CHAPTER -I
INTRODUCTION
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The health of young is of great importance for the future of societies. In this context, the suicide rate is a sensitive measure of psychological and social state of a nation. An examination of the suicide rate, worldwide, of young adults may reveal something of their well-being. The latest available data on rate of suicide (Registrar General of India, 2006) shows that more than one lakh persons (1,18,112) in the country lost their lives by committing suicide during the year, "2006". This indicates an increase of 3.7 per cent over the previous year's figure. The number of suicides in the country during the decade (1996-2006) has recorded an increase of 33.9 per cent. The rate of suicide in Punjab has been reported to be 3.0 per cent, while in Chandigarh only this account gets doubled i.e. 7.8 per cent (Registrar General of India, 2006). Though suicides, unfortunately, are fast becoming a natural concomitant of the fast paced lives we live in, suicide remains such an enigma that the reasons for so many adolescents and young adults choosing to take their own life are unclear. Even scientists, are yet to unravel this mystery while lives continue to be lost. Our knowledge of what happens in the core of one's mind that drives a person to commit suicide is, unfortunately, poor.

Suicide has been described as the process of different stages, starting with thoughts of death and suicide and ending in self-afflicted death (Vilhjalmsson et al., 1998). Suicidal Ideation (SI) refers to the thoughts about taking one's own life with some degree of intent (Johnston, 2006). The previous research has confirmed that the intensity of suicide ideation is an important predictor of suicide attempts and completion of suicide (Beck et al., 1989). The dramatic increase in suicides in the past years, especially among young people has prompted numerous investigations into its cause. Research on suicidal ideation involving college students shows that this population may be specially at risk. It is, therefore, that this study is proposed in the direction of examining suicide ideation among young adults, an important component of suicide behaviour and the factors associated with the thoughts (suicide ideation).

It is presumed that there are two sources which compel an individual to end or thinking of ending his life. The sources are internal and external factors. Internal
factors include psychological makeup of a person whereas external factors include family factors and social support.

Cognitive factors have long been recognized as important in the etiology of adult suicidal behaviour.

As Shneidman (1996) noted, "Every single instance of suicide is an action by the dictator or emperor of your mind. But in every case of suicide, the person is getting bad advice from a part of that mind (that is in a) temporarily panicked state and in no position to serve the person's best long range interests".

From psychological perspective two constructs hopelessness and self esteem are modulating variables of suicidal behaviour (Vinas et al., 2002). These two variables along with a negative perception of one's environment constitute the three essential elements (negative triad) of Beck's (1976) Cognitive Theory of Depression (Vinas et al., 2002). Individuals who manifest or act out suicidal behaviour frequently are seen to possess lower self esteem (Marciano and Kazdin, 1994). It has been established that low self esteem is directly linked with depressive symptoms (Allgood, 1990). Contrarily, adolescents with high self-esteem might not cope with difficulties by blaming themselves and becoming depressed, rather they manage the stress in more constructive ways (Dumont & Provost, 1999).

Hopelessness is another cognitive variable that has received the most attention as a risk factor for suicidal behaviour. Hopelessness is a negative view or negative set of attitudes regarding the future. According to Beck's Cognitive Theory of Depression (Beck et al., 1979), this negative view of the future is a part of the cognitive triad. (along with a negative view of one self and one's world that is characteristic of the thinking of depressed individuals. Among adults, hopelessness repeatedly has been found to be associated with repeated self harm behaviours (Scott et al., 1992) and eventual suicide (Brown et al., 2000) in clinically referred samples. While, hopelessness has been found to be a strong predictor of suicidal ideation (Aguilar et al., 1997), alternatively, hope has been found to be related strongly to reduced suicidality (Range & Penton 1994).

According to Johnston (2006) suicide is a significant risk to those with borderline personality disorder (BPD). He further estimated that 1 in 10 people with
BPD, will successfully kill themselves. The young individuals who admit suicidal
temptations may be characterized by certain traits and attitudes which are associated
with psychopathology. It is significant to emphasize that very few empirical
investigations have been made to examine the relationship of suicide behavior with
personality traits like extraversion, neuroticism, Psychoticism, etc.

The important role that family plays in the physical and mental health of its
members has already been established. It can be a source of risk or protection for the
individual under stress. There is consistent evidence showing that children exposed to
problematic family circumstances during childhood are at an increased risk of later
suicidal behaviour. Rates of suicide attempt and suicidal ideation in particular may be
elevated among individuals exposed to parental conflicts, family disorganization etc.
and those who reported feeling less securely attached to their parents. While a
growing body of research suggests that exposure to adverse family circumstances
during childhood increases young people's risk of later suicidal behaviour (Beautrais
et al., 1999), at the same time positive family environment can prove itself to act as a
protective factor. Family cohesion, parental warmth and affection may help the
individual at risk of suicidal thoughts to escape the negative effects of the stressors.
Family should also be viewed as the primary unit of health care (Turk et al., 1997).
According to Reis (1984), 70%-90% of all illness episodes are handled outside the
formal health care system and self treatment within the family provides substantial
proportion of health care throughout the life cycle. Illness prevention, illness
acquisition and illness treatment behaviour are all associated with family modeling
and family functioning. It is therefore, pertinent to explore the contribution of family
as a risk or protective factor for suicidal thoughts among individuals.

Social support refers to information or actions (real or potential) that
individuals had to believe that they are cared for, valued, or in a position to receive
help from others when they need it (Heller, 1979). It has been conceptualized as a
coping resource that affects to a great extent in which a situation is appraised as
stressful (Lazarus, & Folkman, 1984) and enables a person under stress to change the
situation, to change the meaning of the situation, or to change his or her emotional
reactions to the situation (Thoits,1986). Social support is associated with better
psychological health in general and reduces the negative psychological consequences

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of exposure to stressful life events (Cohen & Wills, 1985). Social support is embedded in ongoing social interactions that are part of an ever changing network of social relationships. Thus, social support can assume a preventive function as well as curative function.

This study is, therefore, being proposed to examine the risk and protective functions of individual's psychological factors like self-esteem, hopelessness and personality makeup in an interplay with external factors like family functioning and social support in the dynamism of suicidal ideation.

There are at least two ways in which exposure to family adversity and psychological processes of an individual may be related to the development of suicidal behaviour. Firstly, it is possible that these factors may have a direct effect on later suicidal behaviour reflecting the fact that exposure to earlier adversity increases an individual's susceptibility to suicidal behaviour. Secondly, a casual chain process may exist between these variables in which exposure to childhood adversity leads to the development of mental ill health and other problems in adolescence, which in turn, increases risk of suicidal behaviour.

It is said that practically all human knowledge can be found in books and libraries. Unlike other animals that must start afresh with each generation, man builds upon the accumulated and recorded knowledge of the past (Best, 1978). For progress in any field of life, research is very important. Its constant addition to the vast store of knowledge makes progress possible in all areas of human endeavour. That is why, it is necessary that a man must be familiar with what has been done by the previous investigators. The following account presents literature related to ideas, theories, methods, hypothesis, explanations and other relevant information used in formulating the present problem. An attempt has been made to record the available literature under the following headings:

a) Gender differences in incidence of suicide ideation.

b) Hopelessness and suicide ideation.

c) Self-esteem and suicide ideation.
d) Personality and suicide ideation.

e) Family functioning and suicide ideation.

f) Social support and suicide ideation.

A) GENDER DIFFERENCES IN INCIDENCE OF SUICIDE IDEATION.

Identifying variables that indicate greater risk of suicide in different genders as well as investigating whether risk factors associated with suicide differ by gender, are important tasks.

Fuse (1980) noted that the female suicide rate was relatively higher as compared to the male suicide in Asian nations.

Barraclough (1988) has looked at the ratio of male to female suicide rates in nations of the world by age. In those, aged 5 to 14, the author reported that the female suicide rate often exceeded the male suicide rate, especially in Asian and Latin American nations. For those aged 15 to 24, he reported a wide variation in the male/female suicide rate ratio with again some nations reporting higher suicide rates for women aged 15 to 24 than for men. Barroclough felt that it was important to search for explanations of this variation in the male/female suicide rate ratio.

Lester (1990) sought to explore this variation by examining the male/female suicide rate ratio in a sample of nations for each age group and to explore the associations of the ratio for the different age groups. The sample of nations was all those reporting 1980 suicide rates to the World Health Organization and whose populations were greater than one million (so as to ensure some degree of reliability to suicide rates). Some nations reported zero suicide rates from both sexes for particular age groups. These nations were eliminated from the sample (Egypt, Guatemala, Israel, Kuwait, Northern Ireland, Panama, Scotland, Syria, and Thailand).

In contrast, Hawton (1992) reported that the suicide rates of females have declined especially in older women or remained fairly stable particularly in the young.

Schmidtke et al. (1996) demonstrated this pattern throughout countries in
Europe, with findings from Helsinki, indicating that Finland maybe one exception.

Canetto & Sakinofsky (1998) analyzed the health, socio-economic indicators for suicide ideation and behaviour, in which gender is one of the most frequently replicated predictor. Also, very few studies have examined interactions by gender for each of the risk factors while adjusting for other confounders.

Hawton (1998) reported that it is well recognized that males tend to use violent means of suicide more often than do females. Greater suicidal intent, aggression, knowledge regarding violent means and less concern about bodily disfigurement are all likely explanations for the excess of violent suicide in males. It suggests that causal factors and possibly, protective factors have changed in different directions in the two genders; social factors, especially linked to changes in gender roles, seem the most likely explanation.

Cantor (2000) documented that in recent years, several countries have experienced an increase in suicide rates in males, particularly in the younger age groups.

Cheng & Lee (2000) found that the rates of suicide in most countries, including Denmark, are higher in males than in females. China is one important exception, with very high rate in females, especially young women in rural areas.

Qin et al. (2000) epidemiological study of risk factors for suicide in males and females in Denmark reported that there are important gender differences in suicidal behaviour. Authors examined the gender differences in risk factors for suicide in Denmark. A time-matched nested case-control design was performed using Danish Longitudinal Register Databases to obtain 811 suicide cases and 79871 controls. A history of hospitalized mental illness was the most marked risk factor for suicide for both genders. Unemployment, retirement, being single and sickness absence were significant risk factors for men, whereas having a child 2 years old was significantly protective for women. The relative risks for suicide differed significantly between genders according to psychiatric admission status and being the parent of a child 2 years. However, adjustment for these factors did not eliminate the gender differences in suicide risk. Risk factors for suicide differed by gender and gender differences could not be explained by differential exposure to known risk factors. These reflect
not only differences in etiology, which were the primary focus of Danish study but also other important variations by gender in relation to the nature of suicidal behaviour and its prevention and treatment.

Verdoux et al. (2001) found that a history of hospitalized young women with mental disorders, unemployment and being single were all associated with an elevated suicide risk in Denmark.

The above literature shows that males tend to use violent means of suicide than do females. Greater suicidal intent, aggression, knowledge regarding violent means and less concern about bodily disfigurement are all likely explanations for the excess of violent suicide in males. It suggests that causal factors and possibly, protective factors have changed in different directions in the two genders; social factors, especially linked to changes in gender roles, seem the most likely explanation (Hawton, 1998).

B) HOPELESSNESS AND SUICIDE IDEATION

The identification of the relationship between hopelessness and suicidal behaviour has been an important discovery in psychology, advancing the understanding of the relationship between depression and suicidal behaviour.

Beck (1963) considered hopelessness to be the key factor in connecting depression and suicide. In the overall sample, hopelessness, as well as depression and anxiety with somatic, phobic or interpersonal manifestations were associated with less intense general suicidal desires. Only unusual thinking appeared to be a core characteristic of the more serious ideation involving a plan to kill oneself. In the case of the depressive subsamples, the implications of interpersonal anxiety and hostility, together with serious suicidal intent, have also been corroborated by other researchers (Strang & Orlofsky, 1990; Farmer, 1987). The specific relationship between hopelessness and suicidal intent was not found with other diagnostic groups in this study.

Beck et al. (1990) showed that hopelessness has been shown to mediate the indirect relationship between depression and suicidal behaviour. Platt and Robinson (1990) also revealed that the construct of hopelessness plays a significant role in the
etiology and maintenance of depression.

Hawton et al. (1993) found that hopelessness regarding peer support was related to issues of self-worth in depression, while hopelessness about parental support was related directly to depression and suicidal ideation.

Hewitt et al. (1994) argued that hopelessness has long been treated as a monolithic entity, researchers have recently begun exploring domain-specific dimensions of hopelessness so as to clarify the relationship between hopelessness and elements of psychological disturbance in their study of hopelessness regarding parental and peer support in adolescents.

Mendonca & Holden (1996) associated the link between hopelessness and suicidal intent for two categories of suicidal thoughts, and the associations of these two categories of thoughts with a range of symptoms were also examined. The patients with suicidal thoughts were assessed at the crisis unit of a psychiatric hospital. In interviews suicidal intent was assessed using the Beck's Scale for Suicidal Ideation while psychological distress was assessed using both the Beck's Hopelessness Scale and the Derogates Symptoms Checklist. Ideation items describing the frequency, duration and acceptance of a wish to die were observed to be significantly correlated with feelings of hopelessness.

In their study, Hewitt et al. (1998) assessed global or general hopelessness, achievement hopelessness and social hopelessness among inpatient alcoholic sample; and demonstrated the centrality of impaired interpersonal relations in promoting suicidal crisis.

An appraisal of the studies reviewed above reveal that hopelessness as a cognitive variable is found to be a better indicator of suicide related behavior.

C) SELF-ESTEEM AND SUICIDE IDEATION

Allgood (1990) reported that low self esteem has a positive main effect on depressive symptoms. Thus, it is likely that without ample family support and sufficient self-esteem, adolescents cannot cope adequately with life stressors such as paternal psychopathology. In contrast, youths with solid self esteem and a supportive family may be less depressed not because those factors buffer the effects of stress but
simply because their positive self image and the love and care they receive from their families independently attenuate depressive symptoms.

Dumont & Provost (1999) found that adolescents with high self esteem might not cope with difficulties by blaming themselves and becoming depressed but rather manage in more constructive ways.

McGee et al (2001) examined the longitudinal relationship between self esteem along with hopelessness and thoughts of self harm in the mid childhood years and suicidal ideation at ages 18 and 21. Path analysis was used to establish separate models for boys and girls. For boys, suicidal ideation seemed to have stronger roots in childhood, with significant paths from low self esteem and hopelessness to early thoughts of self harm. For girls, self esteem had a small but significant direct effect on the later suicidal ideation. The findings provide support for the idea that individual characteristics such as feelings of hopelessness and low self esteem act as generative mechanism.

DeMan & Gutierrez (2002) examined one hundred and thirty one undergraduate university students who participated in a study of the relationship between suicidal ideation and level of instability of self-esteem. Results of correlation analysis and an analysis of covariance showed that suicidal ideation was significantly related to level of self esteem, but not to instability of self esteem. An interaction effect showed that for individuals with high self-esteem, variation in self-esteem stability did not have a significant moderating influence, whereas for those with low self-esteem stable self-esteem appeared to be a protective factor.

Vinas et al. (2002) assessed the psychological factors including self esteem and hopelessness associated with suicidal ideation in pre adolescent children. A sample of 361 students, average age 9 years was taken. Two groups were formed, on the basis of the presence (n =34) or absence (n - 44) of suicidal ideation. Hopelessness and self esteem were compared in both the suicidal ideation and the control groups. Students with suicidal ideation generally presented lower self esteem and greater hopelessness.

Victor & Delores (2005) examined the relationship among stress, self esteem and suicidal ideation among late adolescents in a group of college students. Multiple regression analysis indicated that both self esteem and stress were significantly related
to suicidal ideation. Low self esteem and stressful life events significantly predicted suicidal ideation.

After reviewing the above literature it can be concluded that there seem to be a very strong association between low self esteem and resulting suicide ideation.

D) Personality and suicide ideation.

Pallis & Jenkins (1977) conducted an investigation to study the relationship between extraversion, neuroticism and intent in attempted suicides. Subjects were 151 suicide attempters admitted to a general hospital's Accident and Emergency Department. Form A of the Eysenck's Inventory was administered to all admissions up to 48 hours from medical recovery and prior to a research interview. Results revealed that for males there was an association between low intent to die and impulsivity. For female subjects, the results revealed that there was no association between clinical judgement of intent and extraversion or impulsivity. The study also revealed that for both sexes there was an association between recurrent suicide attempts and neuroticism.

Mehrabian & Weinstein (1985) made an attempt to investigate temperament characteristics of suicide attempters. Subjects were 30 men and 15 women in the 15 to 67 age range. Each subject first responded to a set of three measures that assessed temperament employing a three dimensional scheme. Next, the experimenter conducted an interview that sometimes led to a discussion of the suicide attempt. For the 15 subjects (7 men and 8 women) who volunteered information concerning their suicide attempts, a lethality of suicide measure was obtained. These subjects rated their suicide attempts on a scale ranging from 1 (a gesture e.g., an attempt made with no intention to die) to 5 (a near miss with death and hospitalization). Data from both sexes indicated that suicide-prone individuals have unpleasant arousal and submissive temperaments with reusability, a strong discriminator of suicide attempters relative to the general population. Thus, temperament attributes identified for suicide attempters are best described as neuroticism or trait anxiety.

King et al. (1995) found that in clinical practice, suicide attempts by patients with borderline personality disorders are often estimated to be 'manipulative' and the frequency of suicidal crisis among subjects with borderline personality disorders may cause clinicians to underestimate their seriousness of borderline patients' intent to die.
Isometsa et al. (1996) conducted a study to establish relationship of suicide among subjects with personality disorders and concluded that suicide victims with personality disorders were almost always found to have had current depressive syndromes, psychoactive substance use disorders or both.

Engstrom et al. (1997) found that the suicide risk among people with personality disorders is seven times the expected value and among people treated for attempted suicide 38 times the expected value.

Castro et al. (1998) examined the relation between para suicide and mental disorders. The main aim was to provide a better follow-up of para suicidal subjects focusing on their diagnostic profile with regard to whether the para suicide intention was death or not. A total of 235 parasuicide outpatients (PS) and a comparison group of 235 non-para suicide out-patients (CG) were surveyed. A structured interview was applied to both groups. Para suicide intention was appraised by means of the Beck's Suicide Intent Scale. The para suicide patients were divided into two groups, depending on whether their intention was death or not and they were matched with their CO counterparts. The diagnostic profile of each group was analyzed and differences in diagnosis distribution were found on the rates of major depression, and alcohol dependence.

Mann et al. (1999) found that previous suicide attempts, impulsivity, older age, antisocial personality, higher education and depressive mood are risk factors for further suicidal behaviour among subjects with borderline personality disorder.

Soloff et al. (2000) conducted an investigation on characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder. Eighty-one inpatients with borderline personality disorder plus major depressive episode were compared to 77 inpatients with major depressive episode alone on measures of depressed mood, hopelessness, impulsive aggression, and suicidal behavior, including lifetime number of attempts, degree of lethal intent, objective planning, medical damage and degree of violence of suicide methods. No significant differences were found in the characteristics of suicide attempts between patients with borderline personality disorder and those with major depressive episode. However, patients with both disorders had the greatest number of suicide attempts and
the highest level of objective planning. An increase in either impulsive aggression or hopelessness or a diagnosis of borderline personality disorder predicted a greater number of attempts. Hopelessness predicted lethal intent in all three groups and predicted objective planning in the group with both disorders.

Suominen et al. (2000) examined the relation between suicide attempts and personality disorder. The purpose of the study was to compare clinical characteristics of suicide attempters with or without personality disorders. A systematic sample (n=114) of patients from consecutive cases of attempted suicide referred to general hospitals in Helsinki, was interviewed and diagnosed according to DSM-III-R. Forty-six subjects with DSM-III-R personality disorders were identified and divided into clusters A (n=4), B (n=34), and C (n=8). These subjects were compared with 65 suicide attempters without personality disorders in terms of clinical characteristics and treatment received. Suicide attempters with personality disorders more often had a history of previous suicide attempts and lifetime psychiatric treatment than comparison subjects. However, suicide attempts did not differ in terms of suicide intent, hopelessness, lethality or impulsiveness between subjects with or without personality disorders. Although suicidal behavior is a more persistent feature among those with personality disorders, their clinical characteristics at the time of a suicide attempt may not differ from those without personality disorders.

Verdoux et al. (2001) designed a study to assess the baseline characteristics associated with a greater risk of suicidal behavior (suicide and para suicide) over the 2 years following a first admission for psychosis and the associations between sociability and outcome. First admitted subjects with psychosis (n=65) were assessed at 6 monthly intervals over a 2 year follow up period. Over this period 11.3% of the patients displayed suicidal behavior. Baseline predictors of suicidal behavior were found to be lifetime history of para suicide before first admission. Subjects with suicidal behaviour presented a longer duration of psychotic symptoms and a greater risk of being readmitted. Subjects with substance misuse over the follow up period were seven times more likely to engage in suicidal behaviour. Subjects with a previous history of para suicide with a deteriorating clinical course or with substance misuse are at increased risk of suicidal behavior in the 2 years after the onset of first psychotic episode.
After reviewing the above literature it can be concluded that there is a strong association between personality disorders and suicide ideation. According to the analysis the suicide risk among people with personality disorders is seven times the expected value and among people treated for attempted suicide 38 times the expected value (Barraclough, 1997).

(e) Family Functioning and Suicide Ideation

Kosky et al. (1986) compared suicidal depressed youths and non suicidal depressed youths, noting that suicidal ideation was clearly associated with disturbed and hostile interfamilial relationships. They stated that, "we cannot be satisfied with symptomatological predictions of suicidal potential behavior. We should rather focus on the family interactions and be alerted by the presence of discord, hostility in the family, etc".

Asanow and Carlson (1988) reported that lack of family support discriminated attempters from non-attempters after controlling for the severity of depression and suicide. Burbach et al. (1989) in a small study sample using Parental Bonding Instrument showed that persons diagnosed as having non depressive mental disorders are more likely to have parents with affectionless control. Rey and Plapp (1990) have shown that adolescents with disruptive behaviour disorders report their parents as affectionless and controlling.

Adams et al. (1994) found that the inverse association of family cohesion with plans of suicide in simple models and with attempts in the multivariate models is consistent with studies which have shown that children who do not perceive their families to be cohesive and emotionally supportive or who perceive high levels of conflict or dysfunction are at a greater risk for suicidal behaviours.

Hollis (1996) assessed the specific influence of family relationship difficulties over and above the effect of depression on the risk of suicidal behavior. Two hundred eighty four cases of suicidal behaviour defined as suicidal ideas, attempts or threats were compared with 3,054 non suicidal controls, using stepwise logistic regression. The variables independently associated with suicidal behaviour were an operationally defined depressive syndrome, family discord, disturbed mother-child relationship and lack of familial warmth. Although, depression is the largest single factor for
suicidal behaviour, family relationship difficulties make a significant independent contribution to this risk.

Blacher et al (1997) determined that family cohesion and marital status are significant predictors of mental health. People with close families are less prone to depression and suicidal behaviour. This closeness with family members protects against physical and emotional stress by providing a natural support system.

Kaplan et al. (1997) examined the rate of suicide attempts and the exposure to risk factors for suicide. Semi-structured and structured diagnostic interviews were used in the assessment of psychopathology of adolescents and their parents. Risk factors for the suicide included family disintegration i.e., perception of the family as lacking cohesiveness and a diagnosis of depression, disruptive behavioural disorders, substance abuse and dependence.

McKeown et al. (1998) examined predictors for suicidal behaviour in young adolescents. The incidence rates were found to be 1.3% for attempts and 1.7% each for plans and ideation. Increasing family cohesion was protective for suicide attempts. Cohesion scores were covered for those who moved from referent group to suicidal behaviours at follow up compared with those who remained in the referent group, with progressively lower scores for ideation, plans and attempts.

Fergusson et al. (2000) examined associations between childhood circumstances, adolescent mental health and life events and the development of suicidal behaviour in young people. Data were gathered over the course of a 21 year longitudinal study, of a birth cohort of 1265 children born in New Zealand. The measures collected included: patterns of suicidal behaviour (ideation, attempt), social background, family functioning, parental and individual adjustment during childhood and the dynamics of mental health and stressful life events during adolescence and early adulthood. 20% of the sample reported having thought about killing themselves and 5% reported having made a suicide attempt. The profile of those at greatest risk of suicidal behaviour was that of a person reared in a family environment characterized by socio-economic adversity, marital disruption, poor parent child attachment and exposure to sexual abuse.

Poland & Lieberman (2003) found that a family history of suicide and/or
mental illness is associated with increased suicide risk. In addition, youth who perceive as lacking family cohesion and having more conflict and violence i.e. chaotic home environment, are at increased risk for suicidal behaviour.

Cuffe et al. (2005) studied the association of family and social risk factors with psychopathology in a longitudinal study of adolescents. They concluded that family structure, family cohesion and stressful life events are associated with affective disorders in adolescents.

On reviewing the above literature it is evident that there is strong association between family functioning and suicide ideation. Findings do suggest that decreasing perceived cohesion is associated with risk for more severe forms of suicidal behaviour.

(f) Social Support and Suicide ideation

Research concerned with responses to stress has been prominent in the psychological literature for a considerable period of time. After the publication of Holmes & Rahe's (1967) scale assessing the impact of life changes, this research area expanded even further. Although the effects of stressors on individual's states of well being have been thoroughly documented, it has been equally apparent that situations alone can account for only a small portion of the variance of predicting distress.

In more recent years, investigators have explored a number of individuals' different variables in the hope of explaining why some people readily succumb to the effects of stressors while others appear to be more resilient. Kobasa (1979, 1982a) has defined what she refers to as "hardiness", Garmezy (1981) speaks of "vulnerability," and Murphy & Morality (1976) write of "resilience" as terms describing the resistance to stress.

Recent research has also provided relatively consistent evidence that an internal locus of control serves as a life stress buffer (e.g., Lefcourt, Miller, Ware, & Sherk, 1981; Johnson & Sarason, 1978). This is consistent with the finding that instrumental and problem focused coping facilitates life stress adjustment (e.g., Mitchell, Cronkite, & Moos, 1983). Therefore, to the extent that masculinity is related to instrumentality (Spence & Helmerich, 1981), it too should function as a life stress
buffer. Direct support for this hypothesis was reported by Nezu et al. (1986), who found a significant negative life events X masculinity interaction in the prediction of college student's depression, with high masculinity buffering the effects of high recent life stress. This interaction was significant for both male and female subjects. However, Nezu et al. (1986) cross-sectional design renders this finding difficult to interpret, especially given masculinity's high correlation with psychological adjustment measures (Whitley, 1983, 1985).

In brief, it can be pointed out that these and other investigators have examined the role of a number of variables that constitute these larger constructs. Among such variables have been locus of consol (Lefcourt, Miller, Ware, & Sherk, 1981, Kobasa, 1979, Sarason et al. 1978), a sense of commitment (Kobasa, 1982), the response to challenge (Johnson & Sarason, 1979), a sense of humor (Martin, 1985; Lefcourt et al. 1984), and social support (Husaini, 1982; Wortman, 1981). This latter, factor, social support, is one of those self-evident variables that laypersons assume have an ameliorative effect on stress. Less well established is the fact that social support is an entity that itself is affected by our experiences, for better (e.g., Martin, Davis, Baron, Suls, & Blanchard, 1994, Murrell, 1985, 1992; Taylor, 1990) or worse (Lepore et al., 1991; Kaniasty et al., 1990; Atkinson et al., 1986).

In a review of the occupational stress literature, Buunk (1990) made a distinction between four different conceptualizations of social support. First, from a sociological perspective, social support has primarily been viewed in terms of the number and strength of the connections of the individual to others in his or her social environment; in other words, the degree of one's social integration or the size and structure of one's social network. According to Rook (1984), social integration may promote health, among other things, by behaviour providing stable and rewarding roles, by promoting healthy behaviour, by deterring the person from ill-advised behaviour, and by maintaining stable functioning during period of rapid change. A second perspective on social support has been provided by authors who equate social support with the availability of satisfying relationships characterized by love, intimacy, trust or esteem. For instance, Cutrona & Russell (1990) have shown that certain provisions of relationships, including attachment and reassurance of worth, can act as buffers against stress. In the third perspective, the perceived
helpfulness view, social support constitutes the appraisal that under stressful circumstances, others can be relied upon for advice, information and empathic understanding, guidance and support. In this context, there is some evidence for the assumption that the mere perception that one can turn to someone for help already reduces stress (Sarason & Sarason, 1986). Finally, for some authors the concept of social support refers primarily to the actual receiving of supportive acts from others, once a stressful situation has come into existence. While the foregoing perspectives assume a certain preventive function of support against stress, this perspective focuses upon the curative function of actual help when a person is under stress (Barrera, 1986). Although, all these conceptualizations may be important for understanding the role of interpersonal relationships' in reducing stress, the four levels may bear different relationships to health and well-being.

Regardless of how it is conceptualized, social support would seem to have two basic elements: a) the perception that there is sufficient number of available others to whom one can turn to in times of need, and b) a degree of satisfaction with the available support. These two factors in social support may vary in their relation to one another, depending on the individual's personality. Some people may think that only a large number of available helpers provide sufficient possibilities of social support. Others may consider that even one person is adequate. How gregarious people are and how comfortable they face with others may determine the number of supports they believe necessary. In the same way, satisfaction with the support perceived to be available may be influenced by personality factors such as self-esteem and a feeling of control over the environment. Recent experiences may also influence a person to regard the support available as satisfactory or not satisfactory.

Social support generally refers to helpful functions performed for an individual by significant others such as family members, friends, coworkers, and

1 Despite this increased interest, many aspects of social support remain to be investigated (Boyce, 1985). One such aspect concerns the origins of social support. Specifically, the identification of factors from childhood that promote or inhibit adults capacity to for significant relationship that provide support. Perusal of studies on social support reveals a striking diversity of conceptualizations and operational definitions of that concept (House and Kahn, 1985; Weiss, 1974). As Boyce (1985) indicates, measures of social support have included psychological assets (Nuckolls, Cassel, & Kaplan, 1972), social network affiliation (Berkman & Syme 1979), and perceived social support (Florian, Mikulincer, & Bucholtz, 1995; Helageson. 1993; Pierce Sarason, 1991) to name a few.
relatives (Thoist, 1985). Social support can take many forms: it can include socio-emotional aid, such as sympathy and group belonging (House, 1981; Cobb, 1976). Support can also be given in the form of instrumental aid. This type of support entails actions or materials that allow the enrolment of obligations such as job duties and child-rearing (House, 1981). A third form of support is informational aid, which can include advice and personal feedback that facilitates problem solving efforts. The various forms of support are relatively independent of each other and show discriminate validity with respect to outcome measures (Schwarzer & Leppin, 1992).

Emotional support conveys to a person that he or she is cared for and valued and is typically more strongly associated with reduced psychological distress than other forms of support (Thoits, 1985; Cohen & Mckay 1983; House, 1981; Turner, 1981; Heller, 1979).

Implicitly, if not explicitly, explanations of the buffer effect almost always imply that the benefit of support availability operates through the actual mobilization of support in times of distress. However, researchers who have examined whether received support accounted for the relation between perceived support and well-being have found no evidence for a motivational role for actual support receipt (e.g., Lakey, & Cassady, 1990; Wethington & Kessler, 1986). In fact, only a handful of studies, in which careful attention was paid to the contextual match of the stressor, person, and support characteristics, have revealed beneficial effects of support receipt (e.g., Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993; Kaniasty, & Norris, 1992; Okun, Sandier, & Baumann, 1988). A greater number of studies have revealed no effects or, worse, positive associations between receipt of support and psychological distress, implying that received support has potentially negative effects on well-being. Thus available evidence speaks against the notion that the effect of perceived support on well-being is mediated by the actual provision of support (Kessler et al. 1992).

Nonetheless, a reverse mediation process is still plausible wherein receiving support promotes perceptions of support and their protective influence on health. Whereas the immediate beneficial effects of received support may be elusive and confined to specific contexts of particular life events and populations (Dunkel-Schetter &. Bennett, 1990; Eckenrode, & Wethington, 1990), the more general impact received help on mental health could be indirect through its influence on perceived
support. Wethington & Kessler (1986) suggested this possibility and found same evidence that the effect of received support on psychological distress was mediated by perceptions of support availability.

The purpose of this study is to examine whether there are any factors associated with suicidal ideation in young adults. It is expected that the adults with suicidal ideation will have more hopelessness, negative cognition, problematic personalities, negative family functioning and poor social support than those who do not possess suicidal ideation.

Objectives of the study

The study starts with the following objectives:

1. To examine the relationship of the Depression with Suicide Ideation.
2. To ascertain the relationship of Hopelessness with Suicide Ideation.
3. To examine the relationship of Negative Cognition with Suicide Ideation.
4. To examine the relationship of Neuroticism with Suicide Ideation.
5. To find out the relationship of Psychoticism with Suicide Ideation.
6. To ascertain the relationship of Social Support with Suicide Ideation.
7. To ascertain the relationship of Anxiety with Suicide Ideation.
8. To find out the relationship of different dimensions of family environment like Cohesion, Expressiveness, Conflict, Independence, Achievement Orientation, Intellectual Cultural Orientation, Active Achievement Orientation, Recreational Orientation, Moral Religious Emphasis, Organization and Control with Suicide Ideation.