CHAPTER-1

INTRODUCTION AND CONCEPTS OF THE STUDY
The suicidal tendency among people as well as the suicidal
death, both have reached the alarming stage not only in our society but
in other societies of the world also. According to an estimate over
crores of the people kill themselves each year in the world. It may be
defined as a behaviour in which a person kills him or herself or takes
his or her own life. In America, one of the well advance countries the
world, the current estimate of suicidal death is over thirty thousand
(30000) each year (Silverman, 1997). In India the situation is even
more grave. The recent statistics about the suicidal deaths presents a
very painful picture of it. According to reports, about 300 people per
day or about one lac people each year commit suicide in India, a
country of religion and cultural faith. (NCRB 2000-2001; ICMR-
2000). In Japan 30,227 killed themselves in 2004 and in China about
700 people kill themselves per day.

These figures are just the eye opener about this tragic threat to
human lives. Indeed the actual figures may be even more startling as
many self inflicted deaths are attributed to other “more respectable”
causes in official records (O’Donnell & Farmer, 1995; Silverman,
1997). There is another aspect also of suicides known as attempted
suicide but not completed. The number of such cases are also rapidly
increasing. In some cases it has been reported that the entire family
opted suicide owing to one or other reason. As regards the causes of
suicidal deaths, parasuicidals are suicidal ideation the reasons are
many, not just a few. This incidence or behaviour has been the subject
of interest for sociologist, psychologist and mental professionals as well. As a result of it this problem has been evaluated from different point of views. In psychological literature it is seen as a self-destruction or self harm leading to the end of the life of the person concerned. In recent approaches to the classification of mental or behavioural disorders suicidal behaviour is included in each and every approach. The relatively more popular approach, DSM-IV classifies it into Axis I which covers the mental disorders related to mood disorders.

It is already stated in the preceding paragraph that there may be numerous causes of suicidal behaviour or ideation and a number of studies have been conducted in this area of research. The researches done in this area, reveal that any one who commits suicide as a means of making oneself free from the problems confronted by him or her actually does not do so willingly but performs this tragic act under pressure of some conflicts, frustrations or pressures created by one or the other types of factors. Some scholars are of the view that suicidal attempt is actively a cry for the sympathy from others. So if someone comes to help the person who is under the influence of suicidal ideation, this tragic event might be prevented. If this becomes possible, the precious human resource may not only be saved but rather may be preserved for the well being of the individual concerned and the family members of the victim as well as the society. This will proved to be a boost for the survivors of the members of the family of the person who unfortunately opts suicide to get rid of the problems of life. In such a state of dejection the psychological or social support or assistance
provided to the person concerned may act as a means of great relief and in some cases it may prove as a panacea also.

Let us see which occupational group is at higher risk of suicide (NCRB 2000-2001)

**Table 1.1 : Relative Risk Positions of Suicidal Attempts for Some Groups.**

<table>
<thead>
<tr>
<th>Group at risk</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>House wives</td>
<td>20%</td>
</tr>
<tr>
<td>Employees</td>
<td>12.7%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.5%</td>
</tr>
<tr>
<td>Students</td>
<td>5%</td>
</tr>
<tr>
<td>Retired</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

NCRB report also reveals that 38.3% suicidal deaths occurred due to poison consumption, being the highest, 27.4% hanged themselves. 10% set themselves on fire, and some victims opted rail track and rivers etc. It is wonderful to note in rich state like Punjab 29.8% killed themselves with electric shock. The 35 major cities of India and also other cities as well as rural areas are noticing marked increase in suicidal deaths.

No doubt there is no scarcity of studies on suicidal death or ideation, inspite of it our knowledge about the antecedents of suicidal ideation as well as its consequences for survivors of the family members and also for the society is not well understood. The majority of studies on suicidal deaths or ideation has been conducted in
countries other than ours, specially western countries. In our country it has not received the attention it actually deserves. The scholars over here are not so actively engaged in identifying the causes of suicide and assessing its consequences as well but the state of knowledge about the suicidal behaviour in western countries is far exhaustive and intensive as compared to our knowledge in this regards. (O’Connor et. al. 2003; Pinhas et. al. 2002). This state of our knowledge about it clearly indicates that there may be several moot questions in this field which need clarifications regarding the causes and consequences of this mental disorder leading to untimely deaths of crore of people all over the globe.

It was in view of the above that the problem of the present study was framed and the topic covers some of the important personal, social and psychological factors assumed to be responsible for suicidal deaths or suicidal ideation. Thus it is obvious that it is an etiological study of suicidal behaviour covering an exhaustive range of variables associated with suicidal ideation. The paucity of properly planned empirical studies any where in general and in our context in particular made the present researcher plan and execute this study. So undertaking the present study is fully justified and the variables covered in it are absolutely relevant. The topic of the study was thus framed as under :

**An Etiological Study of Suicidal Behaviour** :

**Objectives** :

The major objectives of the present study are illustrated below :

1. To ascertain the effects of self-esteem, if any, on suicidal tendency.
2. To evaluate the affects of depression, if any, on suicidal ideation.
3. To ascertain the effects of age, if any, on suicidal ideation.
4. To compare the male and female respondents from the point of view of suicidal ideation.
5. To assess the effects, if any, of employment status on suicidal ideation.
6. To compare the respondents of rural and urban setups from the point of view of suicidal ideation.
7. To evaluate the differential effects, if any, of cultural context on suicidal ideation.
8. To ascertain the effects of family types, if any, on suicidal ideation.

Concepts of the Study

This study tapped suicidal ideation as the dependent variable and self-esteem depression, age, employment status, sex, environment, culture and family types as the independent variables.

Suicidal Ideation:

Suicide has been declared as a major health problem in almost all the countries of the world. It may be defined as taking one’s own life. Suicidal deaths are avoidable provided such ideation is traced and tackled in time. In other words, suicide is a permanent solution to a temporary problem by the person concerned (Coon, 2003). According to estimates, suicide rate among children has doubled since 1980 and that the elderly account for one in five suicides. It is estimated that nearly half a million people world wide kill themselves each year.
most countries the young adult group seems to be at the higher risk. Suicide is the number one cause of death among the 25 to 35 year old age group and accounts for 30% of all deaths among men and 25% of all death among women (NCHD-2000).

There are several other factors which increase the likelihood of suicidal attempts on national level the antecedents of suicidal deaths have been listed as under (ICMR-2006)

Table 1.2 : Some Major Causes of Suicidal Deaths (National Level)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Depression</td>
<td>35%</td>
</tr>
<tr>
<td>Economic problems</td>
<td>16%</td>
</tr>
<tr>
<td>Poverty unemployment</td>
<td>10%</td>
</tr>
<tr>
<td>Family problems</td>
<td>9%</td>
</tr>
<tr>
<td>Marital problems</td>
<td>9%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>7%</td>
</tr>
<tr>
<td>Father-son dispute</td>
<td>7%</td>
</tr>
<tr>
<td>Academic</td>
<td>4%</td>
</tr>
</tbody>
</table>

Thus mental depression happens to be the most important determinant of suicidal deaths in our country. Similar is the position in other countries also. Since this study was conducted in Jaunpur and its neighbouring areas, so it would be useful to present the statistics of suicidal deaths in Jaunpur and eastern U.P. The reasons are as under:
Table 1.3: Some Major Causes of Suicidal Deaths in Eastern U.P.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Factors</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Family tension</td>
<td>36.66%</td>
</tr>
<tr>
<td>2.</td>
<td>Poverty/Debt</td>
<td>26.66%</td>
</tr>
<tr>
<td>3.</td>
<td>Unknown factors</td>
<td>16.66%</td>
</tr>
<tr>
<td>4.</td>
<td>Frustration in Love</td>
<td>6.66%</td>
</tr>
<tr>
<td>5.</td>
<td>Political</td>
<td>3.33%</td>
</tr>
<tr>
<td>6.</td>
<td>Other frustrations</td>
<td>3.33%</td>
</tr>
<tr>
<td>7.</td>
<td>Illegitimate relationships</td>
<td>3.33%</td>
</tr>
<tr>
<td>8.</td>
<td>Mental disorders</td>
<td>3.33%</td>
</tr>
</tbody>
</table>

If we compare the two figures, it would be clear that on national level depression is number one cause of suicide but in eastern U.P. number one cause is family tension. The other factors include age, sex, marital status, ethnicity or race recent occurrence of several life events, e.g. frustration in love, failure in examination, family quarrels debt, poverty and dowry problems etc. Similarly personality factors, easy access to a means of suicide, drug and alcohol abuse and mental disorders etc. make suicide more likely. These factors are presented in Figure-1.1. Factors may be grouped as personal vulnerability (or risk) and resiliency and precipitating factors (Radomsky etc. 1999)
Fig.1: Occurrence of suicide is related to either of the several factors, assigned to three groups.

Thus it is obvious that any one may commit suicide provided he or she is under influence of suicide instigating factor or factors. No segment of society is immune. Nonetheless, some groups are at higher risk than others.
Table 1.4 : The Monthwise Analysis of Suicidal Deaths in Jaunpur District in 2006

<table>
<thead>
<tr>
<th>Month</th>
<th>Suicidal death</th>
<th>Months</th>
<th>Suicidal Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>3</td>
<td>February</td>
<td>5</td>
</tr>
<tr>
<td>March</td>
<td>2</td>
<td>April</td>
<td>6</td>
</tr>
<tr>
<td>May</td>
<td>5</td>
<td>June</td>
<td>0</td>
</tr>
<tr>
<td>July</td>
<td>5</td>
<td>August</td>
<td>11</td>
</tr>
<tr>
<td>September</td>
<td>10</td>
<td>October</td>
<td>10</td>
</tr>
<tr>
<td>November</td>
<td>3</td>
<td>December</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 1.4 shows that 66 persons killed themselves in Jaunpur (U.P.) in 2006. It included 36 females and 30 males. The majority (15%) hanged themselves.

Some Specific Cases of Suicidal Deaths:

During this study details about over thousand of cases of suicidal deaths were collected from different sources including print and electronic media. Some of the such cases may briefly be mentioned in this context to throw light on the major causes of suicidal deaths. Analyses of such deaths were caused by different types of factors including family tension, poverty, frustration in love and psychological disorders etc.

1. **Two jump in front of train, end life.** Two women committed suicide by jumping in front of a train at Karkaha village (Phoolpur, Varanasi) on 27.4.2004. Another body was found adjoining Kashi Railway Station area. Reason unknown (HT. 28.7.04).

2. **Family Tension a Major Cause : Jumping into the well very common among women :** A lady with three children jumped into the well. She was
rescued by villagers but the children died. Family tension was said to be the reason behind it (Jagran, 4.5.2005). She belonged to Rehari (Chandwak, Jaunpur). Another woman killed herself by hanging after a quarrel with her husband. She was 21 and belonged to Manikpur, Maruadeeh (Jagran 5.8.04). A lady belonging to Bariwan (Cholapur, Varanasi) committed suicide due to family tension. She too jumped into the well (Jagran 30.6.05). Another women immolated herself along with two innocent daughters also in Gyanpur town (Amar Ujala, 31.5.05)

A woman named Shivangi (24) of Adampur (Varanasi – Jagran 5.7.05) hanged herself. A family of seven committed suicide due to family troubles. Six of them consumed poison and one hanged himself (Tollygunje, Charu Market, Kolkata, Hindustan Times, July 18, 2004).

3. Frustration in love may lead to suicide : Sunita (20) and Lallu (23) of Sheopur, students of Mariahun P.G. College, Mariahu, Jaunpur loving Shivangi hanged herself

Sadhana committed suicide by jumping into the well  Rekha Patel killed herself by hanging

Introduction
each other consumed poison and ended their lives as they could not get family support for their relationships (Hindustan, May 18, 2007). A married women of Kheta Sarai (Jaunpur) when failed to marry a man of her choice killed herwelf alongwith her three children. Shabana Bano (26) thus opted suicide (Hindustan, May 5, 2004). Many others also opted this way for ending their lives.

4. An Ex-Minister & a Dy General Manager end their lives : A well known politician Mr. Balram Singh Yadav (Ex-minister and senior Congress leader) shot himself with his own revolver (Jagran 5.7.05) at his Etawah residence. Though the reason was not disclosed by the family but chronic illness was attributed for it.

Mr. Rakesh Agrawal (51) Dy General Manager (NTPC-Singrauli) was found dead in his room. He hanged himself from the fan (Amar Ujala 4.6.05). The reason remained untraced.

5. Dowry takes many lives : A number of women suffering from pressure of dowry by their in-laws often commit suicide, e.g. Seema (22) of Arjunpur (Kotwali, Mirzapur) killed herself by hanging from fan and poisoned her
two children also (Hindustan, 2.2.06). Similarly Shalini Mailik (23) of Prashant Vihar (New Delhi) hanged herself and blamed in-laws in her note. She too became victim of greed (Times of India, 26.10.05).

6. **Poverty & debt a major threat to lives**: Several people take their lives due to poverty and debt, a major cause of suicide. Mr. Anant Misra (Rapti Nagar, Gorakhpur) committed suicide along with his family member as he was badly perturbed by debt. (Hindustan, 14.8.04). In New Delhi (West Azad Nagar) bogged down by mounting financial losses a 43 yrs. old business man and his family members hanged themselves (Times of India, 30.9.05). Several farmers in different parts of the country have taken their lives so far owing to debt and poverty. Poverty swallowed four in Gorakhpur (Hindustan, 14.8.04). In South Kolkata a family of seven opted suicide as they were badly poverty ridden (Jagran, 19.7.2004).

7. **Psychological disorders causing suicidal deaths**: In many cases people suffering from some sort of psychological disorders and getting no proper care and support may opt to end their lives. This happened with Ajai Gupta (24) of Pandeypur (New Colony, Varanasi). He hanged himself (Jagran, 28.5.04).

These cases are just our eye opener. There may be so many unfortunate people...
who find no way except to make an end of their life. Such people may get rid of
trouble in their view, but leave a lot troubles and misfortunes for their survivors
and relations, no doubt. Such cases must be identified and be given psychosocial
support to face the challenges bravely.

**Suicide Contagion (Werther effect)**

If a well known person commits suicides, its communication
leads to increase in suicidal attempts by others. It is known as suicide
by contagion or Werther effect named after Goethe’s fictional hero
who killed himself due to failure in love. Its publicity increased
suicides by 12% (Philips 1974). The imitative behaviour is said to be
responsible for it (Jones, 1992).

**Fatal and Non-Fatal Suicidal Behaviour**—

A common distinction in the literature has been drawn between
those who complete suicide and those who attempt suicide but for
whom the outcome is not death. The latter is usually inferred to as
‘para suicide’. Typically, the two are said to be distinguished by the
seriousness of the suicidal intent those who do not actually complete
suicide or believed to want to survive and to have made a suicide
gesture for psychological ends (for example, manipulation, a cry for
help). Such distinctions, however, fail to reflect that not all persons
who engage in non-fatal suicidal acts actually wish to survive;
conversely, not all suicidal deaths are intended. As Taylor observes
‘most suicidal acts are undertaken with ambivalent intention’
(1984:143). However, the idea of ambivalent intention should not be
used to trivialize what is a very serious and meaningful act even when
death is not the outcome when considering suicidal behaviour it is thus
more helpful to define it in terms of outcome (i.e. fatal or non-fatal) so as to avoid making assumptions about the individual’s suicidal intent and the personal significance of the suicidal behaviour (Canetto, 1994).

Fatal and non-fatal suicidal behaviour have been linked respectively to a number of factors which suggest differences between the two. Fatal suicidal behaviour is more common in men, in those over 40 years of age, living alone, widowed or divorced, and is associated with alcohol problems and physical illness. It also tends to be carefully premeditated. Drugs over dosage is the cause of death in approximately 50 percent of completed suicides and other violent methods, such as hanging, drowning, shooting, gassing, jumping from buildings or in front of vehicles or trains, account for the remainder. The methods of committing suicide appear to be influenced by cultural and historical circumstances.

Non-fatal suicidal behaviour, by contrast, is more common in young women (two-third are women under 25 years of age), tends to occur in response to an acute personal crisis and is a more impulsive act. It remains one of the commonest reasons for admission to a general hospital. The method most frequently used in acts of non-fatal suicide is an overdose of medically prescribed psychotropic drugs. According to Jack (1992), every year in the U.K. as many as 215,000 people deliberately poison themselves with drugs; this represents the most common method of suicide among women.

The ‘Self-harm syndrome’

Distinction has been drawn between non-fatal suicidal behaviours where the intention at some level at least, appears to be to
kill oneself and those instances where the individual engages in self-harm as an end in itself. Such behaviour has been variously referred to as 'deliberate self-harm syndrome' or 'wrist-cutter syndrome'. There is general agreement that self-harm is an intentional behaviour primarily aimed at expressing and relieving feelings which the individual feels unable to manage in any other way (Favazza, 1989). It may involve, for example, individuals cutting their wrists or any surface of the skin, burning themselves with cigarettes or scraping their skin with graters. Repeated self-harm only rarely results in suicide.

It seems that repeated self-harm is commonly associated with borderline personality disorder (Tantam and Whittaker, 1993). The motivations ascribed to those individuals who self-harm repeatedly include the desire to reduce tension; a means of restoring a sense of being 'real' following depersonalization; a substitute for suicide which allows the individual to expiate guilt, and a means of controlling relationships and the ambivalent feelings they arouse as self-harm has the effect of both distancing others and allowing individuals to protect themselves against rejection.

Researchers have reported that there is a link between suicide and depression (Hirschfeld & Davidson, 1988). Notwithstanding such a correlation, there is accumulating evidence to suggest that hopelessness itself often a symptom of depression- is the key variable in depression determining suicidal behaviour (Beck et. al., 1985b). A high level of hopelessness, whether rated on a scale or assessed clinically, is among the best predictors of eventual death by suicide (Beck et. al., 1989). At a practical level, this means that when faced
with a client who expresses suicidal ideation it will be important to assess their degree of hopelessness. For example, whether they can envisage any solutions for their problem or even a future. Verbal expressions of hopelessness by a client are often suggestive of suicidal intent and this needs to be explored with them.

**Some prominent symptoms of suicidal ideation:**

There may be some symptoms which must be paid due attention in order to identify persons who might be considering for suicidal attempts. Coon (2003) has listed such points as under:

**Warning Signs of Potential Suicide**

- Withdrawal from contact with others
- Sudden swings in mood
- Recent occurrence of life crisis or emotional shock
- Personality change
- Gift giving of prized possessions
- Depression/hopelessness
- Aggression and/or risk taking
- Single car accident
- Preoccupation with death
- Drug use
- Death imagery in art
- Direct threats to commit suicide
Myths About Suicide

Following myths are interesting:

**Myth 1: People Who talk about suicide don’t actually commit suicide.** Undoubtedly, there are many people who threaten suicide without ever going through with it. Nonetheless, there is no group at higher risk for suicide than those who openly discuss the possibility.

**Myth 2: Suicide usually takes place with little or no warning.** It is estimated that eight out of ten suicide attempts are preceded by some kind of warning. These warning may range from clear threats to vague statements. The probability of an actual suicide attempt is greatest when a threat is clear, when it includes a detailed plan, and the plan involved a relatively deadly method.

**Myth 3: People who attempt suicide are fully intent on dying.** It appears that only about 3-5 percent of those who attempt suicide definitely want to die. About 30% of the people who make an attempt seem ambivalent. They arrange things so that their fate is largely a matter of chance. The remaining two thirds of suicide attempts are made by people who appear to have no interest in dying. They only want to send out a dramatic distress signal. Thus they arrange their suicide so that a rescue is quite likely. These variations in intent probably explain why only about one-eighth of suicide attempts end in death.
Myth 4: People who are suicidal remain so forever.

Many people who become suicidal do so for a limited period of time. If they manage to ride through their crisis period, thoughts of suicide may disappear entirely. Apparently, time heals many wounds—if it is given the opportunity.

Practical Consideration in Assessment Management

Assessment of Risk

Therapists may be faced with two possible assessment tasks: (a) that of assessing the potential risk of suicide in some one who has not attempted suicide (or is in between episodes); and (b) that of assessing suicidal intent following an attempt and risk of farther attempts. The initial assessment with a client following a suicide attempt is very important because for many this assessment is the only contact with a mental health professional that they are likely to accept. The overall aims of the assessment interview in such cases will be.

1. To establish a working alliance which will encourage the client to engage with therapeutic help. Although one of the aims of the assessment is together information about the attempt and the psychosocial situation of the client, the primary aim is to establish a relationship where the client can feel understood, not blamed and where painful thoughts fantasies, wishes and feelings towards self and other can be thought about.

2. To understand the circumstances of the attempt and the intentions behind it.

3. To assess future risk.
4. To work with the client towards formulating a plan of action of which individual therapy may form a part.

While some therapists may be faced repeatedly with the task of assessing some one who has just attempted suicide, for more common in clinical practice is the question of how we manage clients' expressions of suicidal thought suicidal ideation is not uncommon and occurs in people who have no formal psychiatric problems. Passing thoughts, for instance, of killing oneself or wishing one would never wake up again, can occur in people who are only feeling mildly depressed or simply low in mood. When such thoughts are expressed either directly or indirectly (for example, I can't see any point any more) in the context of a therapeutic session, they should always be taken seriously and followed up with a sensitive assessment of the level of intent. In such a situation the therapist may need to engage more actively with the client even of their usual therapeutic stance is a more passive silent one.

**Assessment of suicidal intent**:

The assessment of suicidal intent is best inferred from the circumstances surrounding the attempt, such as:

1. The behaviour of the person just before and after the attempt.
2. The expected lethality of the drugs use (if an overdose) as believed by the person as people vary in their knowledge of the effects of drugs. Suicidal intent does not always correlate with actual bodily harm inflicted.
3. Whether any efforts was made to seek help after the attempt.
4. The degree of hopelessness.
5. An exploration of whether the client actually wanted to due.
6. An exploration of the motivations and intentions behind the act.

The characteristics of a suicide attempt which suggest serious suicidal intent are as follows:

- Act carried out in isolation.
- Timed so that intervention by others is unlikely.
- Precaution taken to avoid discovery.
- Preparation made in anticipation of death.
- Extensive premeditation.
- Suicide note left.
- Failure to alert others following the attempt.

When faced with a client who has just attempted suicide, it will be important to assess the probability of his doing it again. The greater the probability the more difficult it may be to continue seeing the client in therapy without psychiatric/medical back-up. Deciding about hospitalization is a complex matter as there are advantages and disadvantages to this.

The characteristics associated with increased risk of repeated attempts are as follows:

- Previous attempt (those who have attempted suicide once represent a 27-fold greater risk of subsequent successful suicide compared to the general population. (Hawton and Fagg, 1988).
Psychiatric problems
Abuse of drugs or alcohol
Social isolation
Middle or old age
Male sex
Antisocial personality
Unclear reasons for previous attempt.

**Theoretical approaches:**

There is but one truly serious philosophical problem and that is suicide. Judging whether or not life or is not worth living amounts to answering the fundamental question of philosophy. (Camus, 1955.11)

Central to any psychological approach to the question of suicide is an attempt to understand why some people choose to take their own lives. In the above quote, Camus firmly locates suicide as a philosophical concern. His perspective is all too often missing from psychological accounts of suicide. **There are some cultures, the best known of which is the Japanese, where the act of suicide is considered a noble deed under certain circumstances** (for example, the Kamikaze attacks of the Second World War). It is also sometimes the case that we find it quite difficult to decide in individual instances when we look at the quality of life of the person who has committed suicide whether there might not have been some justification in this ending of life. However, this point of view is fundamentally opposed to
the ethics of the caring professions which are dedicated to preserving life.

**Biogenetic models:**

Proponents of biogenetic theories argue that suicidal behaviour has in many instances, a neurochemical basis. For example, Slaby (1994) has studied the changes in the metabolism of the indoleamine serotonin. His results suggest that impulsive violent behaviour (both self and other-directed) is associated more with disturbances in serotonin metabolism in the brain that in mood disorders. Such disturbances have been reported in suicide, homicide, assaults, rape and eating problems (Cohen et al., 1988). However, as may so-called healthy people also reveal such abnormalities it is clear that no firm conclusions can be drawn regarding the biogenetic basis of suicidal behaviour.

**Psychological models:**

Cognitive models have focused on specific patterns of thought commonly identified in suicidal individuals (Williams and Wells 1989). Neuringer (1988) found that suicidal people are prone to dichotomous thinking. They tend to be rather rigid in their thinking and this impedes the resolution of problems as it prevents them from entertaining flexible, alternative options. It has also been observed that suicidal people have quite polarized views about themselves and their problems.

Freud (1917) understood the suicidal act as the results of unconscious forces. He viewed the urge to self-destruction as an attack
against a loved one with whom the individual had identified and towards whom he or she harboured hostile wishes. Such views have been greatly developed since Freud’s time and modern psychoanalytic models in this area converge on the central importance of unraveling the fantasy underlying the suicidal behaviour as the key to understanding the motivation to kill oneself; for instance, the attempt may reflect the person’s need to punish another or the self or to merge with another through death (Campbell and Hale, 1992). Such approaches suggest that the suicidal act reflects a conscious aim of killing oneself and more specifically of killing the body; and a less conscious aim of surviving. Killing the body is understood to be the means to an end – the end paradoxically being to survive, albeit in another dimension. According to Campbell and Hale (1992), the suicide fantasy is rooted in childhood and more specifically in the mother-infant relationship and the mother’s previous incapacity to accept the infant’s projections.

**Vulnerability of Suicide:**

This brief overview of theoretical approaches to suicide suggests that suicide is frequently understood to be symptomatic of some other core disturbance. Research has shown that certain factors are typically associated with, and perhaps even causally related to, suicidal behaviour. Such background factors alert us to the likelihood of increased risk of suicide in a person who expresses suicidal ideation. But knowing that a person belongs to a high-risk group does not necessarily imply that she will commit suicide. This knowledge should be used as part of an overall formulation of the likelihood of risk:
increase as the factors accumulate for any given person who is suicidal. The background factors listed below should always be considered alongside subjective risk factors; that is, the individual’s feelings, thoughts, idiosyncratic meanings and her general emotional state at the time of assessment. Factors associated with an increased risk of suicide include:

1. Social status (male, single, divorced or widowed, living in a deprived urban area over 40).

2. Family psychiatric history (especially suicide, alcohol dependence and depression)

3. Previous psychiatric history (especially depression, alcohol abuse and previous suicide attempts).

4. Broken homes (adults who kill themselves more often come from broken homes, death of at least one parent in childhood is common).

5. Precipitating factors are likely to vary according to the individual’s social environment and what is considered stressful by the person, the more common appear to be

   • Physical illness

   • Recent loss (e.g. divorce, bereavement)

   • Disharmony with a key other which may lead to social disruption.
How to prevent Suicide:

There is no simple and dependable way to prevent someone from going ahead with a threatened suicide. However, no doubt some thing can be done in this regard.

1. Taking suicide talk seriously: When people talk about suicide in vague generalities, it's easy to dismiss it as "idle talk" and let it go. However people who talk about suicide are a high-risk group, and their veiled threats should not be ignored.

2. Providing empathy and social support: It's important to show the suicidal person that you care. People often contemplate suicide because they see the world around them as indifferent and uncaring. Hence, you must demonstrate to suicidal person that you are genuinely concerned so provide empathy.

3. Identifying and clarifying the crucial problem: The suicidal person is often terrible, confused and feels lost in a sea of frustration and problems. It is a good idea to try to help sort through this confusion. Encourage the person to try to identify the crucial problem. Once it is isolated, it may not seem quite so overwhelming.

4. Suggesting alternative courses of action: People thinking about suicide often see it as the only solution to their problems. This is obviously an irrational view. Try to chip away at this premise by offering other possible solutions for the problem that has been identified as crucial suicidal people often are too distraught and disoriented to do this on their own so offering alternative actions.
5. **Capitalizing on any doubts** : For most people life is not easy to give up. They are racked by doubts about the wisdom of their decision. For instance, if a person expresses concern about how her or her suicidal will affect family members, capitalize on this source of doubt.

6. **Encouraging professional consultation** : It is important to try to get a suicidal person to seek professional assistance. Just because you talk a person out of attempting a threatened suicide does not mean that the crisis is over. The contemplation of suicide indicates that a person is experiencing great distress. Given this reality, professional intervention is crucial. The caring person should not hesitate in it.

**Independent Variables** :

The present study tapped self-esteem, depression, age, sex, employment status, environment culture and family types as the independent variables. The effects of these variables were ascertained on suicidal ideation.

**Self-esteem** :

Self-esteem is an aspect of self-concept, which is defined as a collection of beliefs about one’s basic nature, unique qualities and typical behaviour (Wieten & Lloyd, 2003).

According to Mishcel (1981), self-esteem refers to the individual’s personal judgement of his or own worth.
Weiten and Lloyd (2003) define self-esteem as one's overall assessment of one's worth as a person: it is the evaluative component of the self-concept.

Self-esteem is a global self-evaluation that blends many specific evaluation about one's adequacy as a student, an athlete, a worker, a spouse, a parent, or whatever is personally relevant. Fig. 1.2 shows how specific elements of self-concept may contribute to self-esteem. If one feels basically good about oneself he/she probably have high self-esteem. Sometimes, the term positive self-concept is used as a synonym for self-esteem.

![Fig. 1.2](image-url)  
**Fig. 1.2 :** The structure of self-esteem. Self-esteem is a global evaluation that combines assessments of various aspects of one's self-concept (Adapted from Shavelson, Hubner & Stanton, 1976)

**Introduction** 28
Studies generally show self-esteem to be quite stable over time (Baumeister, 1991; Robins, Norem, & Cheek, 1999). In other words, if one has high self-esteem today he is likely to have high self-esteem six months or two years from now. While it’s true that baseline self-esteem is stable, it’s also true that the ups and downs of daily life can produce short-term fluctuations in self-esteem. People seem to vary in the degree of which self-esteem is experienced as stable. And those whose self-esteem fluctuates in response to daily experiences are highly responsive to feedback from others—they are more moved by praise and more sensitive to criticism (Kernis & Waschull, 1995).

Investigating self-esteem is difficult for several reasons. For one thing, it is difficult to obtain accurate measures of self-esteem. The problem is that researchers tend to rely on self-reports from subjects which obviously may be biased. Second, in probing self-esteem it is often quite difficult to separate cause from effect. A large volume of correlational data tell us that certain behavioural characteristics are associated with positive or negative self-esteem.

Influences of Self-Esteem:

Among researchers, self-esteem has always been a popular concept. In recent years, the topic has captured the public’s attention as well. The following review makes it clear.

Self-Esteem and Adjustment:

It has long been thought that individuals with low self-esteem held strong negative views about themselves. In reality, it seems that
the self-views of these individuals are not more negative, but more confused (Campbell, 1990; Campbell & Lavellee, 1993). In other words, their self-concepts seem to be less clear, less complete, more self-contradictory, and more susceptible to short-term fluctuations than the self-views of high self-esteem individuals (Campbell, 1990). According to Roy Baumeister (1998), this "self-concept confusion" means that individuals with low self-esteem simply don't know themselves well enough to strongly endorse many personal attributes on self-esteem tests, resulting in lower self-esteem scores. People who lack clarity about their abilities are less confident of success and more likely to set lower goals for themselves compared to those with high self-esteem (McFarlin, Baumeister & Blascovich, 1984). In contrast, individuals with high self-esteem persist longer in the face of failure, although sometimes they fail to recognize when it is pointless to persevere.

In the emotional sphere, low self-esteem is associated with unpleasant moods and with greater emotional ups and downs than high self-esteem (Campbell, Chew & Scratchley, 1991). Also, people with low self-esteem tend to develop more emotional problems than those with high self-esteem (Leary & Kowalski, 1995; Pillow, West & Reich, 1991). Among other things, they are more likely to report that they are troubled by anxiety, depression, irritability, aggressiveness, feelings of resentment and alienation, unhappiness, insomnia, and psychosomatic symptoms.

Low self-esteem is also associated with less effective social skills. People who are low in self-esteem often feel socially awkward,
self-conscious, and especially vulnerable to rejection (Rosenberg, 1985). This fear of standing out in a negative way also makes them tentative and cautious in their interactions with others (Baumeister, Tice, & Hutton, 1989; Heatherton & Ambady, 1993). By contrast, those with high self-esteem expect and want to stand out in a positive way, so they are usually more assertive in their social interactions. Because those with low self-esteem have difficulties in social encounters, they are also often lonely (Olmstead et al., 1991). Finally, individuals with low self-esteem are more easily persuaded to change their views and more likely to conform to peer pressure (Brockner, 1983).

Because self-esteem affects expectations, it operates in a self-perpetuating fashion. As can be seen in Figure 1.3 individuals with low self-esteem may have negative expectations about their performance (in a social situation, at a job interview, on a test). As a result, they feel anxious and may not prepare for the challenge. Then, when they fail, they often blame themselves—delivering one more blow to their already battered self-esteem (Brockner, 1983). Of course, this cycle also works (in the opposite way) for those with high self-esteem; Positive expectations usually produce high effort and low anxiety, successful outcomes, and self-praise. Thus, positive feelings about the self are perpetuated. In either case, the important point is that self-esteem affects not only the present but also the future.
Figure 1:3 : The vicious circle of low self-esteem and poor performance. Low self-esteem is associated with low or negative expectations about performance. These low expectations often result in inadequate reparation and high anxiety, which heighten the likelihood of poor performance. Unsuccessful performance triggers self-blame, which feeds back to low self-esteem. (Sharon et. al. 1993).

The table given here (Table 1.5) contains some trait terms characterizing high and low self-esteem individual (Mischel, 1981).
Table 1.5: Descriptive Trait Terms of High and Low Self-esteem.

<table>
<thead>
<tr>
<th>Self-esteem</th>
<th>Descriptive trait terms</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td>Active, assertive, successful, little childhood destructiveness, less anxiety, self-confident.</td>
</tr>
<tr>
<td>Low</td>
<td>Discouraged, self-depressed, unlovable, fearful of angering others, isolated from others, shrank away from being noticed.</td>
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**High Self-esteem versus Narcissism**

Having positive feelings about oneself would seem to be highly desirable, but that is not always the case. Problems arise when people’s self-views are inflated and unrealistic. Narcissism is the tendency to regard oneself as grandiosely self-important. Narcissistic individuals passionately want to think well of themselves. They are preoccupied with fantasies of success, believe that they deserve special treatment, and react aggressively when they experience threats to their self-views (ego threats). By contrast, individuals whose self-appraisals are positive but realistic are not so susceptible to ego threats and are less likely to resort to hostility and aggression in the face of them. Roy Baumeister, an eminent researcher on the self, speculates that narcissists who experience ego threats are likely to engage in aggression such as partner abuse, rape, gang violence, individual and group hate crimes, and political terrorism (Baumeister, 1999; Baumeister, Smart, & Boden, 1996).

Is there any evidence to support this idea? In a series of studies, researchers gave participants the opportunity to aggress against...
someone who had either insulted or praised an essay they had written (Bushman & Baumeister, 1998). The narcissistic participants reacted to insults with exceptionally high levels of aggression (see Fig. 1.4). It is important to note that thinking well of oneself (high self-esteem) does not lead to aggression; rather, it is the desperate need to validate and grandiose self-image that is the problem.

These findings have important practical implications (Baumeister et al., 1996). Most rehabilitation programs for spousal abusers, delinquents, and criminals are based on the inaccurate belief that these individuals suffer from low self-esteem. In opposition to this view, current research suggests that efforts to boost (already inflated) self-esteem are misguided; a better approach would be to help such individuals develop more self-control and more realistic views of themselves.

![Figure 1.4: The path from narcissism to aggression. Individuals who score high on narcissism perceive negative evaluations by others to be extremely threatening. This experience of ego threat triggers strong hostile feelings and aggressive behaviour toward the evaluator in retaliation for the perceived criticism. Low scorers are less likely to perceive negative evaluations as threatening and, therefore, behave much less aggressively toward evaluators. (Bushman and Baumeister, 1998).](image-url)
Determinants of Self-Esteem:

The foundations for high or low self-esteem appear to be laid very early in life. For this reason, psychologists have focused much of their attention on the role of parenting in self-esteem development. Indeed, there is ample evidence that parental involvement, acceptance, support and exposure to clearly defined limits have marked influence on children’s self-esteem (Felson, 1989; Harter, 1993). Two major dimensions underlie parenting behaviour: acceptance and control (Maccoby & Martin, 1983). Diana Baumrind (1967, 1971, 1978) identified four distinct parenting styles as interactions between these two dimensions (see Figure 1.5). Baumrind and others have found correlations between parenting styles and children’s traits and behaviours, including self-esteem (Feiring & Taska, 1996; Maccoby & Martin, 1983). Authoritative parenting (high acceptance, high control) is associated with the highest self-esteem scores. Authoritarian parenting (low acceptance, high control), permissive parenting (high acceptance, low control), and neglectful parenting (low acceptance, low control), are second, third and fourth in line, respectively. Note that these studies were correlational, so they don’t demonstrate that parenting style causes high or low self-esteem. As children grow into adolescents, peers begin to rival parents as a source of self-esteem; by college age, peers have much more impact on self-esteem than parents do (Harter, 1993).
Parental acceptance

<table>
<thead>
<tr>
<th></th>
<th>Low控制高</th>
<th>Low控制低</th>
</tr>
</thead>
<tbody>
<tr>
<td>高接受</td>
<td>权威</td>
<td>忽视</td>
</tr>
<tr>
<td>(低接受，高控制)</td>
<td>(高接受，高控制)</td>
<td>(低接受，低控制)</td>
</tr>
<tr>
<td>低接受</td>
<td>放任</td>
<td>低控制</td>
</tr>
<tr>
<td>(低接受，低控制)</td>
<td>(高接受，低控制)</td>
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Fig. 1.5: Baumrin's parenting styles: Four parenting styles result from the interactions of parental acceptance and parental control.

Children (and adults) make their own judgments about themselves as well. Perceiving oneself as successful in domains that are highly valued is important in these self-evaluations (Harter, 1993). One study found that preadolescents' self-esteem was affected by the quality of competition they faced in school (Marsh & Parker, 1984). In this study, children from schools in higher socioeconomic class areas with "high quality" competition (high-ability reference group) were compared to children of similar ability from schools in lower-class areas with "low quality" competition (low-ability reference group). Surprisingly, the children in the low-quality schools tended to display greater self-esteem than children of similar academic ability enrolled in the high-quality schools. This finding that self-esteem is boosted by being a "big fish in a small pond" has found widespread support.
(McFarland & Buehler, 1995). Thus, it seems that individuals compare themselves to others in their specific reference group, not to a general reference group (other students in the country).

**Ethnicity, Gender, and Self Esteem:**

Because prejudice and discrimination are still pervasive, it has generally been assumed that members of minority groups have lower self-esteem than members of the dominant majority group. In fact, there is a good deal of evidence to the contrary (Garnets & Kimmel, 1991; Gray-Little & Hafdahl, 2000; Harter, 1993).

How is it that minority group members often have high self-esteem when it seems that they shouldn’t? A review of research in this area suggested that minority group members use a number of strategies to protect their self-esteem from the effects of being stigmatized (Crocker & Major, 1989). These include attributing negative appraisals to prejudice against their group instead of to themselves, and devaluing those qualities on which their group fares poorly and valuing those attributes on which their group excels. In addition, minority group members use their own group as their dominant reference group, not the relatively advantaged majority group. This in-group comparison ensures that minority group individuals are similar to others and, therefore, that they compare positively to them. This experience leads them to feel good about themselves.

Although females are not a minority group, they resemble ethnic minorities in that they tend to have lower status and less power than males. Thus, it should come as no surprise that the popular press
abounds with reports of low self-esteem in adolescent girls and women (Orenstein, 1994; Pipher, 1994). Is there any empirical basis for this assertion? In a massive undertaking, researchers examined gender differences in self-esteem by statistically summarizing the results of several hundred studies (respondents ranged from 7 through 60 years of age) as well as the data from three nationally representative surveys of adolescents and young adults (Kling et al., 1999). In both analyses, males scored higher on self-esteem than females, although the differences were small for the most part. The largest difference occurred in the 15 to 18-year-old age group.

Experts cite a number of factors that could easily contribute to genre differences in self-esteem. These factors include relatively few societal messages that support esteem building in girls, the overemphasis on physical appearance in girls and women, violence against girls and women, and low rates of athletic participation among girls (Kling et al., 1999). Given these powerful influences, what accounts for the relatively small gender differences actually found in self-esteem? First, gender role expectations probably inhibit high self-esteem development in both females and males. There is increasing concern about the high price boys and men pay for adhering to traditional male gender expectations (Pleck, 1995). Second, females seem to use the same strategies to bolster their self-esteem as other stigmatized groups do (Kling et al., 1999). Thus, they value feminine attributes, devalue masculine qualities, attribute negative personal appraisals to sexist prejudice, and compare themselves to other females rather than males.
Building Self-esteem:

People who are characterized as having low self-esteem actually have moderate or average self-esteem. It is only because they score lower on self-esteem tests than individuals who rate themselves very positively that they are classified as having low self esteem (Baumeister, Tice & Hutton, 1989).

People with low self-esteem lack detailed knowledge above themselves as well as confidence in the accuracy of what they do know (Campbell & Lavallee, 1993). In contrast, those with high self-esteem know more about themselves, and their self-beliefs are more internally consistent, more stable, and more certain (Campbell, 1990). Also, those with low self-esteem have a self-protective orientation so they avoid situations in which they might fail and focus on improving their shortcomings. Those with high self-esteem have a self-enhancing orientation: They capitalize on their strong points and pursue success ever when it’s risky.

There is ample evidence that efforts at self-improvement can pay off by boosting self-esteem. Following are seven guidelines for boosting self-esteem. Whether your self-esteem is high or low, you may have habits that can undermine your self-regard. These guidelines are distilled from the advice of many experts, including Rogers (1977), Ellis (1984), Hamachek (1992), McKay and Fanning (2000) and Zimbardo (1977).
1. Recognize that you control your self-image:

The first thing you must do is recognize that you ultimately control how you see yourself. You do have the power to change your self-image. Social comparison theory suggests that people need such feedback and that it would be unwise to ignore it completely. Your self-image resides in your mind and is a product of your thinking. Although others may influence your self-concept, you are the final authority.

2. Learn more about yourself

People with low self-esteem don’t seem to know themselves in as much detail as those with high self-esteem. Accordingly, to boost your self-esteem, you need to take stock of yourself. (KcKay & Fanning, 2000). To get a clearer picture, pay careful attention to your thoughts, feelings, and behaviour and utilize feedback from others.

3. Don’t let others set your goals

A common trap that many people fall into a letting others set the standards by which they evaluate themselves. Others are constantly telling you that you should do this or you ought to do that. Thus, you hear that you “should study computer science” or “ought to lose weight”. Most of this advice is well intentioned and may contain good ideas. Still, it is important that you make your own decisions about what you will do and what you will believe in.

4. Recognize Unrealistic goals

Even if you truly value certain ideals and sincerely want to achieve certain goals, another question remains. Are your goals
realistic? May people get in the habit of demanding too much of themselves. They always want to perform at their best, which is obviously impossible. For instance, you may have a burning desire to achieve national acclaim as an actress. However, the odds against such an achievement are enormous. It is important to recognize this reality so that you do not condemn yourself for failure.

5. Modify negative self-talk

The way you analyze your life influence how you see yourself (and vice versa). People who are low in self-esteem tend to engage in various counterproductive modes of thinking. For example, when they succeed, they may attribute their success to good luck, and when they fail, they may blame themselves. Quite to the contrary, you should take credit for your successes and consider the possibility that your failures may not be your fault. Albert Ellis has pointed out that people often think irrationally and draw unwarranted negative conclusions about themselves.

6. Emphasize your strengths

This advice may seem trite, but it has some merit. People with low self-esteem often derive little satisfaction from their accomplishments and virtues. They pay little heed to their good qualities while talking constantly about their defeats and frailties. The fact is that everyone has strengths and weaknesses. You should accept those personal shortcomings that you are powerless to change and work on those that are changeable, without becoming obsessed about it. At the same time, you should take stock of your strengths and learn to appreciate them.
7. Approach others with a positive outlook

People who are low in self-esteem often try to cut others down to their (subjective) size through constant criticism. This faultfinding and generally negative approach to interpersonal transactions does not go over well with other people. Instead, it leads to tension, antagonism, and rejection. This rejection lowers self-esteem still further. You can facilitate your esteem building efforts by recognizing and reversing this self-defeating tendency. Approaching people with a positive, supportive outlook will promote rewarding interactions and help you earn their acceptance. There is probably nothing that enhances self-esteem more than acceptance and genuine affection from others.
Obversensitivity to rejection

Fig. 1.6 The vicious circle of low self-esteem and rejection. A negative self-image can make expectations of rejection a self-fulfilling prophecy, because people with low self-esteem tend to approach others in negative hurtful ways. Real or imagined rejections lower self-esteem still further, creating a vicious circle.

Depression:

Modern age is rightly called the age of anxiety, depression and worries etc. Such psychological problems have recently grown to an alarming stage in developed and developing countries as well. Even in India, where the cultural and spiritual level is quite high, the number of depressed persons is increasing everyday, leading to various types of
problems. At present there are 12.10 crore people suffering from depression.

According to Sarason and Sarason (2002), depression is a serious mental illness with a wide variety of mood variations of melancholy, sadness, disappointment and despair. It is a combination of emotional, cognitive and behavioural symptoms. Broadly speaking, a person faces an uncomprehending situation either courageously or succumbs to emotions that would precipitate into various types of depressive illnesses. We all, at one stage or the other, come across mentally demanding environment, temporarily or continuously. But, if an abnormal pattern of behaviour in a normal environment is shown repeatedly, it calls for immediate consultation and therapy.

**Defining Depression:**

Sarason and Sarason (2002) defines depression as a pervasive feeling of sadness that may begin after some loss or stressful event, but that continues long afterwards. Inappropriate though patterns that generalize every event as a calamity are characteristic.

According to Carson et al., (2000), depression is a emotional stage characterized by extraordinary sadness and dejection.

According to Secunda et al., (1973), “depression may constitute the most prevalent form of the psychopathology”. Woodruff et al. (1974) summarized cross-cultural data that suggests at least five percent of men and nine percent of women will suffer from clinically significant episodes of primary depression. Primary depression is depression in persons with no previous psychiatric history other than
affective disorder. Depressive mood also occurs throughout the entire spectrum of psychopathology and especially associated with anxiety neurosis, hypochondria, a number of organic brain syndromes, marital adjustment (Cdeman & Millar, 1975) and possibly alcoholism. A survey by the National Institute of Mental Health (NIMH, 1973) found that 17.5 percent of 4,45,115 people receiving psychological treatment had been diagnosed as suffering from some type of depression. Bosse et al., (1975) found depression especially prevalent among college students.

The earliest known description of depression as Hippocrates made a psychological disorder is about 400 B.C. (Jelliffe, 1931). Hippocrates attributed the disorder to movement of black bile into the brain in a manner that 'dark ended' the spirits. About five hundred years later, in A.D. 80, the physician Aretacus described the melancholic person as 'sad, dismayed and sleepless, they become this by their agitation and loss of refreshing sleep and at a more advanced stage they complain of a thousand futilities and desire death' (Beck, 1967). Aretacus is also remembered for having delineated different types of depressive syndromes including the manic depressive syndrome (Woodruff, Goodwin & Guze, 1974).

Types of Depression

Depressive reactions vary in severity and in the type of behaviour and thought exhibited. The diversity of symptomatology has led to numerous attempts to distinguish meaningful subtypes of depression.
I. Normal grief and psychopathological depression: The criteria used to distinguish between normal and psychopathological depression are depth, duration and extent of depression to which depressive reaction is associated with guilt, feeling of worthlessness, delusions, and hallucinations.

II. Exogenous (reactive) and endogenous depression: Exogenous depressive episodes are caused by factors from outside the body, including infections and psychological causes like some loss or stressful events, such as the death of a loved one or the loss of a job. Endogenous depressive episodes are caused by factors from inside the body such as having biochemical or genetic etiology. Distinction between exogenous and endogenous depression is based on whether or not the depressive episodes appear to be a reaction to some life circumstances.

III. Neurotic and psychotic depression: Martarano and Nathar (1972) stated that neurotic depression is diagnosed when the depressive episodes seems to be a reaction to some environmental loss, such as nervousness and tension and psychotic depression is diagnosed when the depressive episodes does not appear to be a reaction to some environmental loss.

IV. Primary and secondary depression: Robins and Guze (1972) have proposed that depression should be classified as primary versus secondary. Primary depression is diagnosed when depressive episodes occur in persons with no previous history of psychopathology except to previous episodes of mania or depression. The primary category provides a group that is symptomatically pure for depression.
Secondary depression is diagnosed when depressive episodes occur in persons with previous history of psychopathology other than depression or mania.

V. Bipolar and unipolar depression: The bipolar and unipolar depression is based on the presence or absence of recurrent manic episodes. Bipolar mood disorders are diagnosed when depressive episodes occur (Perris, 1966; Woodruff et al., 1974). Unipolar mood disorder is diagnosed when manic episodes do not occur. Both Schuyler (1974) and Winokur (1973) have suggested that bipolar and unipolar depression should be considered subcategories of primary depression. Research on bipolar and unipolar depression suggests that the distinction is useful. There is evidence that bipolar depression runs

![Diagram of mood disorders](image)

Fig. 1.7 Episodic patterns in mood disorders. Episodes of emotional disturbance come and go unpredictably in mood disorders. People with unipolar disorders suffer from bouts of depression only, while people with bipolar disorders experience both manic and depressive episodes. The time between episodes of disturbance varies greatly.
in families to a greater degree than does unipolar depression suggests that the distinction is useful. There is evidence that bipolar depression runs in families to a greater degree than does unipolar depression (Akiskal & McKinney, 1973). Mindelwicz (1974) found that physical illness was more prevalent in the lives of bipolar patients who were studied than it was in the lives of unipolar patients. In most instances bipolar depression is a less severe condition than unipolar depression.

If compared, one may notice some differences between manic and depressive episodes.

Table 1.6: Differences between Manic & Depressive episodes

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Manic episode</th>
<th>Depressive episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Elated, euphoric, very sociable, impatient at any hindrance.</td>
<td>Gloomy, hopeless, socially withdrawn, irritable.</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Characterized by racing thoughts, flight of ideas, desire for action and impulsive behaviour, talkative, self-confident; experiencing delusions of grandeur</td>
<td>Characterized by slowness of thought processes, obsessive worrying, inability to make decisions, negative self-image, self-blame, and delusions of guilt and disease.</td>
</tr>
<tr>
<td>Motor</td>
<td>Hyperactive, tireless, requiring less sleep than usual, showing increased sex drive and fluctuating appetite.</td>
<td>Less active, tred, experiencing difficulty in sleeping, showing decreased sex drive and decreased appetite.</td>
</tr>
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</table>
SYMPTOMS OF DEPRESSION

Symptoms of depression are behavioural, motivational, affective, cognitive and somatic in nature (Beck, 1976). The affective symptoms of depression include feelings of sadness, apathy, and anger. Back (1972) and Woodruff et al. (1974) revealed that the most commonly reported complaint by depression is feeling of sadness. A significant proportion of depression, are visibly nervous, and some are interpersonally hostile.

The cognitive disturbances in depression may be viewed in terms of the activation of a set of three major cognitive patterns that force the individual to view himself, his world and his future in an idiosyncratic way. The progressive dominance of these three cognitive patterns leads to the other phenomena that are associated with the depressive state. This is known as cognitive model of depression.

Symptoms of depression can be broadly divided into five general areas: emotional symptoms, cognitive symptoms, somatic symptoms, behavioural symptoms and other symptoms.

(i) Emotional symptoms: Depressed or dysphoric (unpleasant) mood is the most common and obvious symptom of depression. Most people who are depressed describe themselves as feeling utterly gloomy dejected or despondent. There is no clear-cut line dividing normal sadness from the depressed mood that is associated with depression. The severity of a depressed mood can reach painful and overwhelming proportions.
(ii) **Cognitive symptoms:** Depressed people show slowed down thinking, that they have trouble in concentrating and that they are easily distracted. Thought processes are almost completely shut down. Guilt and worthlessness are common preoccupations. Depressed patients blame themselves for things that have gone wrong, regardless of they are in fact responsible. They focus considerable attention on the most negative features of themselves, their environments and the future -- a combination that Beck (1967) has labeled the 'depressive triad'.

(iii) **Somatic Symptoms:** The somatic symptoms of depression are related to basic physiological or bodily functions. They include fatigue, aches and pains and serious changes in appetite and sleep patterns. Sleeping problems are also common, particularly troubling to sleep.

(iv) **Behavioural Symptoms:** The symptoms of depression include changes in the things that people do and the rate at which they do them. The term psychomotor retardation refers to several features of behaviour that may accompany the onset of serious depression. The most obvious behavioural symptom of depression is slowed movement. Patients may walk and talk as if they are in slow motion. Others become completely immobile and may stop speaking altogether. Some depressed patients pause for very extended periods — perhaps several minutes - before answering a question.

(v) **Other Symptoms:** Studies reveal that depression is persistent sadness lasting for more than two weeks, loss of interest in usual activities, weigh loss, sleep disturbances, energy loss, fatigue, hyperactive or slowed behaviour, decreased sexual drive, feelings of worthlessness, difficulty in concentrating or making decisions,
recurrent suicidal thoughts and memory loss. These symptoms are categorized in other symptoms as discussed below:

1. **Depressed mood:** This may include a sad, cranky or irritable mood. Excessive physical complaints and apathy also define this symptom.

2. **Loss of interest or pleasure in most activities:** This may take the form of ‘non caring anymore’ or loss of interest in hobbies. For example, someone who lives golf may suddenly find excuses not to play. This may also show up as a decreased interest in sex. Physicians call this lack of interest ‘anhedonia’.

3. **Indecisiveness or diminished ability to concentrate:** This may take the form of being easily distracted or having memory difficulties. Job that require concentration may become almost possible to perform.

4. **Recurrent thoughts of death:** Thoughts of one’s own death are common in depression. These can range from a general feeling that others would be better off if one were dead to making specific suicide plans and preparations. These feelings should always be treated as an emergency and require immediate medical attention.

5. **Sleeping difficulties:** Insomnia can mean difficulty in falling asleep, waking and restlessness during the night or waking up earlier than usual and not being able to fall back to sleep.

6. **Feelings of worthlessness or excessive guilt:** This symptom includes unrealistic negative self-evaluations, unrealistic self-blame or very low self-esteem. Sometimes, a sense of guilt can also reach
delusional proportions (such as feeling that you are to blame for world poverty).

7. Significant weight loss or gain: An example of ‘significant’ weight loss or gain could be gaining or losing over five percent of body weight in a month, when not dieting or trying to gain weight. Weight gain or loss is usually the result of changes in appetite.

8. Psychomotor agitation or retardation: Psychomotor agitation may appear as pacing, having trouble sitting still, hand writing or pulling at skin. Examples of psychomotor retardation can include either long pause before answering questions and/or slowed thinking, speaking and moving.

Depression, a Problem for Everyone

During the school year, up to 78 percent of all college students suffer some symptoms of depression. At any given time, from 16 to 30 percent of the student population is depressed (McLennan, 1992; Wong & Whitaker, 1993).

Why Students Get the Blues. Why should so many students be “blue?” Various problems contribute to depressive feelings. Here are some of the most common:

1. Stresses from college work and pressures to choose a career can leave students feeling that they are missing out on fun or that all their hard work is meaningless.

2. Isolation and loneliness are common when students leave their support groups behind. In the past, family, a circle of high
school friends, and often a boyfriend or girlfriend could be counted on for support and encouragement.

3. Problems with studying and grades frequently trigger depression. Many students start college with high aspirations and little prior experience with failure. At the same time, many lack basic skills necessary for academic success.

4. Another common problem is the breakup of an initiate relationship, either with a former boyfriend or girlfriend or with a newly formed college romance.

5. Students who find it difficult to live up to their idealised images of themselves are especially prone to depression (Scott & O'Hars, 1993).

6. An added danger is that depressed students are more likely to abuse alcohol, which is a depressant (Camatta & Nagoshi, 1995).

Recognizing Depression.

Most people know, obviously enough, when they are “down”. Aaron Beck, an authority on depression, suggests you should assume that more than a minor fluctuation in mood is involved when five conditions exist:

1. Consistently negative opinion of oneself.

2. Frequent self-criticism and self-blame.

3. Placing negative interpretations on events that usually wouldn’t bother oneself.
4. The future looks bleak and negative.

5. Feeling that responsibilities are overwhelming.

**What can be done to combat depression?**

Bouts of the college blues are closely related to stressful events. Learning to manage college work and to challenge self-critical thinking can help alleviate mild school-related depression.

Attacks of the college blues are common and should be distinguished from more serious cases of depression. Severe depression is a serious problem that can lead to suicide or a major impairment of emotional functioning. In such cases it would be wise to seek professional help.

**Theories of Depression**

In recent years, researchers have shown that physical changes in the body can be accompanied by mental changes as well. Medical illnesses such as stroke, a heart attack, cancer, Parkinson's disease, and hormonal disorders can cause depressive illness, making the sick person apathetic and unwilling to care for his or her physical needs, thus prolonging the recovery period. Also, a serious loss, difficult relationship, financial problem, or any stressful (unwelcome or even desired) change in life patterns can trigger a depressive episode. Very often, a combination of genetic psychological, and environmental factors are involved in the onset of a depressive disorder. However, the etiology of depression is unknown. The upsurge of research activity in the last two decades however has produced a number of important findings. The causes may include genetic, familial, biochemical,
physical, social and psychological factors. These causes are described in the form of theories.

I. Psychoanalytic Theory of Depression:

The psychoanalytic theory of depression underwent several important changes during the period of 1911 of 1945. Abraham (1911, 1916), who wrote the first psychoanalytic treatise on depression, introduced the concept of anger turned against the self. Freud’s (1917) analysis followed Abraham’s account generally, except that Freud also proposed a hypothesis of object loss. Cameron (1963) and Fenichel (1945) however focused on the etiological importance of low self-esteem. The attempt here is to provide an integrated account of the various psychoanalytic theories of depression.

Predisposing personality factors: As emphasized, a fundamental hypothesis of psychoanalysis is that early childhood experiences lead to the development of personality factors that influence adult behaviour. More specifically, the individual is hypothesized to progress through five stages of psychosexual development during the period of infancy to adolescence. In order of occurrence, the five stages are the Oral, Anal, Phallic, Latency and Adolescent stages. Either excessive or insufficient gratification at any of the first four developmental stages is postulated to lead to personality needs that predispose the individual to psychopathology by limiting the range of life situations to which the individual can adopt.

The personality factors that psychoanalysts have postulated to be associated with depression are dependency, anger and low self-esteem. Psychoanalytic theory suggests that excessive dependency needs are
maladaptive consequences of adjustment during the oral stage of development, that excessive hostility towards others is usually a maladaptive consequence of either the oral or anal stage of development and that low self-esteem can be a maladaptive consequence of childhood experiences during any stage of development and that low self-esteem can be a maladaptive consequence of childhood experiences during any stage of development.

Psychoanalytic theory also proposes that hostility is associated with depression. The postulate is designed to account for the self-deprecation that is found in severe depression as well as for the anger towards others that is found in mild depression. According to Erickson (1950) low self-esteem and hostility and also can occur as a consequence of maladjustment during the phallic developmental stage and as a natural consequence of failure to attract members of the opposite sex during adolescence.

**Dynamics:** The psychoanalytic theory of depression proposes that the precipitating factors like loss, failure, criticism and success combine with predisposing personality factors dependency, low self-esteem, an external definition of self worth, hostility and guilt produce depression.

**Reinforcement Theory of Depression**

Forster (1966, 1973) proposed that there are a number of ways in which people become depressed so that no single etiology exists. Under this view, depression can result from any of the following events. 1. A high level exposure to aversive events or to do need to avoid aversive events e.g. life is a chore of avoiding possible failures.
2. A low level of positive reinforcement. 3. A sudden change in the environment resulting from the loss of a discriminative stimulus that controls a large amount of behaviour e.g. retirement, death of a loved one. 4. Exposure to reinforcement schedules that require a large amount of work or effort to earn reinforcement; and 5. The expression of anger that annoys other people and thus deprives one of a significant source of positive reinforcement. Lazarus (1968) has expressed a theoretical position similar to Foster (1966, 1973). This theory has received some tentative supports.

**Imbalance Theory of Depression**

Davis' (1975) imbalance theory proposes that the critical factor in depression is the ratio of adrenergic to cholinergic substances at critical sites in the central nervous system. Basically, biogenic amines facilitate certain central nervous system functions and cholinergic substances inhibit these same central nervous system functions. However, more research is needed to evaluate its validity.

Winokur (1972) found that most of the research on genetic factors in depression is concerned with the manic depressive syndrome, but recently a number of studies have appeared on other types of depression as well. Solid evidence suggests that there is a genetic component to manic depression. Perris (1966) reported that the relatives of bipolar depressives were more likely to develop bipolar than unipolar depression and that the relatives of unipolar depressives were more likely to develop unipolar depression.
Beck’s Cognitive Theory:

Beck’s theory of depression has been one of the most prominent theories of depression for over 30 years. After being disenchanted with psychodynamic theories of depression early in his career he developed his own cognitive theory of depression. (Beck, 1967).

According to this theory early childhood negative experiences produce dysfunctional assumption that leave a person vulnerable to depression. Later in life if certain critical incidents (stressors) serve to activate those assumptions. Once activated, these dysfunctional symptoms trigger automatic thoughts that in turn produce depressive symptoms which further feel the depressive automatic thoughts. The figure presented here portrays his theory.

(i) Depressive schemes or dysfunctional beliefs: Such beliefs are negative and rigid, extreme and counter productive. It may develop during childhood and person feels himself as worthless.

(ii) Negative automatic thoughts: It involves unpleasant pessimistic predictions. Such pessimistic predictions tend to center on three themes of what beck calls the negative cognitive traits.

A. Negative thoughts about the self (e.g. I am ugly, worthless).

B. Negative thoughts about one’s experiences and the surrounding world (e.g. no one loves me, people treat me badly).

C. Negative thoughts about one’s future – (e.g., It is hopeless because things will always be this way.)
Fig. 1.8: Beck’s Cognitive Model of Depression. Early negative experiences lead to dysfunctional belief which make person depressive.

Over the past 30 years an enormous amount of research has been conducted testing various aspects of Beck’s theory.
Elements of depression

Elements of depression encompass a symptomatological picture that varies from person to person. These are helpful to manifest and understand depression, these elements are as follows:

1. Wood element: Wood element consists of characteristics such as spring, wind, eyes, tears, shouting, anger and sourness etc. There are also more subtle features pertaining to this element that are less obvious, but can be of great value when determining a person’s elemental predominance.

2. Fire element: This element has quite different features than those of wood. A fire element depression most often has to do with relationships and ‘heartbreak’. Most frequently, fire types feel letdown or disillusioned by love. Their depression is usually of illogical nature, in that they get over one heartbreak and then move on the next. Their depressions can be quite severe, and they can often become suicidal due to their impulsive and ‘living on the edge’ character type. Fire predominance includes symptoms of anxiety, chest pains, nightmares off a vivid nature and a lack of laughter and the ability to feel joyous.

3. Earth element: Earth element encompasses its typically characteristic digestive imbalances. However, in depressive episodes, Earth types tend towards significant changes in there eating habits. Some may have no appetite whatsoever; whereas others become very hungry and try to eat in order to fill the dark emptiness inside. It appears to be a way of seeking warmth and comfort. When depressed, Earth elementers become unmovable, perhaps because they have a
tendency towards dampness. At any rate, they virtually sink into their depression and become heavy and unmotivated.

4. **Metal element**: This element winds up depressed when there is loss or grief. Often these emotions can be repressed and manifest in unusual respiratory difficulties, asthma and frequent upper respiratory infections. Commonly, when depressed, metal types sigh, cry and sob and lack a sense of boundary between the ‘self’ and others. This is a Freudian term that depicts the person who takes the pains and suffering of the world on his own shoulders. Therefore, this type of a case may also involve a sense of grieving that seems overwhelming and all encompassing.

5. **Water element**: In strong contrast to the above-mentioned elements, is the Water element. This is the most clinically significant and potentially dangerous type of elemental depression. This is the element that is mostly influenced by the pre-natal, genetics. In these cases, the patient is depressed and does not have any insight into reasons that may have caused the descent into a depressive illness. These patients are most susceptible to severe psychological imbalances, such as schizophrenia, psychoses and severe major depressive episodes. In many cases, the patients become despondent and are unable to do even the simplest of chores for themselves. Their depression seems to reach down into the very core of their being - their spirit and soul. These patients become incommunicable, and sink rather deeply into their illness. These are the most difficult of all of the elements to treat successfully.
Other independent variables:

Besides, age, sex, employment status, environment (rural-urban) culture (Hindu-Muslim) and family types are also covered in the present study as the independent variables or as causes of suicidal ideation. It is reported that suicide risk increases with age. This is most true for males. The period of greater risk for females is between 33 and 64 years of age with their risk decreasing at age 65 and beyond. Regarding sex, it is said that men commit suicide about three times more than women, although women will make suicide attempts about three times more frequently than men. The researches reveal that unemployed kill themselves at a higher rate as compared to employed people. According to reports urban people attempt suicide more than their rural counterparts.

Whether culture has to do some thing with suicidal behaviour, needs answer even to day. Some researcher opine that people having deep faith in culture and religion commit less suicides than those who are not religious or less religious. This needs to be tested.

In our context there are two types of families even today, i.e. joint and nuclear families. Such families have their own family setups and characteristics. The joint families consist of not only parents and children but others also like grant fathers and mothers, brothers and sisters etc. The joint venture and mutual caring is the specific feature of joint families. It helps in managing personal problems of its members very harmoniously. In contrast to it nuclear families are characterized by self-consideredness. Their social horizon is very limited. It may have adverse effects on children with regard to adjustment,
interpersonal relationships and self-concept development. Since the family structure is fastly changing, it is exerting various types of effects on children, adolescents and other people.

Family: The family in its most common form is a lifelong commitment between a man and woman who feed, shelter and nurture their children until they reach maturity. Families arose tens of thousand years ago and serve the societies in many ways.

Functions of family: The families serve the following functions:

1. To promote physical survival and health of child and other members of society.
2. To foster the skills and behavioural capacities for economic self-maintenance.
3. To foster behavioural capacities for cultural values such as morality, religion, wealth, prestige etc.
4. To socialize children.
5. Reproduction - replacement for dying members are provided.
6. To provide emotional supports to face problems and troubles etc.