidly. Some of the elements may be in conflict, and the substructure may be isolated from major psychic structures, as happens in symptom formation and in paranoid systematization. Structure that function integratively, on the other hand, harmonize elements flexibly and bring them into relation with the major psychic structures.

The role of SF in depression had been explored in prior studies, e.g., Basu et al. (1997) found that SF was specially found to be contributory factor for depressed sample.

It can be said that the persons attempting suicide are unable to relate the totality of the experiences. Due to this deficit they generally focus on a single aspect of the situations and failed to integrate and synthesize the experience emotionally into the necessary gestalt, and might take the extreme step of attempting suicide.

5.1.12 Mastery Competence (MC)

MC is another ego function that has been found to be different among two groups. The attempted suicide group has poor MC as found from the lower mean value.

The function of mastery competence related to the individuals capacity to master his environment relative to his resources (White, 1967). The resources are largely subsumed...
under the other ego functions. MC also refers to how well an individual's ego assets are utilized in interaction with the environment. Mastery competence differentiates between individuals with regard to their degree of active striving to deal with situations, overcome obstacles and actualize their potentials. This function has three components-1) objective performance relative to assets, 2) subjective sense of competency or expectation of success and 3) the degree of concordance between actual performance and expectations.

Alfred Adler treated mastery extensively in his writings. As childhood is a period of helplessness and dependence, feelings of inferiority are universal and may be increased by body or organ defects (real or imagery), parental neglect, rejection, older siblings and other factors. Compensatory strivings for power, personal achievements, and mastery over the external environment follow. Hendrick (1934) discussed the concept of mastery as 'an inborn drive to do and to learn how to do'. He saw it as an ego instinct, the others being the needs for self preservation and for nourishment. The manifestations of the mastery instinct are the rudiments of the various ego functions, and their purpose is the 'adjusting the environment to one self'.

Sense of competence describes the subjective side of one's actual experience. Self confidence is a manifestation of the sense of competence: trusting one's own judgment, accepting difficult undertakings. Lack of self confidence and anxiety at having to make decisions are characteristics of many individuals suffering from neurosis. White (1967) ventures the idea that a strong sense of competence may be one of the most important bases for differentiating psychological health from neurosis. White has most clearly emphasized that while self esteem depends in part upon feeling that one is loved, another important part depends upon being effective in dealing with environmental demands, challenges and requirements.

Another kind of active mastery that has been extensively treated is often designated 'coping'. Visotsky et al. (1961) were concerned with active mastery as shown in coping behaviour under extreme stress. Comprehensive work on active mastery and coping has been done by Murphy et al. (1962). She defines the process of mastery as involving the simultaneous and successive use of various devices and resources in response to new
challenges. Coping capacity derives from native equipment for the ability to use integrative capacities flexibly and from environmental support.

If coping and adjustment are the integral part of mastery competence concept then it must facilitate adaptation to ones environment. Hartmann (1939) spoke of adaptation in terms of reality mastery: ones productivity, ability to enjoy life, and mental equilibrium. He referred to three forms of adaptation: alloplastic action, in which adaptation comes by changes individual imposes in his environment; autoplastc action, in which changes are made in the individuals own self; and a third form that consist of choosing a new environment advantageous for the functioning of the individual.

Better mastery competence ability enables an individual to utilize the analytic insights to work through and resolve conflicts. Basu et al. (1997) showed the roles of MC along with other ego functions in depression. Poor mastery competence in ‘attempted suicide’ group results in low self confidence and inability to use ones potential resources in face of challenge. This inability to cope with the stressful situation probably leads to choose maladaptive behaviour that is ending ones life without exploring other alternatives.

Integration of the ego functions

In the present study all ego functions are found to be impaired in clinical group. Then the question is – ’Is there any particular ego profile for suicidal patients’? The answer is probably ‘No’. Suicide and deliberate self harm is not a unitary psychiatric diagnosis. It is in effect found in various conditions ranging from psychiatric disorder like major depressive disorder, substance abuse, schizophrenia, panic disorder, borderline personality disorder, chronic medical illness or psycho social conditions where hopelessness prevails. Thus ego function profile will reflect the ego function pattern of underlying conditions.

So what does the ego function profile of current study reflects? As the present study is done on attempted suicide patients who do not have any underlying psychosis, substance abuse, personality disorder and chronic medical conditions ego function pattern is free from any effect of these disorders. Impairment in all ego functions implies the severity of
psychopathology of attempted suicide. According to Witkin et al. (1962) the less differentiated the personality, the greater the tendency for a number of ego functions to show maladaptive features at the same time. It is not surprising that the more serious the psychopathology, the more disturbances in the related ego functions occur. Clear distinctions among ego functions and their differential implications are more the exception than the rule. All the major ego functions are in fact multidimensional and complex, rather than unitary and simple. Hartmann applied the interference notion to the various ego functions. He often emphasized the ways in which various ego functions interfere with each other in the process of adaptation. Interference of defensive processes with other areas of ego functions provides the best example of interference as a way in which ego functions interrelate when there is an absence of severe ego regression. But when regression is severe, interference takes the form of secondary failure of one ego function because of the regression of another. Hartmann talked about cooperation among ego functions as a major way in which they interrelate.

Reality testing, for example depends on at least the ego functions and processes of attention, perception, memory, secondary process thinking, delay of discharge, judgment, and reflective awareness (Hurvich, 1970).

Sense of reality has been linked to regulation and control of drives. Depersonalization has been regarded as a means for preserving control of drives (Grinberg, 1966). Possibly the most overlap occurs between sense of reality and object relations, for a major component of each is "the distinction between self and object representations". Milner (1957), Beres (1960), Rose (1963) relate sense of reality to ARISE. Arlow (1966) formulated that depersonalization may represent a defense against intrapsychic conflict i.e. SR is related to DF. As is evident from the above discussion many of the EFs are inter-linked. Reduction in the number of variables would make their manipulation easier for conceptual purposes. From factor analytic study of ego functions assessment 3 factors namely, "adequacy in everyday functioning", "physical, interpersonal and intra personal reality orientation" and "flexibility and self confidence" (Basu et al., 2000) have came out. From the above discussion it can be seen that impairment of all the ego functions in attempted suicide group indicates impairment mainly in "adequacy in everyday
functioning” (responsible ego functions in this group are- DC, TP, DF, SB and AF), “physical, interpersonal and intra personal reality orientation” (responsible ego functions in this group are-RT, JD, SR and OR) and “flexibility and self confidence” (responsible ego functions in this group are-AR, SF and MC) (Basu et al., 2000).

5.2 Role of cognitive style and depression in attempted suicide

Cognitive style is one's typical way of perceiving, thinking, remembering and problem solving (Allport, 1937). It has been described as a predictable pattern of behaviour within a range of individual variability (Cornett, 1983); a way of responding to and using stimuli in a learning environment (Claxton & Ralston, 1978); a preference for processing information and learning (Dunn & Dunn, 1978); the way individuals organize experiences (Kolb, 1984); and an expression of psychological differentiation within characteristic modes of information processing (Witkin & Goodenough, 1981).

Cognitive style has long been considered as a risk factor for suicide and depression. The cognitive-behavioural perspective originally developed by Beck (1976) emphasizes a set of dysfunctional attitudes, cognitions and images associated with depressive symptomatology. In Beck’s cognitive theory, cognitive distortions cause depression and are associated with maintenance of the disorder. The ‘cognitive triad’ involves negative views of one’s self (S), one’s world and current situation (W), and the future (F). The cognitive theory delineates the importance of cognitive distortions, the ‘cognitive triad’, and a conception of negative self image which is called negative self schemas.

The cognitive perspective is elaborated further by hopelessness theory (Seligman, 1975). In hopelessness theory ‘depressogenic attributional style’ leads individual to regard stressful life events as permanent rather than temporary, and affecting most of one’s life rather than a specific aspect. Certain attributional styles lead to personal or internal, rather than global or external explanations of the depressive disorder.

In the present study all the components of cognitive styles, i.e., W, S and F has been found to differ significantly among normal group and the ‘attempted suicide’ group. In cognitive style test greater score implies poor cognitive styles. Lower mean value has
been found in normal group indicating their better coping and problem solving ability over the attempted suicide group.

The link between cognitive style and suicide is very subtle. It is based on two hypotheses; first, the suicide is associated with constrictive cognitive style rather than with style \textit{per se} and second, that suicide is correlated with an increase in negative affect (Sheehy & O'Connor, 2002).

In the attempted suicide group self has been perceived as defective and incompetent. Negative or unpleasant experiences are attributed to this defective self. Experiences are interpreted in a distorted and negative way, environment seemed to be extremely demanding and interaction with the world becomes constricted. At the end future becomes also negative and hopeless and defeat or failure is anticipated. The person unable to take the other alternative and ends his life. High risk suicidal patients tend to endure impairments in their social and interpersonal problem solving abilities. This is often most noticeable in difficulties experienced when conceptualizing, identifying and formulating appropriate solutions to the social problems. Studies revealed that suicidal people generate fewer as well as less relevant solutions to a number of social dilemmas (Pollock & Williams, 1998). Suicidal and depressed individuals tend to generate overly general autobiographical memories and take longer to recall positive memories than matched controls (Williams, 1997; Williams & Broadbent, 1986). The suicidal person is able to access general but not specific memories. These memory biases have been attributed to changes in problem solving proficiency (Evans et al., 1992). Difficulties accessing specific events from long-term memory are likely to diminish one's problem-solving capacity. Thus suicidal individuals engage in efforts to solve interpersonal dilemmas burdened by a significant information processing handicap.

Apart from genuine difference in cognitive style between two groups, significant negative co relational value has also been found out with suicidal ideation in 'attempted suicide' group. It seemed perception of W, S and F has positive/direct relation with development of psychopathology of suicidal behaviour. Earlier research has also highlighted the role of cognitive style in development of depression and suicide (Blackburn et al., 1986,
Levenson & Newringer 1971, Kaplan & Pokorny 1976, Orbach et al., 1998). The present study also confirms the fact.

In normal group negative view of self is correlated with ideas of suicide. However, normal group differs from the ‘attempted suicide’ group in that world and future are not correlated with ideas of suicide. It signifies that extremely demanding environment with hopeless future in ‘attempted suicide’ group drives them to take the extreme step of attempting suicide, whereas a less demanding environment with future hope prevent the normal group from attempting suicide.

Severity of depression is found to be more in ‘attempted suicide group’ than their normal counterparts as found from the greater mean values. It must be remembered in this context that depression found in the normal group is in sub clinical level and does not lead to any kind of pathology. Depressives are regarded as high risk group with respect to suicide: epidemiological studies show a strong relation between depression and suicide. Almost 95% of all persons that commit or attempt suicide have a diagnosed mental disorder. Depressive disorders account for 80% of this figure. Leading to the hypothesis that suicide is the mortality of depressive illness. Roughly 50% individuals who have successfully committed suicide carried a primary depressive diagnosis (Barklage, 1991). Kessler et al. (2005) reported that 88-89% of suicide attempters met psychiatric diagnosis among which depressive disorders are most often diagnosed. 9 times greater odds of suicidal act among respondents with a major depressive episode are reported by Blackmore et al. (2008).

5.3 Role of number of life events in attempted suicide

Numbers of stressful life events are also found to be greater in case of ‘attempted suicide’ group (Table-1). The number of stressful life events in last 1 year have significant positive correlation with suicidal attempt in ‘attempted suicide’ group (Table-5). The roles of stressful life events in the etiology of various diseases are well known. Earlier studies also mention stressful life events give rise to development of various psychiatric disorders (like depression) in susceptible persons [Dohrenwend & Egri (1981), Paykel
One of the most influential models of the suicidal behaviour is the stress-diathesis or stress-vulnerability model (Mann, 2002). This suggests that certain individuals are predisposed to suicidal behaviour (which may be related to sex, religion, familial and genetic factors, childhood experiences, psycho-social support systems, access to lethal methods or biological factors). The vulnerability only leads to suicidal behaviour when the individual encounter the stressor (which could be a mental disorder, alcohol or drug abuse, a medical illness or a psychosocial crisis).

A study exploring the role of stress in adolescent suicidal attempters, showed that this group experienced more stressful life events than depressed patients or general population controls (Paykel et al., 1974). Elevated level of major negative events and exit events in the previous year has been found among suicide attempters (Adams et al., 1994). Family disruption and discord, loss of relatives due to divorce or separations or death, and problems in family, interpersonal relations derived from parental psychiatric illness are important aspects of stressful circumstances experienced by suicidal adolescents (Pfeffer, 1996; Sharma et al., 2008).

The result suggests that though ego functions are more deficient, life events are more in number, cognitive styles are more impaired and depression is more severe in attempted suicide group (as observed from table-1 and table-3), the dynamics of development of suicidal ideation is an intriguing one.

5.4 ‘Pathway to suicide’: Role of ego functions, number of stressful life events, cognitive style and depression in formation of suicidal ideation and suicidal attempt

“Suicide is characterized as the final common pathway of diverse circumstances, of an interdependent network rather than an isolated cause, a web of circumstances tightening around a single time and space” - Havens, 1965.

HMRA was applied to find out the relative contributions of various predictor variables in development of suicidal behaviour which includes suicidal ideation and suicidal attempt. The predictor variables were entered in a specific order. The underlying theoretical
consideration was among all the predictor variables, ego functions were considered to be most stable personality constructs. It determines one's typical way of perceiving and interpreting the life events which is considered as cognitive style of a particular individual. When this interpretation revolves around a negative view of world, self and future (cognitive triad), clinical depression sets in that ultimately leads to suicidal behaviour.

Hierarchical Multiple Regression Analysis (HMRA) suggests that in normal group ego functions predict suicidal ideation, but the combined effects of life events and cognitive styles do not significantly increase suicidal ideation. However, when depression ensues, that leads to increase in suicidal ideation. We might say that in this study both suicidal ideation and depression in normal group are in sub-clinical level, as the subjects are screened by G.H.Q. Previous studies by various authors revealed suicidal ideation in 'so called 'normal population' (Paykel et al., 1974; Besozzi, 1972; Holmstrom, 1972; Lonnqvist et al., 1980; Venkavarao et al., 1986).

In 'attempted suicide' group (Table-7) with deficient ego functions when the life events occur, suicidal ideation does not significantly increase. However, when impaired cognitive styles take place suicidal ideation significantly increases. With impaired cognitive styles, when severe depression develops that will lead to significant suicidal ideation culminating to attempted suicide.

The above result suggest important role of cognitive styles. Combined effect of deficient ego functions, impaired cognitive styles predict suicidal ideation in clinical level, when along with these factors depression in clinical levels sets in, probably suicidal ideation develops to such an extent that it leads to suicidal attempt (as all the present subjects of 'attempted suicide' group of the study had a history of suicidal attempt). Suicidal patients are assumed to share the frequent occurrence of the depressed patients' negative thinking, compounded by logical errors, and tendency for long term belief structures to be activated by depression (Beck, 1967). Majority of people who attempt or commit suicide are found to have a mood disorder. Up to 90% of people attempted suicides have been found to have depression at the time of their attempt (Beautrais, 1996; Fry & Teesson,
The cognitive factor of negative evaluation of future has found to be more closely related to attempted suicide (Minkoff et al., 1973).

From HMRA of both ‘attempted suicide’ and normal group, it is apparent that life events has no role in development of either suicidal ideation or suicidal attempt as found from the present study. Though the numbers of stressful life events are found to be significantly more in the attempted suicide group, but it does not play significant role in predicting suicidal ideation beyond the impact of ego functions. Although puzzling, this picture is not unique to this study only. Other studies that compared suicidal and non-suicidal adolescent samples have found similar results. Brent et al. (1988) compared psychological autopsies and found no differences in frequency of stressors between the two groups.

In both the groups’ ego functions and depression plays the major role in development of suicidal ideation. Cognitive style plays an important role in development of suicidal behaviour in ‘attempted suicide’ group as well, but it has lesser role in development of suicidal ideation in normal group. This affirms the proposition of importance of cognitive styles. There is no evidence that specific cognitive dispositions prime people for suicide, but there are obvious indications that suicide is associated with a constriction in cognitive style (Sheehy & O’Connor, 2002). Other researcher also documented the role of restricted cognitive style in attempted suicides (Levenson & Neuringer, 1971; Kaplan & Pokomy, 1976; Orbach et al., 1987). Guha et al. (2006) found similar result in attempted suicides in the Indian setting.

Attempts have been taken to relate cognitive styles and ego functions. From results of HMRA for further analysis (Table-8 – Table-13), it is observed that ego functions significantly predict cognitive styles both in normal and ‘attempted suicide’ groups. Life Events do not predict cognitive style in both the groups. Hence, probably development of impaired cognitive styles is related to deficient ego functions in ‘attempted suicide’ group and adaptive ego functions predict better cognitive styles in normal group. Hence, the above result suggests that strength of ego functions probably contribute to change of perception toward world, self and future. Till date, the research literature has taken note
of features of cognitive functioning and ego adaptation that are characteristic of suicidal individuals despite their array of dynamic conflicts. Hartman & Loewenstein (1962), suggested that the decisive factor in suicide, given a depressive context, was to be observed in the pathology of the ego. Empirical research has frequently characterized the thoughts and cognitive controls of suicidal patients as rigid and inflexible (Farberow, 1965; Levenson & Neuringer, 1971). A loss of perspective, a paucity of alternatives, and an overall cognitive rigidity have been observed repeatedly in these patients. The suicidal individuals pay excessive attention to a particular disturbing area in his life and view it as unchangeable or unavoidable.

Further attempts have been taken to relate ego functions, life events and cognitive styles to predict depression. From results of HMRA of further analysis (table-14 and 15), it is revealed that in normal group, ego functions contribute to develop depression but life events and cognitive styles do not. Whereas in ‘attempted suicide’ group ego functions and cognitive styles contribute to develop depression but life events do not. Attributional style is closely linked to cognitive aspect of personality. Severe life events did not appear to influence attributional style, once current mood and diagnosed depression were taken in to account (Ball et al., 2008). It also implies that if cognitive styles are impaired to lesser extent they do not lead to pathological depression. Blackburn et al. (1986) found the relationship between negative cognitive style and vulnerability to depression. Cognitive styles have been investigated as vulnerability factor for depression onset, especially when attributions are in response to negative life events (Abramson et al., 1989). People differ not only in their cognitive abilities but also in terms of their cognitive styles: their habitual pattern of approaching cognitive tasks. Variation in the ways people process information can predispose person to certain disorders or provide certain protective coping mechanisms. Research and theory has repeatedly implicated faulty information processing in the onset of anxiety and depression (Gotlib & Hammen, 1992). People who regard the causes of negative events as global, stable and internal (due to the self) are more likely to develop depression. Certain facets of personality are strongly associated with major depression and one explanation is that personality is the vulnerability factor for depressions.
5.5 The Integration of the Findings

The present study in its effort to investigate the role of ego functions in suicide has brought about some interesting findings. The differences between the two groups have been significant on all the psychological variables under study (ego functions, number of stressful life events, cognitive style, and depression). From the findings of the present study, no particular ego profile, which can be labelled as ‘ego profile of suicidal persons’ has emerged. Rather all the ego functions namely, RT, JD, SR, OR, TP, AR, DF, SB, AF, SF and MC are found to be poor in the attempted suicide group. Among the 12 ego functions RT, JD, DC, TP and SB are found to be negatively correlated with suicidal attempt in attempted suicide group. As ego function profile is not a description of symptomatology, rather it is an overall impression of the functional status of the individual in relation to social and physical reality; the above findings suggest the resultant level of dysfunction among the suicidal group.

Cognitive style including world, self and future have been found to be negative and distorted in nature in the attempted suicide group. Though, there is a significant difference in experiencing number of stressful life events in the two groups, but stressful life events do not seem to contribute much in developing suicidal ideation in both normal and attempted suicide group.

It is often assumed that suicide is directly linked with depression because the vast majority of persons who attempt suicide or commit suicide, show signs of depression. However, recent research has made it increasingly clear that the major precipitant of suicide is hopelessness (Beck et al., 1985). In fact, when the relationship between hopelessness and suicide is taken into account, no relationship between depression and suicide remains. The apparent relationship between depression and suicide is due primarily to the high incidence of hopelessness among depressed individuals.

The depressive individuals have not only negative cognitive ‘triad’, but also they have incongruity between thoughts, feelings and behaviour. They generally lose their goal oriented behaviour, and adequate planning ability in face of different life situations.
Depression and suicidal behaviour are related to a certain amount of cognitive rigidity (Marzuk et al., 2005).

The suicidal person tends to endure a pessimistic view of the future, their general environments and themselves and they tend to manifest a depressogenic attribution style. This kind of thinking can be associated with an extended phase of negative affect and cognition, leading to decrements in problem solving and an increased sense of hopelessness which in turn elevates their suicide risk. Traditionally measured along three dimensions – internal-external, stable-unstable, global-specific depressed and suicidal individuals tend to attribute negative life events to internal, stable and global causes (Peterson et al., 1982).

Hence, from the above result it might be said that deficits of ego functions contribute to develop cognitive distortions characterized by negative perceptions towards world, self and future. This leads to develop clinical depression which produces suicidal ideations that sometimes ends up in suicidal attempts.

Hence diagrammatically the model will be as following in 'attempted suicide' group:

Diagram:

- Impaired Ego Functions
- Impaired Cognitive styles
- Clinical depression
- Suicidal ideations
- Suicidal attempts.