CHAPTER II

REVIEW OF RELATED STUDIES

AND

FORMULATION OF HYPOTHESES
Mental disorders of one kind or another have been a favourite topic of writers for many centuries, and the public’s changing conceptions of mental disorders have been strongly influenced by popular literary and dramatic works. Though certainly not the first to explore this area, William Shakespeare is especially notable for having created a number of characters whose actions resemble certain behaviours. We now associate with official recognized patterns - characters such as Lady Macbeth (obsessive – compulsive behaviour), King Lear (paranoia), Iago (antisocial personality), Ophelia (depression / melancholy), and Othello (obsessive, paranoid jealousy). The fascination with abnormal behaviour has continued in modern writings, often in autobiographies. An earlier autobiographical account of psychosis, A Mind that Found Itself (1908/1970) by Clifford Beers, played a significant role in the development of mental hygiene movement in the United States. We seem to have an insatiable curiosity about bizarre behaviour, and – in addition to accounts we read in books most of us avidly seek and devour newspaper, radio, and TV accounts on the subject. Though we surely learn some thing from these accounts, we also may be narrowing our perspective because the popular media typically simplify issues, appearing to give answers when, in fact, they barely succeed in posing the correct questions. The daily press regularly carries stories about seemingly demented people and often seeks to legitimize these stories by citing mental health professionals who more often than not have never examined these people. Such arm chain diagnoses are useless (and probably unethical) in the majority of cases. Abnormal behaviour includes the more traditional categories of mental disorders alcoholism and schizophrenia, for example – as well as prejudice and discrimination, wasteful use of natural resources, pollution of air and water, irrational violence and political
Suicide has always been a topic of considerable interest, but in many ways it is difficult issue to study. The empirical research on suicide has progressed from a consideration of precursors and dynamics to the investigation of the total impact of death in general and self-destructive death in particular. A number of observations, case studies, and investigations focus on the debilitating effects of a completed suicide within the family. A number of studies cited the following reactions as common sequelae among close survivors: reality distortion, tortured object relations, massive guilt, disturbed self-concept, depression and self-destructiveness, search for meaning, and implate mourning. Through the ages, philosophers and theologians have written extensively about suicide motivation and the nature of the act. For most of human history, however, its perception and meaning was largely defined by religion, and it was regarded as a moral problem. Following the rise of suicide in several European countries including France, Germany, England and Italy in the 19th century, statistical and interpretative studies of suicide had multiplied. These studies investigated statistical correlations between suicide rates and social-demographical variables such as occupation, urbanization, religion, heredity, race, climate and mental health. The rise was also attributed to the passing of the traditional social order, and to industrialization and individualism. There is no one reason why people decide to kill themselves.

Suicide is a complex human behaviour and is the final common pathway for many human problems. This self-destructive act can reflect many motivational determinants, personal and interpersonal, biological, familial, and cultural. For many, it is a response to loss, separation and abandonment. For more young people, it may represent a release from the despair of what seems to be barren future or the hopelessness of being a victim of child abuse. For others, it may be impulsive act, experienced as revenge for rejection. For some persons, it may symbolize desire to be reunited with lost loved one. Suicide can also be a response
to the disordered thinking of psychoses, a toxic state such as drug use, or the
cognitive distortions that occur with depressive illness or schizophrenia (cf.
Bluementhal, 1988, p.940). Suicide has been theoretically examined through **four**
broad lenses, the historical perspective of culture, religion and philosophy,
psychological and sociological perspectives, and most recently through the **scientific advances of neurobiology**. These prevailing theories and subsequent
empirical research on suicide, and adolescent suicide specifically, with few
exceptions, are based upon the assumption that suicide is indicative of pathology.

Many professionals have experienced the “horror story of the bright young
student with the unlimited potential who brutalizes the sensitivities of his or her
family and friends with the most wanton act of self – abuse. The meaning of
suicide, the question of suicide is a core problem for philosophers, writers, and
theologians; it is an issue of importance for most of us, whatever we do or do not
believe. One could further argue that individual suicide stories are an essential and
missing element in the puzzle of adolescent suicide – stories not just of
adolescents who have attempted or successfully taken their lives, but also stories
of those who have not struggled with this decision. As a consequence, suicide has
always been a topic of considerable interest in different geographical areas of the
world because an examination of the suicide rate, worldwide, of young adults may
reveal something of their well - being. In addition, suicide remains such an
enigma that comparative statistics have their own interest.

Recently there has been upsurge of interest in the philosophical and
psychological issues in death and dying, as well as in the investigation of suicide.
The literature on suicide is extensive and includes literary and philosophical
analyses and numerous investigations of sociological, demographical and
psychological dimensions related to suicide. Despite effort and theory which
began long before Durkheim and Freud, the most pressing question of society
remains unanswered.
In the historical perspective, it can be seen that probably there has been no human society or period in recorded history in which the phenomenon of ‘suicidal behaviour’ was nonexistent (Latha, Bhat, & D’Souza, 1996, p.26). There is substantial evidence of the disturbing nature and extent of suicidal subject. Suicides are numerous in Shakespeare’s plays, and in the entire romantic theater. Suicide has a place in ethics, history, literature and art. Physicians, jurists, and theologians are concerned about it. It continues to provoke curiosity, to awaken sentiments of pity and terror, and to offer rich, paradoxical material for discussion. Many facets exist which arouse deeper human interest and which the sciences of man have more reasons to examine.

The World Health Organization (WHO) has identified suicide as an increasingly important area of public health, and has issued guidelines to member state in order to develop and implement co-ordinated, comprehensive, national and international strategies to halt this trend by the year 2000 (WHO, 1990)

CULTURE, RELIGION, PHILOSOPHY AND SUICIDE.

Historically and across cultures, there has been no consistent philosophical belief about suicide. The act has been assigned both good and evil implications, causes and justifications. Suicide poses an ethical issue that is ultimately a matter of values and how we reason about them. The story of what various people have thought and done about suicide does not settle the problem of what is right and good about it.

Despite a lack of detailed answers from individuals as to the contribution of one’s beliefs about suicide may make in the decision making process, there are general examples of the various values associated with suicide. Many of these values historically indicate that suicide is a form of pathology such as individual wickedness or a personal weakness. For example, the Islamic faith condemns suicide as it hinders Kismet-Allah’s control over life and destiny. However, an exception to this rule, as so vividly displayed in recent terrorist attacks, seems to exist in the case of suicide bombers and terrorists, for which perhaps there is a
sanction for acts that behoove a country and culture. Likewise, Japanese have seppuku and hari-kari; and the Hindu’s have suttee-all sanctioned forms of suicide.

Christianity’s historical approach to the morality of suicide is inconsistent. Medieval Christians put a stake through the heart of those that committed suicide and buried them at crossroads instead of blessed ground with the belief that otherwise the soil would be poisoned. However, the Bible never censured suicide. The stories of the suicide of Samson, Saul, Abimelech and Acitophel are told in the Bible without condemnation. Saint Augustine was perhaps the first to codify Christian values against suicide, to make the condemnation of suicide absolute through his assertion that suicide was a violation of the sixth commandment of God, “Thou Shalt not Kill” (Jamison, 1999; cf. Jennifer, 2005). Elsewhere both good and evil are implied in the meaning and righteousness of self-destructive acts. Nothing in itself is either good or evil, neither life nor death. Although suicides have been reported through history with several biblical references to self-destructive acts and reports of suicidal behaviour have been found in most ancient literary texts, the contemporary study of suicide, however, began around the turn of the century with the contributions of two major streams of thoughts, ‘sociological’ and ‘psychological’. In this context, it can be emphasized that there is a need for information about the various aspects of suicidal behavior, so that further strategies can be planned to aid this particular group.

In 1989, the World Health Organization recommended that member states should:

(i) recognize the problem as a priority in public health;

(ii) develop national preventive programme, where possible interlinked to other public health policies; and

(iii) establish national coordinating committees.

Realizing the gravity of the phenomenon of suicidal behavior there is an ongoing debate concerning the rationality of feelings of wanting to die, assisted
suicide and euthanasia. The phenomenon has been attracting the attention of a wide variety of medical and social disciplines including philosophy, theology, history, psychology, sociology, psychiatry and criminology (e.g. Shukla, Verma, & Mishra, 1990. It continues to provoke curiosity, to awaken sentiments of pity and terror, and to offer rich paradoxical material for discussion.

The problem of suicide is an increasing concern in U.S. society. During 1985 there were 28,500 reported suicides (Metropolitan Life Insurance Company, 1986). The suicide rate among young adults is particularly disturbing. The suicide rate of persons 15-24 years old more than tripled between 1950 and 1980 (Ross, 1980, Strother, 1986) moving from the fifth leading cause of death in 1950 among this age group to the third in 1980 (Curran, 1987) to the second in 1989 (Rudd, 1989). Moreover, among this age group during the 10 years period from 1970 to 1980 (Curran, 1987) there was a 40% increase in suicidal deaths with a total of 49496. It is important to note that these statistics do not include a large number of deaths that are not reported as suicide to spare the family from the social stigma of suicide (Shreve & Kunkel, 1991) which suggests that the reported suicide rates are underestimated.

For the past 14 years, suicide in Hong Kong has slightly but significantly increased. The unstandardized suicide rates for males and females increased by 26% and 32% from 1981 to 1994. After adjusting for the change in age distribution, the increase since 1981 was 7.7% and 14.9% for males and females respectively. Taiwan had the higher suicide rates among the three places (Hong-Kong, Taiwan, and Beijing) in the early 1980s. A very significant decrease was observed over the 14 years, especially among females. The relatively high suicide rate among Chinese and Asian women are also equally well documented (Lester, 1994). Nevertheless, in Hong Kong the female suicide rate could well be the highest in the world. The sex ratio was about 1 in Beijing, which could well be the lowest sex ratio in the world. The high female suicide rate relative to the male rate has been said to relate to low female social status in that society (Diekstra, 1992).
The male: female ratios in the suicide rates in 1994 were 1.3, 1.9 and 1.0 for Hong Kong, Taiwan and Beijing respectively. Beijing had a higher female than male suicide rate in the age group 15-24. Girls aged 5-14 had a higher suicide rate than boys in Hong Kong. However, the male suicide rate was consistently higher than the female rate for all age groups in Taiwan (cf Yip, 1996).

According to a 1993 study, the suicide rate in Sri Lanka is five times that of India though it has a higher per capita income and the literacy rate is more than double of ours. With 29 people killing themselves out of every 1,00,000 as against just six in India, the suicide rate in Sri Lanka is the highest in Asia and one of the highest in the world. Looking beyond India, compare Denmark with the USA. Denmark is prosperous and peaceful the USA is prosperous but violent. Within any country in the world it has been found that the suicide rate is higher among affluent sections of society though logically economically – deprived households should have more suicides because of an atmosphere of tension resulting from financial pressure.

In India too, more than one lakh persons (1,13,914) lost their lives by committing suicide during the year 2005. The number of suicides in the country during 1995-2005 (last decade) has recorded an increase of 27.7% (89,178 in 1995 to 1,13,914 in 2005). Figures compiled in 1983 by the National Crime Records Bureau, New Delhi. All the above mentioned data has been shown the in following Figures I and II respectively:
Figure 2.1: Number of suicides committed during 2001-05

Source: Crime Record Bureau, New Delhi.
Figure 2.2: Growth rate of suicide during 2001-05

Source: Crime Record Bureau, New Delhi.
Suicide Rates in Indian States and UTs.

Figure compiled in 2005 by National Crime Record Bureau show that West Bengal has reported the highest number of suicides (15,015) accounting for 13.2% of total suicides followed by Maharashtra (14,426) accounting for 12.7%, Andhra Pradesh 13,442 (11.8%), Tamilnadu 12,076 (10.6%), Karnataka 11,557 (10.1%) respectively.

Source: Crime Record Bureau, New Delhi.
Family problems’ and illness revealed the major cause of suicide as it comprised nearly 22% of suicides among the specified causes. Love affairs (3.1%), bankruptcy (2.7%) and poverty (2.2%) are the other causes driving people towards suicides.

**Figure 2.4: Different Causes of Suicides During 2005**

Source: Crime Record Bureau, New Delhi.
The overall male: female ratio of suicide victims for the year 2005 was 64:36. However the proportion of boys and girls suicide victims (up to 14 years of age) was 52:48 i.e. almost equal number of teens (boys and girls) have committed suicides. Researchers have clearly revealed that social and economic causes have led males to commit suicides, whereas emotional and personal causes have mainly driven females to end their lives.

**Figure 2.5 : Gender and Age Group of Suicide during 2005**

![Graph showing gender and age group of suicide during 2005](image)

Source: Crime Record Bureau, New Delhi.
It is also clearly indicated through numerous studies that the majority of suicide victims are from the primary level (25.8%) while illiterate suicide victims accounted for 23.0% and only 2.1 % suicide victims were graduates and post graduates. Similarly 24% and 16.8% suicide victims were having middle and higher secondary education levels respectively.

![Figure 2.6: Education wise break-up of suicides during -2005](image)

Source: Crime Record Bureau, New Delhi.

The Police record says, in 1997, there were 59 suicides in UT of Chandigarh as compared to 65 in 1996. The figures were 41 in 1994 and 36 in 1996. In 1998, 32 men and 17 women ended their lives on their own until September 30, 1998 and the current data of attempted and completed suicide in Chandigarh is as under:
Table-2.1 : Attempted and completed suicides in Chandigarh

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A = Attempted Suicide  C = Completed Suicide  
Source: Dainik Bhaskar, Hindi daily news paper, dated 28th August, 2005

**Socio-cultural and Psychological Explanations of Suicide**

The physician is no stranger to death. Clearly, a major goal of the practice of medicine is to avert untimely mortality. Therefore, the clinician may be particularly perplexed by patients who willfully want to end their lives. There is no one reason why people decide to kill themselves. Suicide is a complex human behavior and is the final common pathway for many human problems. This self-destructive act can reflect many motivational determinants personal and
interpersonal, biological, familial and cultural. For many, it is a response to loss, separation and abandonment. For some young people, it may represent a release from the despair of what seems to be endless. For others, it may be an impulsive act, experienced as revenge for rejection. For some persons, it may symbolize the desire to be reunited with a lost loved one. Suicide can also be response to the disordered thinking of psychoses, a toxic state such as drug use, or the cognitive distortions that occur with depressive illness or schizophrenia (cf. Bluementhal, 1998, p.940).

In 1897, Durkheim (Durkheim, 1951) examined society’s influence and control over the individual. In his book Le Suicide, Durkheim, formulated four types of suicide. The first, “altruistic” suicide occurs as a result of society’s expectations of the individual. In the United States, the most frequent form of suicide is the egoistic type, where the individual has poor social support and few connections to the society. The third category of suicide according to Durkheim’s theory is anomie suicide, where the individuals’ relationship to society is suddenly shattered, such as when a young person is confronted by the law or unexpectedly loses a job. Fatalistic suicides, the fourth type described by Durkheim, occur when individuals lose control over their own destiny (Schneidman, 1979).

DEPRESSION, HOPELESSNESS, AND SUICIDAL BEHAVIOR

The World Health Organization study into the Global Burden of Disease (Murray & Lopez, 1998) demonstrates clearly that depression is the most prevalent disability and this disability plays a central role in determining the overall health status of a population. Depression covers an extremely wide spectrum of experience, from the almost universal experiences such as grief and bereavement to apparently inexplicable despondence and melancholy. Depression as a psychological disorder is replete with symptom characteristics that are internal to the individual. These features include symptoms of cognitive, emotional, behavioral, and physiological impairment or dysfunction.
Depression and depressive (mood) disorders in children and adolescents may be viewed as internalizing disorders. Until the 1970s, it was believed that depressive disorders resembling adult depression were uncommon among the young. Preadolescent children were thought incapable of experiencing depression. Depression in adolescent was often seen as a normal feature of development, so called adolescent turmoil. However, in the 1970s and early 1980s, several investigators began to diagnose depression in young people using adult criteria. Indeed, recent epidemiological studies have reported that as many as 1 in 10 adolescent girls suffer from depressive disorders (Olsson & Von Knorring, 1999; Angold et al., 1998). Previous notions of “adolescent turmoil” or the perspective of the adolescent who is “just going through a moody stage” are no longer viable conceptualizations (Offer & Schonert-Reichl, 1992). This is amply evident when one considers the large numbers of depressed and suicidal youth, a significant number of whom do not survive to adulthood or do so with significantly reduced psychosocial competence or functioning.

Depression in children and adolescents may be considered as significant perturbation of mood. A depressed youngster may experience a range of symptoms, some of which may be overt, such as irritability or distinctly sad appearance, and others may be covert, as illustrated by feelings of low self-worth, hopelessness, suicidal thoughts, and guilt. In young people, depression represents a negative psychological state that may be characterized as one of intense, subjective misery, despondency, and in some youngsters, irritability. In young children, this affective state may be characterized as being moody or distant from others and slow to respond to social interactions with peers and family. Depression in children and adolescents can cause significant impairment in daily functioning and personal and social involvement (Puig-Antich et al., 1985). Although this may characterize a great many adolescents, the depth and quality of these characteristics in depressed adolescents, and in particular, their lack of positive response to previously reinforcing events or activities generally distinguishes depression in adolescents from more normative trials and
tribulations associated with the normative course of adolescence. Some children and adolescents who are depressed also manifest suicidal thoughts and behaviours and show an increased risk for substance abuse (Weissman et al., 1999; Birmaher et al., 1998; Ryan, Puig-Antich, Ambrosini et al., 1987). This is particularly problematic and in some cases leads to death or physically disabling outcomes. Epidemiological data suggests that suicidal behaviours are a serious problem among children and adolescents (Reynolds & Mazza, 1994). Although some youngsters who demonstrate suicidal thoughts and behaviours do not manifest clinical levels of depression, the majority of suicidal youngsters are depressed, with many who view suicide as a way of ending their intense psychological distress. Depressive disorders represent serious forms of psychopathology of childhood and adolescence, given that some depressive episodes may lead to potentially life-threatening or negative outcomes. Based on diagnostic and epidemiological surveys of children and adolescents it is evident that depression is a significant problem among youngsters (Reynolds & Johnston 1994). These data, and the general under treatment of depression in children and adolescents (Keller, Lavori, Beadsle, Wunder, & Ryan, 1991) point to the critical need for study, identification, and treatment of depression in young people.

Depressive illness in children and adolescents include a cluster of symptoms, which have been present for at least two weeks. As suggested by Sugar (1968), in adolescents it may be a part of the adolescent developmental process, resulting from the giving up of childlike security in the drive for separation and independence. In a recent study from India, Nair et al. (2004) reported a prevalence rate of 9.5% and 1.7% among school drop out girls, 2.6% and 0.2% among school going girls, 1.4% and 0.2% respectively among school going boys and nil among college going girls in a sample of 1014 adolescents from grades 9th through 12th using BDI. According to Gove and Herb (1974 cf. Eme,1979), beginning in adolescence, females tend to experience more stress than males. Moreover, they seem more disposed to respond to this stress according to the sex stereotypic pattern of internalization rather than externalization (Garai,
Female adolescents are vulnerable to adverse consequences of events, and perceive more stress in their lives (Goodyear, Kolvir, & Gatzanis, 1986; Compas, Davis, & Forsythe, 1985). Studies in India by Sonapar (1982); Prabhu (1973, 1975, cf. Revathi, 1986) have reported gender differences in nature of stressors and intensity.

Assessment is a procedure basic to the identification of depression in children and adolescents for clinical purposes, as well as for use in the study of biological, social, and psychological characteristics; sequelae; outcome; determination of treatment efficacy; and other research applications. There are two primary categories of assessment measures: those designed for obtaining a diagnosis, and measures developed to evaluate the severity of depressive symptomatology (Reynolds, 1998). In general clinical practice and in a multitude of research applications, the assessment of depression in children and adolescents is typically accomplished using self-report severity measures or clinical interviews, the latter including diagnostic measures and severity measures. Reports by significant others such as parents, teachers, and peers have been used to a limited extent. There are several characteristics of depression that support the use of self-report assessment procedures, given linguistic and metacognitive competence in the child. Depression as an internalizing disorder includes primary symptoms that are internal to the youngster and are not easily observable. Cognitive symptoms of guilt, self-deprecation, suicidal ideation, hopelessness, and feelings of worthlessness are depressive symptoms that are subjective to the child. Some vegetative symptoms such as insomnia, appetite loss, and other problems are sometimes difficult for others to observe and may go undetected by parents and significant others (Reynolds, 1998).

**SUICIDAL BEHAVIOUR AND DEPRESSION**

Epidemiological and clinical studies suggest an association between suicidal ideation and behavior in children and adolescents and the presence of various forms of psychosocial adversity such as stressful life events (Cohen-
Sandler et al., 1982; Dubow et al., 1989; Kandel et al., 1991; Paykel, 1989), lack of social support (Dubow et al., 1989; Pfeffer, 1989), and family dysfunction (Fergusson & Lynskey, 1995; Joffe et al., 1988). Other studies have documented associations between suicidality and problem or risk behaviors such as running away (Shaffer et al., 1996a), assault behavior (Walter et al., 1995; Cohen-Sandler et al., 1982), recklessness (Shaffer et al., 1996b; Clark et al., 1990), weapon-carrying and/or fighting (Orpinas et al., 1995; Woods et al., 1997), sexual activity (Patton et al., 1997; Walter et al., 1995), and tobacco use (Woods et al., 1997), risk factor for attempted and completed suicide in children and adolescents (Gould et al., 1998; Shaffer et al., 1996b). The effect of psychosocial adversity and risk behaviors on increasing the risk for youthful suicidal ideation or behavior, however, is not solely due to the association of these risk factors with the presence of psychiatric disorder. Gould et al. (1996) found that psychosocial factors, such as stressful life events, grade failure or school nonattendance, and poor communication with father were associated with youthful completed suicide, even after adjusting statistically for psychiatric disorder. It is not known, however, whether psychosocial risk factors also increase risk for suicidal ideation and nonfatal attempts after adjusting for psychiatric diagnosis.

Suicide ideation is an important determinant of suicide risk because it precedes suicide. Moreover, suicidal ideation is common, with an estimated annual incidence of 5.6% (Crosby et al., 1999) and estimated lifetime prevalence of 13.5% (Kessler et al., 1999). Since the majority of individuals with suicide ideation will not die by suicide, the clinician should consider factors that may increase risk among individuals with suicide ideation. Although current suicide ideation increase suicide risk (Brown et al., 2000; Fawcett et al., 1990) death from suicide is even more strongly correlated with the worst previous suicide ideation (Wobeser et al., 2002; Clark & Fawcett, 1992).

Psychiatric illness, particularly mood disorders, places individuals at greatly increased risk of suicide (Henriksson et al., 1993) and the National
Institute of Mental Health has declared that the first line of defense against suicide is to recognize and treat mood disorders (NIMH, 2001). Individuals with depression or bipolar illness are more likely to attempt or complete suicide than are persons in any other group of mental disorder (Goodwin & Jamison, 1990).

Several studies have confirmed that the presence of a major mood disorder is a significant risk factor for suicide. Not surprisingly, mood disorders, primarily in depressive phases, are the diagnosis most often found in suicide deaths (Conwell et al., 1996; Henriksson et al., 1993; Rich et al., 1986; Barraclough et al., 1974). Although most suicidal individuals with bipolar disorder occur during depressive episodes, mixed episodes are also associated with increased risk (Tondo et al., 2003; Strakowski et al., 1996; Isometsa et al., 1994a). Suicide ideation and attempts are also common during mixed episodes than in mania (Goldberg et al., 1999).

Depression has almost universally been found to predict all types of suicidal behaviours. However, when future suicide attempts in normal populations of adolescents have been examined, and previous suicidal behaviour is controlled, its unique contribution is as yet uncertain. Only three studies, have so far studied this: Reifman and Windle (1995) analyzed 2 samples. Depression was found to be weakly related to future attempts in one of their samples and in another sample. Lewinsohn et al., (1994) did find major depression modestly predictive; Mckeown et al., (1998) found that a diagnosis of major depression was no longer predictive of future suicide attempts once suicidal behaviour at baseline was accounted for. Low self-esteem has often been found among suicidal attempters. However, self-esteem is highly correlated with both depression and other predictors of suicidal behaviour, such as hopelessness, and previous studies have, therefore, not been able to disentangle the role of self-esteem.

Substantial evidence from psychological autopsy studies of adults (Hangell, Lanke, & Rorsman, 1981; Robins, 1981) and adolescent suicides (Brent, Kolko et al., 1990; Shaffer, Garland & Gould, 1988; Shaffii, Crrigen, &
Wittinghill, 1985) reveal that most people who commit suicide were suffering from a major psychiatric illness at the time of their death, although only a small percentage were being treated (Shaffii, Steltz-Lenarsky, Denick, et al., 1988; Robins, 1981). The risk for suicidal behavior and suicide is increased with almost every major psychiatric disorder (Buda & Tsuang, 1990). Studies of both adult and adolescent populations reveal that over 90% of suicide victims suffered from a psychiatric disorder; less than 10% of people who kill themselves have no documentable psychiatric illness (Shaffii, Steltz-Lenarsky, Denick, et al., 1988). Affective disorders followed by alcoholism are the major psychiatric diagnoses associated with suicide (Winokur & Black, 1987; Hangell, Lanke, & Rorsman, 1981). Of the 90% of adult suicide completers with a psychiatric disorder in these studies, 60 to 80% suffered from a major affective illness. A study (Weissman, Klerman, Markowitz, et al., 1989) reports that 20% of patients with panic disorder and 12% of patients with panic attacks have made suicide attempts. For adolescents populations, between 63-95% of suicide victims suffer from psychiatric illness (Shaffii, Carrigen, & Whittinghill, 1985), with one study demonstrating that one fifth of the suicide victims had a diagnosis of bipolar disorder (Brent, Perper, Goldstrom, et al., 1988).

On the basis of psychological autopsy studies, it has been concluded that 30%-70% of suicide victims are depressed (Isometsa, Henriksson Hillevi, Heikinen, Kuoppasalmi, & Lonnquist, 1994). The reported prevalence of depression among suicide attempters ranges from 30% to 66% (Ennis, Barnes, Kennedy, & Trachtenberg, 1989). Mood disorders are associated with an
increased risk of mortality that has been estimated to range from a 12 fold increase in risk dysthymia to a 20 fold increased risk in major depression (Harris & Barraclough, 1997). Lifetime suicide risk in bipolar disorder has generally been found to be similar to that in unipolar major depression (Tondo et al., 2003; Jamison, 1998). However, several longitudinal studies of patients, followed after an index hospitalization have demonstrated suicide risk in patients with major depressive disorder that are greater than those in patients with either bipolar-I disorder or bipolar-II disorder (Angst et al., 2002). The prevalence of suicide ideation ranges from 47% to 69% in patients with major depressive disorder (Zisook et al., 1999; Bronisch & Wittchen, 1994; Asnis et al., 1993).

Studies have found high rates of suicide attempts among individuals with major depression or bipolar disorder. The lifetime risk of death by suicide in major depression is frequently cited as 15% (Guze & Robins, 1970). The Epidemiologic Catchment Area Study (Robins & Regier, 1991) reported that 25% to 50% of bipolar patients attempt suicide at least once in their lifetime and a small sample of individuals with bipolar I individuals reported a 48% suicide attempt rate (Kessler et al., 1997). Clearly, as Goodwin and Jamison (1990) emphasize, the severity of depression or bipolar illness is a critical factor in any estimate of suicide risk. Winokur and Tsuang (1975) examined the differential risk between bipolar and unipolar patients. In a 30 to 40 year follow up of 76 bipolar patients and 182 unipolar patients, the suicide rates were 8.5% and 10.6% respectively. Most authors agree that the predisposing factor is not the manic state itself but rather the presence of depression that accompanies a mixed bipolar state. Clinical experience suggests that the mixed bipolar state is associated with a particularly high risk of suicide because of the dangerous combination of highly dysphoric mood and a high level of energy and perturbation.

Baldessarini (2003) reported that suicide in bipolar illness occurs not only in bipolar I, but also in bipolar II disorder at similar or possibly somewhat higher
rates. Rihmer and Pestality (1999) found a substantially higher risk of suicide attempts in bipolar II patients than in bipolar I patients. This finding may not be surprising because bipolar II includes severe depressive illness, which is one of the main risk factors for suicide in bipolar disorder as well as unipolar depression. Current depression and current mixed manic depressive states (especially those with severe agitation and dysphoria) are particularly potent risk factors for suicide in bipolar disorder. Mortality in major affective disorders is greater among men than in the general population. Suicide risk is similar in bipolar disorders and major depression, many people with these disorders may attempt suicide early in the course of illness (Baldessarini, 2003).

Studies from India and abroad have consistently reported a high incidence of psychiatric illness in suicide attempters with a reasonable estimate of depression accounting for 75%, alcoholism 15% and miscellaneous psychiatric conditions 8% (Gupta & Singh, 1981; Barraclough et al., 1974). Consistent with other studies (Beautrais et al., 1996a; Ferugsson & Lynskey, 1995a; Deykin & Buka, 1994), attempted and completed suicide (Shaffer et al., 1996; Brent et al., 1993; Hawton et al., 1993; Marttunen et al., 1991) has a strong and independent association with depression and substance abuse.

Recently, Brown and colleagues (Brown et al., 2000) published data from a 20 years prospective study of 6891 psychiatric outpatients, approximately 1% of whom committed suicide. Logistic regression revealed that bipolar disorder and major depression contributed unique risk for eventual suicide in these patients, with hazard ratios of 3.57 and 3.19, respectively. Most recently (Inskip, Harris, & Barraclough, 1998) have used mathematical modeling techniques to determine that the overall risk of completed suicide in mood disorders may actually be closer to 6%. Several researchers have extrapolated rates of mood disorders and suicide from large scale epidemiological studies (Blair et al., 1999; Inskip, Harris, & Barraclough, 1998). Using Guze and Robin’s (1970) assumption of a 15% lifetime rate of death from suicide and the rates of depression in United States
(Kessler et al., 1994), the rate of completed suicide should be about 4 times higher than actually observed (Blair et al., 1999). By modeling data available as of 1994 the risk of completed suicide for people with major depression is estimated at about 3.4%. One could reasonably conclude that the actual lifetime risk of death from suicide for major depression is between 3.4% and 6%, but this overall estimate omits important distinctions among subpopulations.

Tsai et al. (2002) undertook a study of a non-western bipolar sample incorporating sex and age matched living controls to examine variables associated with completed suicide. The proportion of patients (68.3%), which had previous depressive episodes, in the entire study population, is somewhat less than the 80% to 90% for western patients (Kaplan, Sadock, & Grebb, 1994; Goodwin & Jamison, 1990). It is the depressed phase of bipolar disorder (Goodwin & Jamison, 1990) or the severity of concurrent depressive symptoms in manic episode (Strakowski et al., 1996; Dilsaver et al., 1994) that is associated with suicidal in bipolar patients. Thus, only 70.7% of the suicide completers having had a depressive episode could be explained by the fact that the rest of the completers might complete suicide in their first depressed or mixed episode (Tsai et al., 2002).

More direct evidence of the risk of suicide from major depression is available from the National Comorbidity Survey (Kessler et al., 1999, 1994). This study assessed a representative cross sectional community sample with the obvious constraint that respondents were alive; those who had already died were not available for the analysis. Compared to those without any disorder, those with major depression had odds ratio for suicidal ideation and suicidal plans of 11.0 and 9.6, respectively. Among those with ideation, the odds ratio for having a plan or a planned attempt was 1.7 and 2.1, the odds ratio for those without a plan who had an impulsive attempt was 1.9. A metaanalysis of two recent nationwide studies from Scandinavia (Osby et al., 2001; Hoeyer et al., 2000) indicate that an inpatient with major depressive disorder has about a 20 fold risk of completed
suicide. The risk of a non-fatal suicide attempt among patients with major depressive disorder is less precisely known, but is estimated to be about 40% following the first lifetime episode of major depressive disorder (Malone et al., 1995).

Sokero and his associates (2003), examined 269 patients with DSM-IV major depressive disorder. Suicide ideation was prevalent and appeared to be a precondition for suicide attempts among psychiatric patients with major depressive disorder. During the current major depressive episode, 58% of all patients had experienced suicidal ideation; among the 15% of the total who had attempted suicide, almost all 95% had suicidal ideation.

Suicidal behaviour can also be triggered by mood disorders that do not meet the total number of required diagnostic criteria of major depressive disorder e.g., dysthymia, minor depression, recurrent brief depressive disorder, sub threshold major depression (Judd et al., 1998; Kendler & Gardner, 1998; Maier et al., 1997). Recurrent brief depressive disorder also has been associated with increased suicide attempt rates in epidemiologic (Snaith, 2000; Altamura et al., 1995; Angst & Hochstrasser, 1994; Maier et al., 1994; Pezawas et al., 1994; Weiller et al., 1994) and clinical studies (Montgomery et al., 1989). Pezawas and his colleagues (2002) examined 101 patients with recurrent brief depressive disorder, major depressive disorder or combined depression. Combined depression refers to longitudinal diagnostic shifts from recurrent brief depressive disorder to major depressive disorder or vice versa. Patients with combined depression showed significantly higher (p<0.05) scores on measures of suicidal behaviour in comparison with recurrent brief depressive disorder and major depression patients.

Srivastava and Kulshreshtha (1998) undertook a study to find out correlation, if any, between severity of depression and suicidal intent and its relation to various other factors. Sample of the study consisted of 30 patients taken from out patient department who were diagnosed to be suffering from
depression. Pearson correlation coefficient was computed between the scores of suicidal ideation and depression to establish relationship between suicidal intent and depression. The correlation was found to be .046 (p< .05). Correlation coefficient obtained indicated a low positive relationship between severity of depression and suicide intent. Khalid et al. (1997) also reported similar positive correlation (r = .48, p<.05) between scores of depression and suicide intent. This finding is also corroborated by several other studies (Beck et al., 1990; Barraclough & Pallis, 1975).

In another study (Gastel, Schotte, & Maes, 1997) examined the relationships between suicide ideation or suicide attempts and severity of depression, presence of personality disorders, and socio-demographic factors in population of depressed inpatients. A total of 338 depressed psychiatric inpatients were included having major depression with or without melancholic or psychotic features, adjustment disorder with depressed mood or dysthymic disorder. They found that suicidal ideation was significantly related to severity of depression. The items with the strongest predictive value for suicidal ideation were hopelessness, depressed mood, feelings of guilt, and loss of interest.

In the Indian set up Kumar (1990), examined correlates of suicide ideation among university students. This was done separately for males and females. Beck’s scale for Suicide Ideation, Beck Depression Scale, Torrance Test of Creative Thinking, Verbal and Figural Form A, Witkin’s Embedded Figure Test and Sarason’s Life Experiences Survey were administered to a sample of 500 university students comprising of 250 males and 250 females. The findings concerning correlates of suicide ideation among males revealed that some aspect of depression is associated with some aspect of psychosis proneness as well as low sociability. The factor structure do not reveal information about the nature of these components. However, it can be asserted that possibly, some symptoms of depression relevant to cold, impersonal, and egocentric aspects of psychosis...
proneness and lower sociability level are substantially closer to the suicidal wishes.

In contrast, for the female group, the symptoms of depression relevant to cold, impersonal, unempathetic, and egocentric aspects of psychosis proneness, lower sociability level, and cognitive factors, such as pessimism and negative attitudes are substantially closer to some aspect of suicide ideation being closer to social desirability. In interpreting these findings, it is significant to keep in mind that the structural relationship among different variables revealed that some aspect of depression associated with neuroticism failed to reveal any relationship with suicide ideation in case of both males and females.

**Suicidal Behaviour and Hopelessness**

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”).

Hopelessness is the 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 (Beck et al., 1979) cognitive theory of depression, 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 and eventual suicide (Brown et al., 2000; Fawcett et al., 1990) in clinically referred samples. Nevertheless, although a number of cross-sectional studies have focused on hopelessness and juvenile suicidal behaviour (RotheramBorus et al., 2000), a few studies of youths (Myers & Niel, 1978) have examined hopelessness as a predictor of later suicidal behaviour. Hopelessness
has been found to be a strong predictor of suicidal ideation. Alternatively, hope has been related strongly to reduce suicidality. Since a hopeless pessimistic style often is seen in the cognitive/affective suicidal state or in the general characteristics of these individuals outside the crisis state (Rudd et al., 1996; Hughes & Neimeyer, 1993), it has been suggested that help negation may be a demonstration of an overall maladaptive coping style in acutely suicidal samples (Clark & Fawcett, 1992).

Individuals who are acutely suicidal may reject help because they have pessimistic and negative expectations about the worth of such help. In short, they may view their situation as hopeless. Help-negation is implied if suicidal ideation increases and intentions to seek help decreases. Mendonca and Holden (1996) found that factors other than hopelessness appear to be relevant for understanding suicidal ideation. In particular, self reported unusual thinking was found to be the most important predictor in various facets of suicide intent.

Reasons for living or deterrents to suicide have been found to be negatively associated with both recent and previous suicidal behaviour among adults and adolescents (Cole, 1988; Linehan et al., 1983). Dysfunctional attitudes are believed to reflect underlying “depressive schemata” or belief systems that make individuals vulnerable to depression (Beck et al., 1993). Such dysfunctional attitudes promote information processing errors in which depressed individuals filter or dampen the significance of positive information and exaggerate “the meaning and significance of negative information” (Beck et al., 1993). Deficits in problem solving ability have been described as being associated with suicidality; specifically, suicidal individuals often fail to perceive alternatives for solving difficulties, and they narrowly focus on suicide as their only possible solution to problems (Shneidman, 1996). In addition, personal expectations have long been thought to be associated with later behavioural and health outcomes. Individuals considering suicide may assimilate information that is confirmatory of their
negative expectations of the future, therein setting up self-fulfilling prophecies that are predictive of later behaviour.

A cognitive analysis of suicidal behaviour is advantageous because of its direct implications for treatment. To decrease self-destructive behaviour, clinicians need to assist distressed patients in recognizing and reducing maladaptive thinking, while facilitating more positive and adaptive thinking. Studies of adolescents, however, have lagged behind those of adult in systematically examining the cognitive context within which suicidal behaviour occurs, and in particular, the degree to which cognitive variables portend risk for later suicidal behaviour. Evaluation of cognitive distortion may be an important aspect of the assessment of suicidal ideation and risk. Clinicians should be alert to symptoms of cognitive distortion as well as to affective symptoms associated with suicidal intent.

Hopelessness is a psychological dimension that is associated with increased suicide risk (Conner et al., 2001; Brown, 2000; Brown et al., 2000; Fawcett et al., 1990). Hopelessness may vary in degree from having a negative expectation for future. In general, patients with high levels of hopelessness have an increased risk for future suicide (Brown, 2000; Beck et al., 1993; Beck et al., 1990; Beck et al., 1989; Beck & Steer, 1989; Beck et al., 1985). However, among patients with alcohol use disorders, the presence of hopelessness may not confer additional risk (Young et al., 1994; Beck et al., 1989). For patients with depression, hopelessness has been suggested to be the factor that explains why some patients choose suicide, whereas others do not (Beck et al., 1985). Hopelessness also contributes to an increased likelihood of suicide ideation (Uncapher et al., 1998; Gastel et al., 1997) and suicide attempts (Kaslow et al., 1994) as well as an increased level of suicidal intent (Soloff et al., 2000; Mendonca & Holden, 1998; Weissman et al., 1979).

Hopelessness often occurs in context of depression as a “state-dependent” characteristic, but some individuals also experience hopelessness on a primary
and more enduring basis (Beck et al., 1990). High baseline levels of hopelessness have also been associated with an increased likelihood of suicidal behaviours (Young et al., 1996). However, patients experiencing similar levels of depression may have differing levels of hopelessness (Beck et al., 1985) and this difference, in turn, may affect their likelihood of developing suicidal thoughts (Uncapher, et al., 1998).

Depression, however, has several traveling companions which often accompany it in varying degrees. Feelings of hopelessness and helplessness are usually also evident. These are perhaps the feelings most accessible to the consciousness of the client and are more easily pointed out when a client first comes for help. Hopelessness has been found to be a more accurate indicator of the seriousness of the suicidal state than depression (Kovacs et al., 1975; Minkoff et al., 1973; Beck & Beck, 1972). In fact, the caregivers may use the client’s ability or inability to project into the future and make plans as a gauge of the seriousness of suicidal intent. Feelings of hopelessness may be more clearly expressed by the client than feelings of depression. Such communications take the form of remarks like “Nothing feels good to me any more and probably never will”, “Things will never work out”, I can’t see that things will ever be any different”. In addition helplessness is an expression of the client’s experience of importance. One hears helplessness expressed as “I can’t do anything about it”, “No matter what I do it will never change”, “I can’t solve this problem by myself”. It may appear to the caregiver that the client is restored to a helpless state especially if the client should say, “Don’t both of you probably can’t do anything for me, either”. Recognition of this as a covert request for help enables the caregiver to bring this fact to the awareness of the client. More than likely it is an indication that the client has difficulty asking for anything directly. It may be a typical manner of interacting with most other persons in the client’s life.

In several theoretical models of depression, hopelessness has been assigned a critical role in the genesis and maintenance of depressive symptoms (Beck,
Steer, Kovacs, & Garrison, 1985). Moreover, evidence linking hopelessness with suicidal intent and behaviour has also accumulated (Wetzel, 1976; Minkoff, Bergman, Beck & Beck, 1973).

The development by Beck and his group of reliable and valid measures of suicidal intent among suicide attempters (Beck, Morris, & Beck, 1974; Beck, Schuyler, & Herman, 1974) and ideators (Beck, Kovacs, & Weissman, 1979) as well as an instrument for measuring hopelessness (The Hopelessness Scale: Beck, Weissman, Lester, & Trexler, 1974) spurred a series of studies investigating the relationships among hopelessness, depression and suicidal behavior. An investigation of suicide attempters by Minkoff and his associates (Minkoff, Bergman, Beck, & Beck, 1973) found that the intensity of suicidal intent was more highly correlated with hopelessness than with depression. Hopelessness as measured by the Hopelessness Scale, emerged as the moderator variable linking depression and suicidal intent. A validation study found that hopelessness accounted for 76% of the association between depression and suicidal intent in 384 hospitalized suicide attempters (Beck, Kovacs, & Weissman, 1975). Beck (1967, 1963) contended that specific cognitive factors (e.g. hopelessness/pessimism about the future) are more closely related to suicidal intent than are affective aspect of depression alone.

Sokero et al. (2003) examined 269 patients with major depressive disorder. Information was gathered on patients’ levels of depression, anxiety, hopelessness and various other factors. In nominal regression models predicting suicide ideation variables such as hopelessness, alcohol dependence or abuse, low level of social and occupational functioning, and poor perceived social support were found to be significant (p<.05) independent risk factors.

Other investigators have supported the positive relationships among hopelessness, depression and suicidal intent in attempters (Dyer & Kreitman, 1984). Hopelessness was found to correlate more strongly than depression with suicidal intent in alcoholic suicide attempters (Beck et al. 1993).
Wetzel, Margulies, Davis & Karam (1980) examined the relationship of hopelessness to suicide ideation in 73 psychiatric inpatients. They found that although both hopelessness and depression were correlated significantly with suicide ideation, hopelessness accounted for more of suicide ideation variance (56% versus 13%) than depression. When depression was partialled out of the correlation between hopelessness and suicide ideation the correlation remained significantly high ($r = .72$, $p<.05$). On the other hand, when hopelessness was partialled out of the correlation between depression and suicide ideation, the partial correlation was non significant ($r = .10$).

A study (Beck, Steer, Kovacs, & Garrison, 1985) of hospitalized patients with suicidal ideation found that after a 5 to 10 year follow up period, 14 of the 207 patients in the study committed suicide. Of all the data collected during hospitalization, only the hopelessness scale and the pessimism item of the Beck Depression Inventory predicted the eventual suicides, correctly identifying 91% of the completed suicides.

These findings, in conjunction with previous studies showing the relationship between hopelessness and suicide intent, indicate the importance of the degree of hopelessness as an indicator of long term suicide risk across psychiatric diagnoses (Beck, 1986; Beck et al., 1985; Beck, Kovacs & Wiessman, 1979, 1975; Beck, Davis, & Frederick, 1973). Beck (1986) also described a preliminary study with 1969 outpatients evaluated between 1978-1984 in which a Beck hopelessness score of 9 or above identified 15 (93.8%) of 16 suiciders. Finally, when patients who had been hospitalized for depression or suicidal risk rather than for a recent suicide attempt were studied, it was again found that hopelessness, rather than depression per se was a determinant of suicidal intent (Wetzel, Margulies, & Davis et al., 1980; Bedrosian & Beck, 1979).

More recently, Souminen, Isometsa, Henriksson, Ostamo, & Lonnqvist (1997) examined differences in hopelessness, impulsiveness and suicide intent between suicide attempters with either major depression or alcohol dependence,
comorbid major depression and alcohol dependence and those without these disorders. A sample of 114 patients from consecutive cases of attempted suicide referred to a general hospital in Helsinki was interviewed and diagnosed according to DSM-III-R. Suicide intent was measured by the Beck Suicide Intent Scale (SIS) and Hopelessness was assessed by the Beck Hopelessness Scale (HS). Impulsiveness of the suicide attempt was measured by two items of the SIS. Hopelessness was found to correlate significantly with suicide intent ($r = 0.32, p < 0.01$) and to correlate strongly with Beck Depression Inventory scores ($r = 0.69, p < 0.001$). By contrast, suicide intent did not correlate significantly with Beck Depression Inventory score ($r = 0.17, p < 0.103$). Impulsiveness was found to correlate inversely and significantly with hopelessness ($r = 0.24, p < 0.05$) and Beck Depression Inventory scores ($r = 0.60, p < 0.01$). Age did not correlate significantly with suicide intent ($r = -0.02, p < 0.87$), hopelessness ($r = 0.08, p < 0.40$) or impulsiveness ($r = -0.09, p < 0.35$).

Suicide attempts among subjects in four different diagnostic groups were found to differ from each other in terms of hopelessness. In post-hoc comparisons, subjects with major depression without comorbid alcohol dependence were more hopeless than subjects without major depression or alcohol depression or alcohol dependence. None of the possible confounding factors (age, sex, anxiety disorders or any Axis II diagnosis) had a significant main effect, nor were there significant interactions.

Hopelessness is the key mediating variable between depression and suicide intent (Weishaar and Beck, 1992), but not all findings were consistent with this interpretation (Strosahl et al., 1992; Pokorny et al., 1975). It has been reported that hopelessness is predictive of actual suicide both in psychiatric out patients (Beck et al., 1990) and in hospitalized suicidal ideators (Beck et al., 1985). However, the role of hopelessness in the relationship between alcoholism and suicide attempts is not clear. In studies concerning suicide intention the influence of alcohol is rarely discussed (Nielsen et al., 1993). Hopelessness rather than depression has
been found to be the key determinant of suicidal intent, in both alcoholic and non-alcoholic suicide attempters (Beck, Steer and Trexler, 1989). In fact, Beck found that only a diagnosis of alcoholism predicted eventual suicide in a sample of hospitalized suicide attempters (Beck & Steer, 1989).

Suicide attempters with major depression without comorbid alcohol dependence had higher suicide intent and lower impulsiveness than attempters with non depressive alcohol dependence. The authors concluded that suicide attempts may differ between subjects with major depression, alcoholism or both disorders in terms of impulsiveness and suicide intent.

Mendonca and Holden (1996) reported that the intensity of death wishes was more closely related to patient’s unusual quality of thinking than to their degree of pessimism. The purpose of another study by the authors (Mendonca and Holden, 1998) was to expand earlier study (Mendonca and Holden, 1996) beyond simply examining main effects. Mendonca and Holden (1998) examined the comorbidity among three key symptoms associated with suicidal intent namely hopelessness, depression and unusual thinking. A total of 97 patients with suicidal thoughts were assessed using the Beck Hopelessness Scale, the Anxious Depression Scale and Unusual Thinking Factor Scale of the Derogatis Symptoms Checklist 90, and the Beck Scale for Suicide Ideation. It was found that in considering the interaction between key symptoms, the combination of hopelessness and unusual thinking (which consisted of symptoms such as ‘trouble concentrating’ and ‘mind going blank’) was the strongest predictor of the seriousness of current suicidal inclinations.

Linehan and Nielsen (1981) first administered the Edwards Social Desirability Scale (ESDS; Edwards, 1970), the Beck Hopelessness Scale (BHS; Beck et al., 1974), the Suicidal Behavioural Questionnaire (SBQ; Beck et al., 1974), and the Suicidal Behaviour Questionnaire (SBQ: Linehan & Nielsen, 1981) to Settle shoppers. They found significant correlations between BHS and SBQ items and ESDS and SBQ items, as well as a significant negative correlation
between BHS and ESDC scores. When social desirability was controlled for, the correlations between other measures dropped to insignificant. Linehan and Nielsen concluded that social desirability largely determines the correlation between hopelessness and nonfatal suicidal behaviour. Nevid (1983) noted that hopelessness might decrease the tendency to respond in a socially desirable manner, he also questioned the generalizability of Linehan and Nielsen’s (1981) findings to clinical populations. Linehan and Nielsen (1983) also administered their battery to 44 psychiatric inpatients and reported a significant correlation between hopelessness and parasuicide and in contrast to their earlier findings, a non-significant correlation between social desirability and self-reported probability of future suicide was found. When social desirability was partialled out, the correlation between hopelessness and suicidal behaviour did not drop to a significant level.

Using structural equation model, Cole (1988) found that hopelessness correlated with attempted suicide in a student client sample when social desirability and depression were controlled for, but not in a non-client sample. Ivonoff and Jang (1991) examined the relationships among hopelessness, social desirability, and suicidal behaviour in the decade long dispute about the role of social desirability and the ability of the Beck Hopelessness Scale to predict suicidal behaviour. Using a stratified random samples, suicide behaviour remained significantly correlated even after social desirability is held constant, failing to replicate Linehan and Nielsen’s (1983, 1981) findings. In addition a multivariate regression analysis demonstrated that the utility of hopelessness in predicting suicidal behaviour varies with the level of social desirability, consistent with Holden, Mendonca, & Serin’s (1989) results describing an interaction between hopelessness and social desirability. In sum, these findings do not support Linehan and Nielsen’s (1983, 1981) argument describing a spurious relationship between hopelessness and suicidality. On the basis of their partial correlation analysis, the authors argued that the significant correlation between the two is primarily due to their relationship with social desirability.
On the other hand, the findings are consistent (Holden et al., 1989) concerning the interaction between hopelessness and social desirability. Better stated, the ability of hopelessness as measured by Beck Hopelessness Scale to explain suicidality varies with the subject’s level of social desirability. The authors suggested that social desirability should be considered along with hopelessness in assessing suicidality not because hopelessness is a poor predictor or because social desirability helps avoid false negative predictions, but because social desirability interacts with hopelessness. Although hopelessness may decrease the tendency to respond in a socially desirable manner, as Nevid (1983) suggested, this explanation is not sufficient. The authors concluded that further research is needed, examining the interaction between hopelessness and social desirability in clinical / non clinical samples of high social desirability. The relationships of race and ethnicity to these measurements also warrant further study.

Petrie and Chamberlain (1983) administered measures of depression, hopelessness, suicidal behaviour and social desirability in a sample of suicide attempters. They used the Marlowe Crowne Social Desirability Scale (MCSDS; Crowne and Marlowe, 1964). As in the previous studies, they found a significant correlation between hopelessness and social desirability ($r = .30$). Unlike the previous studies, the correlation between hopelessness and parasuicide did not diminish when social desirability and depression were controlled for. However, the correlation between depression and parasuicide did drop when social desirability was covaried. Petrie and Chamberlain (1983) attributed the discrepancies between their results and Linehan and Nielsen’s (1981) findings to differences between treatment and non-treatment population, whereas Strosahl et al. (1984) attributed the differences to the MCSDS, suggesting that it is poor measure of social desirability.

Beck, Steer, Kovacs & Garrison (1985) studied 207 patients hospitalized because of suicidal ideation but not for recent suicide attempts, at the time of
admission. During a follow-up period of 5-10 years, 14 patients committed suicide. Of all the data collected at the time of hospitalization, only the Hopelessness Scale and the pessimism items of the Beck Depression Inventory predicted the eventual suicides. A score of 10 or more on the Hopelessness Scale correctly identified 91% of the eventual suicides. Taken in conjunction with previous studies showing the relationship between hopelessness and suicidal intent, these findings indicate the importance of degree of hopelessness as an indicator of long term suicidal risk in hospitalized depressed patients.

More recently, Mendonca and 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. A total of 97 patients with suicidal thoughts were assessed at the crisis unit of a psychiatric hospital. In interviews suicidal intent was assessed using the Beck Scale for Suicidal Ideation, while psychological distress was assessed using both the Beck Hopelessness Scale and the Derogatis Symptoms Checklist. Ideation items describing the frequency, duration and acceptance of a wish to die were significantly correlated with feelings of hopelessness.

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 sub samples, the implications of interpersonal anxiety and hostility, together with serious suicidal intent, have also been corroborated by other researchers (Strang and Orlofsky, 1990; Farmer, 1987). The specific relationship between hopelessness and suicidal intent, was not found with other diagnostic groups in this study. On the other hand findings suggest that unusual thinking and not hopelessness was the strongest predictor of serious suicidal intent. The regression results in fact suggested that hopelessness and even past history of suicidal behavior do not contribute as significant predictors after
unusual thinking has been taken into account. However, items reflecting preoccupation with a method of self-harm showed only a week correlation with hopelessness, although the relationship varied according to diagnosis. That is, this preoccupation was significantly associated with hopelessness, personality disorder, anxiety disorder and substance abuse subgroups. The authors concluded that factors other than hopelessness, especially unusual thinking appear to be relevant for understanding suicidal ideation. Whatever the source or conceptualization of hopelessness, interventions that reduce hopelessness may be able to reduce the potential for suicide (Brown, 2002; Nordentoft et al., 2002; Dahlsgaard et al., 1998; Beck et al., 1985; Rush et al., 1982).

SUICIDAL BEHAVIOUR AND SOCIAL SUPPORT

Since the 1970’s, the possible influence of social support on health and well-being has attracted the interest of psychologists, sociologists, anthropologists, epidemiologists, and the other public health professionals; seldom has such a diverse group of social and health scientists agreed on the importance of a single factor in promoting health and a unified conceptualization of the meaning of social support, its role in health and mental health, or even how to measure it.

The potential content of the concept of social support has been influenced by many strands of thought, which include Durkheim’s development of the idea of anomie, Cooley’s concept of the primary group and Bowlby’s idea of attachment. The concept of social support forms explanation of differing purpose, operating at very different levels. It can be seen in terms of its social function for individuals, that is, in meeting their needs. It also has a function for subjects own behavior that is in seeking support when it becomes an aspect of coping. Finally, is effects on health and well-being.

According to Caplan’s theory (1974), social support implies an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time. For Caplan, a
social network provides a person with “psychological supplies” for the maintenance of mental and emotional health.

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 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 providing stable and rewarding roles, by promoting healthy behaviour, by deterring the person from ill-advised behaviour, and by maintaining stable functioning during periods 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 perspective assumes a certain preventive function of support against stress, this perspective focuses upon the curative function of actual help when a person is under stress (cf. 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. For example, as Barrera (1986) has suggested, exposure to stress may trigger the enactment of
supportive behaviours by others, thus leading to positive correlations between stress and enacted support.

The relationship of social support to stress and functioning has been widely studied. The absence of social support in the face of adversity is thought to make the individual more vulnerable to stress-induced illness and some have argued that the absence of social ties can itself cause psychological impairment. Studies have also found that people with greater amounts of support are less likely to show depressive symptoms and that support can sometimes buffer the individual so that depression is less likely to occur as a result of exposure to stressful life events (Heller & Swindle, 1983; Mitchell et al., 1982).

While some studies on social support and psychological distress have used representative community samples (e.g., Henderson et al., 1981), others have employed particular subgroups such as working class women (e.g., Brown et al., 1986), the elderly (e.g. Kraus et al., 1989), or others (e.g., Cramer, 1985, 1988, 1990, b.c.; McLennan & Omodei, 1988; Cohen et al., 1986). Social support has long been recognized as a significant factor in the formation of adolescent self-esteem (Rosenberg, 1981). Correlational and longitudinal studies over the last three decades have demonstrated the pervasive influence of affirmation, aid, and affection proffered by parents and peers (Hoffman, Ushpiz, & Levy-Shiff, 1988; Greenberg, Siegel, & Leitch, 1983; Burke & Weir, 1978, 1979; Rosenberg, 1965).

Although most of this research has been cross-sectional in design, an increasing number of prospective studies suggest that prior social support is also negatively related to subsequent psychological distress (e.g. Krause, Liang, & Yatomi, 1989; Brown, Andrews, Harris, Adler, & Bridge, 1986; Monroe, Imhoff, Wise & Harris, 1983; Henderson, Bryne, & Duncan-Jones, 1981).

In addition to evidence that the availability of childhood social support is related to personality development and adult behavior patterns, there is also evidence of the detrimental effects of lack of support in adults. De Araujo and Associates (De Araujo, Van Arsdel, Holmes, & and Dudley, 1973; De Araujo,
Dudley & Van Arsdel, 1972) reported that asthmatic patients with good social support required lower levels of medication to produce clinical improvement than did asthmatics with poor social support. There is much evidence that medical and surgical patients benefit from attention and expressions of friendliness by physicians and nurses.

Henderson (1980) concluded that a deficiency in social bonds may, independent of other factors, be a cause of some forms of behavioral dysfunction. The literature on the nature and role of social support in relation to life events is literally burgeoning. There are now plethoras of findings based on a variety of measures that social support sometimes interacts with life events, and sometimes is directly related to a vast array of mental and physical health outcomes (Thoits, 1982; Gore, 1981; House, 1981; Cobb, 1976).

Crammer (1991) investigated the relationship between psychological distress and social support along with various other health-relevant variables, in a nationally representative sample of some 2050 women and 1873 men. The correlation between family support and distress was reduced from -.13 to -.04 for women and from -.15 to -.10 for men when all other variables were partialled out.

A nation wide survey of stressful life events in China found that problems with interpersonal relationships were the most commonly reported stressor in daily life (Zheng & Lin, 1994). In other situations, a person may be adversely affected by other family members or important individuals in the social network who are experiencing problems. The level of tension for all family members can be increased if one member experiences extreme difficulty, such as chronic or life threatening illness or a psychiatric disability.

One of the puzzling finding in the domain of social support concerns the existence of negative direct as well as a buffer effect (Barrera, 1986). For example, in a study of nurses, Kaufman and Beehr (1986) found that all the significant buffer effects turned out to be the opposite of their expectations: the relationship between sources of stress and stress reactions appeared to be higher
among individuals who lacked these symptoms. Winnubst, Marcelissen & Kleber (1982) found that people who had a high responsibility for others at work became more depressed when their colleagues and superiors were more supportive. In a study carried out by Hobfoll and London (1986) among Israeli women whose loved ones were mobilized in the 1982 Israel-Lebanon war, social support appeared to be related to greater psychological distress. In a study on occupational stress among nearly 2000 employees, Buunk, Janssen, & Van Yperen (1989) noted so called boomerang effects. For example, in some cases social support aggravated the stress reactions or did not affect them all in work units characterized by a high degree of role conflict, while at the same time social support reduced stress reactions in units with a low degree of role conflict. In other words, social support seemed to aggravate instead of alleviating stress.

Theoretical and research evidence also indicates a relationship between disrupted social networks and occurrence of suicidal behaviour. The behaviour has been variously attributed to increasing social isolation (Jacobs and Teicher, 1967), to disturbances in close relationships (e.g., Rosenbaum and Richman, 1970, 1972) and to the impairment of interpersonal communication (e.g., Fawcett et al., 1969).

Existing relationships are also impaired. Clinical interviews with suicide attempters and their relatives reveal an almost universal pattern of family involvement in the process that initiates the suicidal act (Rosenbaum & Richman, 1972). Assessment of communication patterns indicates that the quality of interpersonal communication between spouses deteriorates as the degree of suicidal behavior in one partner increases (Bonnar and McGee 1977). Chronically disrupted relationships, marital isolation and distorted communication all characterize the high risk attempter (Fawcett et al., 1969). A study by Hart, Williams, & Davidson (1988) was aimed to examine the relationship between social network deficits and the occurrence of suicidal behaviour, and to describe the short-term interpersonal consequence of a suicidal attempt. The authors found
that the social networks of suicide attempters are impaired relative to non-suicidal individuals and that improvement in the social network following an attempt with no formal psychiatric disorder, and to measures of perceived adequacy and satisfaction. The findings add support to the importance of psychiatric assessment of the nature and the adequacy of the social network in relation to suicidal individuals.

Marttunen, Aqro, Henriksson, & Lonnquist (1994) examined the relationships between stressors and psychiatric diagnoses among 13-19 years old adolescent suicide victims with alcohol abuse/dependence (N=14), depressive disorders (N=18), and the remainder (N=21). The results indicate that specific psychosocial stressors may be critical for suicidal adolescents with different diagnoses. In the evaluation of suicidal adolescent substance abusers, particularly recent interpersonal separations and family support need to be carefully weighted. The authors also concluded that the disruptions in the adolescent’s interpersonal relationships, excess accumulation of stress, and lacking support from the family may be warning signs of suicide potential and indications for additional social support, for more intensive treatment, or for a change in the treatment setting.

**ATTACHMENT THEORY**

Attachment theory is based on the premise that the quality of affectional bonding between children and their primary caregivers profoundly impacts later psychosocial, emotional and cognitive functioning (Allen & Land, 1999). The core concept of attachment is that early experiences of care translate into internal working models through which future relationships and other social experiences are interpreted (Bowlby, 1973). Secure attachment, an individual’s internalized model of available support, protectional and emotional proximity, is characterized by mutual care, reciprocal connection and emotional closeness, facilitating resilience to later stress, social competence and stability in relationships. Insecure attachment, the experience of attachment figures as unreliable and unresponsive is characterized by the perception of others as untrustworthy and uncaring and by
difficulties with self worth, affect regulation and intimacy (Seigel, 1999). The term “attachment relationship” does not refer to all close connections, but rather to those characterized by an enduring affectional bond of substantial intensity (Ainsworth, 1989). With increasing age, the boundaries between attachment relationships and other close relationships become less distinguishable as relationships serve different functions across the lifespan (Levitt, 2005).

Suicidality describes the cognitive or behavioural characteristics that result from suicidal ideation or behaviour. The literature on adolescent suicidality shows links between suicidal behaviour and a variety of family difficulties, including dysfunctional relationships with parents (Groleger, Tomori, & Kaocmur, 2003), high levels of blame and criticisms (Allison, Pearce, Martin, Mailler, & Long, 1995), poor parent-child communication (Gould, Fisher, Parides, Floy, & Shaffer, 1996) and perceived lack of support between family members (Cambdell, Milling, Laughlin, & Bush, 1993). In addition, a variety of interpersonal factors such as social isolation (Bearman & Moody, 2004) and peer rejection and low levels of close friendship support (Prinstein, Boergers, Spirito, Little, & Grapentime, 2000) have been related to adolescent suicidal ideation and behaviour. Similar findings have been reported in cross-cultural research. For example, suicidal behaviour has been associated with conflict and poor family functioning among South African adolescents (Pillay & Wassenaar, 1997) and with low parental warmth, high-maternal over control, authoritarian parenting and a negative family climate in Chinese adolescents in Hongkong (Lai & Mcbride-Chang, 2001).

The idea that attachment difficulties may have direct involvement in suicidal behaviour has been proposed (Adam, 1994). Adam (1994) suggested that when securely attached adolescent experienced distress they are able to acknowledge their feeling and turn to supportive and trusted relationships for comfort. When adolescents are unable to successfully meet their needs for attachment security, they distress the availability of others and become vulnerable to low self-esteem, depression, helplessness, hopelessness and an elevated risk of
suicidal behaviours. History of suicidal ideation or suicide attempts have been associated with failure to achieve secure attachment and parental unavailability (West, Spreng, Rose, & Adam, 1999), low levels of security and parental emotional unavailability (deJong, 1992) and low levels of care and high levels of over protection by mothers (Adam, Keller, West, Larose, & Goszer, 1994).

Security of attachment during adolescence is associated with trusting, warm emotionally supportive relationships (Allen & Land, 1999). Participants’ relationships with parents were characterized by conflict, abuse criticism, tension and instability. The lack of trusting and supportive relationships was perceived to hide the ability to meet attachment security. Instead of feeling loved and cared for, participants reported feeling rejected, unwanted, unloved and isolated from social and emotional connections. From the participants’ viewpoints, their experiences of love were severely restricted and each felt increasingly helpless, hopeless and valueless. The unavailability of care and support created distant interpersonal relationships, feelings of loneliness and withdrawal. They became vulnerable to suicidal behaviours and, as they described, were unable to turn to others for comfort (Adam, 1994).

During adolescence, when participants required a secure base or safe relationship with parents to provide the security to explore their identities, establish connections with peers and develop as autonomous individuals, home life and relationships with parents were difficult, unsupportive and a source of distress. Limited emotional bonding, intimacy and closeness were described as prohibiting parents from being solicited in times of need. Consistent with the current study, researchers have found low security of attachment (deJong, 1992) and the failure to perceive attachment figures as available and responsive (West et al., 1999) in adolescence with a history of suicidality. When parents could have served as an important resource for guidance and connection, participants experiences left them removed from healthy parent-adolescent interaction.
Research on stress and coping has shown that one of the most effective means by which individuals cope with stressful events is through social support. There is substantial evidence showing the benefits of many forms of social support for both mental and physical health (Seeman, 1996; Theits, 1995). How people decide to solicit and receive support is likely to depend heavily on the nature of the relationships they have with their social networks. Even two equally supportive social networks might differ in the norms that guide interactions and the shared expectations of how a person and the network are connected to each other. Consequently, decisions to seek social support are likely to be effected by these norms and expectations.

Research in cultural psychology has shown that the norms that govern the nature of relationships differ greatly across cultures. In contrast, individuals are encouraged to focus on their relationships and act to maintain harmony within a group in more interdependent cultures, such as in East Asia (Markus & Kitayama, 1991; Triandis, 1989). These differences in expectations and norms about relationships between a person and the social network are likely to affect how and whether individuals seek and use social support. Cultural differences in the use of social support may inform about understanding of the meaning and measurement of this construct.

Social support is defined as the perception or experience that one is loved and cared for, esteemed and valued, and part of a social network of mutual assistance and obligations (Wills, 1991). Taxonomic of social support have usually examined several forms. Information support occurs when one individual helps another to understand a stressful event better and to assertion what resources and coping strategies may be needed to deal with it. Instrumental support, emotional support, and social support has long been known to mute the experience of stress, enhance well-being, reduce the severity of illness and speed recovery from health disorders when that do occur (Seeman, 1996; Thoits, 1995). Social support in terms of specific transactions involving the seeking and
receiving of help in the context of coping with specific stressors (Wills, 1991 e.g., Lazarus & Folkman 1984). A large sociological literature has examined social support using structural measures that assess the number of social relationships and roles in which an individual is involved and the structure of the interconnections among those relations (Wills, 1998; Thoits, 1995). Research has suggested that at least under some circumstances, the perception of social support that remain unutilized is more beneficial than social support that is actually mobilized. Wethington and Kessleffler (1986) found that social support was a strong predictor of adjustment to stressful life events than no support. Overly intrusive social support may exacerbate stress (Shumaker & Hill, 1991). Efforts to provide support to others may be perceived as controlling and interfering by the recipient (e.g., Lewis & Rook, 1999). The support that a network member provides may be different from that which is needed (e.g. Thoits, 1986), failing to match the needs of the recipient member of their social support networks for help during stressful times, support seeking often served as an additional cause of distress, because expressing one’s needs to others was esteem reducing, and/or drawing on another person for support was perceived to tax that other person’s resources, such as time and attention. These findings suggest that as a resource, social support may sometimes be more beneficial in its perception than in its use.

Research has suggested reliable cultural differences since how people view the self and their relationships that may have implications for whether or not they use social support to cope with stress. Westerners tend to view a person as independent and separate from other people, whereas Asian tends to view a person as fundamentally connected with others (Markus & Kitayam, 1991; Triandis, 1989; Shweder & Bourne, 1984). This difference might lead to the assumption that coping via social support would be especially common among Asians, because they place emphasis on interconnectedness with their social group. Asians tend to view a person as primarily a relational entity, independent with others. In these cultural context, social relationships, roles, norms, and group
solidarity typically are more fundamental to social behaviour than an individual’s needs. This independent view of the self holds that a person should conform to social norms and respond to group goals by seeking consensus and compromise; as such, personal beliefs and needs are secondary to social norms and relationships (Kim & Markus, 1999; Fiske et al., 1998).

COPING AND SUICIDAL BEHAVIOUR

Coping can be broadly defined as the cognitive and behavioral efforts that are expanded by an individual with the intention of reducing the effects of stress (Fleming, Baum, & Singer, 1984). Three main approaches to the conceptualizations of coping are apparent in the literature (Menaghan, 1983; Folkman & Lazarus, 1980). The first of these approaches conceptualizes coping in terms of ego processes. Coping is considered as one of a number of defense processes that can be used to reduce tension (e.g., Haan, 1977). This approach has received little attention in the literature, primarily because advocates of it tend to confound coping with outcome-coping is typically considered as the most preferable response to tension (Folkman & Lazarus, 1980). Other researchers have conceptualized coping in trait terms (e.g., Moos, 1974). Coping from this perspective is regarded as a relatively stable predisposition to respond to stressful life events in a particular manner. However, because the existence of stable coping processes has seldom been empirically verified, this approach has also received little support in the literature (Folkman and Lazarus, 1980; Cohen & Lazarus, 1973). The data instead, suggest that coping varies as a function of type of situation being faced. On the basis of such results, Lazarus and Folkman (1984) conceptualize coping as a dynamic process, which will be specific not only to the situation, but also to the stage of the encounter.

Physical health is closely related to emotional and mental health, particularly among middle aged and older adults, a fact documented by a multitude of studies (Felton & Revenson, 1984; Larson, 1978; Palmore & Luikart, 1972). Individuals differ in their adjustment to both acute and chronic illness.
However, coping efforts have been proposed as one means of accounting for these differences since adaptation and numerous studies have documented the importance of individual coping efforts in helping ill adults maintain reasonable levels of emotional well-being (e.g., Moos, 1982; Cohen & Lazarus, 1979). These studies have found typical coping strategies to include: denial, selective ignoring information seeking, taking refuge in activity, avoidance, learning specific illness-related procedures, engaging in wish-fulfilling fantasy, blaming others and seeking comfort from others.

Unfortunately, many of the studies arguing the importance of coping efforts have relied on case study methods or have confounded measures of coping and adjustment by a priori defining groups of good versus poor copers (e.g., Sanders & Kardinal, 1977; Hackett & Cassem, 1975). Nonetheless, more recent and systematically controlled studies have also demonstrated a role for coping in explaining the psychological adjustment of ill adults (Lambert, 1981; Weissman & Worden, 1976).

Studies considering stresses other than physical illness have also provided evidence that adult’s choice of coping strategies influence the emotional outcome of stressful events (e.g., Mananhan, 1982; Pearline, Liberman, Menaghan & Mullan, 1981; Pearlin, & Schooler, 1978). Pearlin et al. (1981) used longitudinal data to confirm that coping affected depression in reaction to involuntary job disruptions: people who coped by making positive comparisons of their situations with others’ and by devaluing the importance of monetary success were more successful in avoiding economic strain, loss of self-esteem and depression. Menaghan (1982) evaluated the role of coping by making optimistic comparisons of one’s situation relative to the past and relative to one’s peers was associated with both lowered distress and with fewer subsequent marital problems. Other coping strategies were effective in only one domain or actually increased distress.
Specific types of coping strategies are more or less effective depending upon the type of stress being faced. Pearlin and Schoolder (1978) found that coping strategies involving commitment and engagement with others were most effective in dealing with stresses arising in close interpersonal relations. In contrast, cognitive manipulations that distanced the person from the problem were most affective for stresses in occupational and economic areas, domains more impersonal and less amenable to control (Pearlin et al., 1981). Folkman and Lazarus (1980) found that “palliative”, or emotion-focused coping, was more likely to be used than “instrumental”, or problem-focused coping, for health problems, especially when the problem was appraised as uncontrollable.

There is sufficient evidence that suggests that depressed and non-depressed individuals may be different in their coping responses. For instance, Coyne, Aldwin, & Lazarus (1981) found that the coping responses of 15 persons from those of 72 non-depressed persons. The depressed persons tended to appraise situation as requiring more information before they could act, and surprisingly, to view fewer events as necessitating acceptance and accommodation. They were more likely to use such responses as seeking advice and emotional support and engaging in wishful thinking.

Billings and Moos (1984) studied the effect of coping on unipolar depression among adults. Their study found that coping responses directed toward problem solving and affective regulation were associated with less severe dysfunction whereas emotional-discharged responses, more frequently used by women, were linked to greater dysfunction.

Coping-skills treatment procedures assume that ineffective strategies for coping with stressful life events are associated with increased psychopathology. There are some data to support a link between childhood depression and problem-solving deficits (Mullins, Siegel, & Hodges, 1985; Doerfler, Mullins, Griffin, Siegel, & Richards, 1984; Kaslow et al., 1984; Kaslow, Tanenbaum, Abramson, Peterson & Seligman, 1983) and research with adults has indicated differences
between the coping processes of individuals high and low in depressive symptoms (Folkman & Lazarus, 1986; Mitchell, Cronkite, & Moss, 1983). Despite the extensive social problem solving literature linking deficiencies in the quantity and quality of children’s social problem solving strategies to poor adjustment (e.g., Asarnow & Callan, 1985; Rubin & Krasnor, 1984; Richard & Dodge, 1982; Spivack, Platt & Shure, 1974; Shure & Spivack, 1972), studies have failed to find relations between depression and the number of alternative strategies generated to solve emotional problems (Mullions et al., 1985; Doerfler et al., 1984).

Investigations have studied the effects of both problem-focused and emotion-focused coping strategies in dealing with negative life changes and chronic strains (Moos and Billings, 1982; Folkman & Lazarus, 1980; Pearlin & Schooler, 1978). Among a group of unemployed persons, for example, those who tried to re-evaluate their situation more favorably were less likely to experience increased symptoms of depression (Pearlin et al., 1981). Similarly, Billing and Moos (1981) found that alcoholic patients and community residents who used more problem-focused coping responses displayed fewer physical and depressive symptoms. The most effective coping styles may involve the use of a wide repertoire of coping responses. For example, although emotion focused coping may help to maintain emotional balance in the face of adversity, the failure to use problem focused strategies is likely to result in long term negative psychological consequences.

Further, several studies have demonstrated a crucial role of coping styles in buffering the impacts of different stressors on the development of overt psychiatric morbidity (Folkman, Lazarus, Gruen, & De Longis, 1986). It appears that it is not the stressor alone that leads to serious outcome, but the way in which the person perceives and responds to it. Thus, Lineham et al. (1986) report that individuals who attempt suicide have more difficulties in coping with interpersonal problems than do no suicidal psychiatric patients or member of the general population. Suicidal patients are less able to consider alternatives (Rydin

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et al., 1990; Cohen; Sandler, & Berman, 1982) or to think flexibly (Orbach, BarJoseph, & Dror, 1990; Orbach, Rosenbheim & Harry 1987; Schotte, & Clum, 1982; Patsiokas, Clum, & Luscomb, 1979), and may persist with ineffective problem solving even after more strategies have been presented (Levenson and Neuringer, 1971).

Several studies have examined the impact of different coping styles on suicide risk. Kotler et al. (1983) compared a group of suicidal inpatients with a non-suicidal group, and reported that the suicidal patients were less likely to use the coping styles of minimization to deal with life problems. Botsis et al. (1994) compared similar groups and reported that the suicidal patients used almost all coping styles less frequently than the non-suicidal patients. Among suicidal patients, the risk of suicide was negatively correlated with the coping styles of minimization, replacement and blame. Suicide risk was shown to be predicted by coping style.

In another study, Josepho and Plutchik (1994) investigated the relationship between interpersonal problems, coping style and suicide risk among 71 adult psychiatric inpatients. They showed that interpersonal problems and the coping style of suppression (tendency to avoid a threatening situation) were found to be significantly and positively correlated with suicide risk. Several other coping styles were found to be significantly associated with suicide risk (Josepho and Plutchik, 1994).

Horesh, Rolnick, Iancu, Donnon, Lepkifer, Apter, & Kotler (1996) examined the coping styles and the suicide risk. A total of 30 psychiatric inpatients admitted because of suicidal behavior were compared with 30 non-suicidal psychiatric in patients and 32 healthy controls on measures of suicide risk and coping styles. The three groups were similar with regard to demographic variables, but the suicidal groups scored higher on the suicide risk scale. Suicidal patients were significantly less likely to use the coping styles of minimization and mapping. They were unable to de-emphasize the importance of a perceived
problem or source of stress. They also lacked the ability to obtain new information required to resolve stressful life events. Four coping styles correlated negatively with the suicide risk (minimization, replacement, mapping and reversal), while another three (suppression, blame and substitution) correlated positively.

Overview

1. In the past 20 years the number of patients hospitalized for suicide attempts has increased sharply in most Western countries (Diekstra, 1982). The number of suicide attempts in third world countries has also been increasing progressively (WHO 1990). Even though a number of studies (Upmanyu et al., 1996; Sharma and Sawang, 1993; Banerjee et al. 1990; Kumar, 1990; Shukla et al., 1990) in India have focused on various aspects of suicidal behaviour, it is still an intriguing problem about which the amount of scientific knowledge is quite incomplete.

2. The current high level of admissions for attempted suicide makes considerable demand on medical and psychiatric services. By studying suicide ideation, scientists could hope to achieve a better understanding of the causes for the suicidal behaviour and ultimately, suggest appropriate remedies. Research on suicide ideation and its related factors could help us to understand this complex behaviour and to effectively institute the preventive and other management strategies.

3. The discussion reveals that a number of attempts have been made to identify the social and psychological aspects of suicidal behaviour. Most of the research on suicide behaviour has utilized adult clinical populations. Much of this work, however, has been concerned with people who have actually attempted or completed suicide. Because of the difficulty in obtaining data on completed suicides, studies actually focus upon surviving suicide attempters. But it is a well known fact that attempted suicides which come to the notice of clinical workers form a very small proportion of the suicidal population. As a result most
investigators utilize small clinical samples of surviving attempters. To circumvent the methodological constraints associated with small clinical samples, some researchers have begun to study suicide ideation in the general population (Vandivort & Locke, 1979; Paykel et al., 1974; Schwab et al., 1972).

Studies of suicide ideation assume that suicide behavior forms a continuum ranging from suicidal ideas to suicidal acts (Bedrosian & Beck, 1979; Paykel et al., 1974; Beck & Gareenber, 1971). This continuum does not imply that all or even most individuals who contemplate suicide make an attempt. Ideation is viewed as a preliminary stage to the more life threatening stages on the continuum, although the majority of persons manifesting suicidal ideas do not seem to progress to the later stages. This contention is supported by the findings of Carlson and Cantewell (1982). In a study of adolescents, they found that 42% of the respondents with severe ideation and 34% of those with slight ideation had made a suicide attempt while virtually none of the respondents who reported no suicide ideation have made an attempt. Suicidal thoughts appear to be a precursor to more extreme suicidal behavior and this suggests that one can learn something about the factors that set the stage for suicidal acts by identifying the causes of suicide ideation.

Kandel, Raveis, & Davies (1991) found that 41% of the females and 16% of the males who scored high on the suicidal ideation scale reported having made attempts to kill themselves. Understanding the dynamics of suicidal ideation in non-clinical samples has important public health implications, since suicide ideation is a strong predictor of suicidal attempts, especially among females (Bonner & Rich, 1987).

4. A review of literature reveals that suicidologists have focused almost exclusively on either clinical patients or those who have attempted or
completed suicide. While there is obvious merit in such studies, many have lacked adequate control groups. Further, those who study clinical patients miss those who do not seek help, while investigators who focus on those who have attempted suicide may be looking at persons who have changed simply because they survived the attempt. Social scientists may be able to obtain valuable information about the precursors in non-clinical populations in greater depth.

5. Despite the association of depression and hopelessness with suicidal behavior, it seems likely that maladaptiveness in the context of psychoticism is more greater and more life threatening than even the most debilitating depression. Indeed the extent of maladaptiveness suggests that suicidal behavior may involve comorbidity of depression with psychoticism in which a circumscribed transient thought disorder suspends the individuals capacity to comprehend the consequences of their actions. After all many suicidal individuals are not fully cognizant of the potentially irreversible impact both on themselves and others of their actions at the time of suicidal episode. The apparent suspension of rationale decision making at the time of the suicidal attempt appear somewhat comparable to the diminished capacity often observed in homicidal behavior; this parallel presumably led. Menninger (1983) to refer to suicide as murder of the self, because the self becomes the target of lethal aggression. The literature suffers from an important omission in the sense that the role of depression in suicide ideation has been examined without bringing ‘psychoticism’ into the purview of the study. The role of psychoticism cannot be ignored in any study of suicide ideation.

6. Although researches in the recent past have provided rich information about suicide ideation, a short coming of most previous studies has been the tendency to determine the relationship between suicide
ideation with just one or two variables. Thus, researches have tended to focus on factors such as depression, hopelessness, social support in isolation etc. As far as can be established, no comprehensive effort has been made to determine the joint effects of a range of factors (e.g. depression, hopelessness, negative automatic thoughts and social support) on suicide ideation in a single study. Much more comprehensive research is needed on this matter.

In the light of the aspects considered above, it would be a matter of interest and great research relevance, therefore, to investigate the relationship of suicide ideation with depression, negative automatic thoughts, psychoticism, anxiety, social desirability, extraversion, and social support separately among male and female college students scoring high and low on hopelessness.

HYPOTHESES

On the basis of the review of literature presented in the preceding paragraphs, the current study starts with the following hypotheses:

1. Suicide ideation will be positively related to depression, negative automatic thoughts, anxiety, psychoticism, social desirability in case of participants high on hopelessness than participants low on hopelessness.

2. Suicide ideation will be related negatively to social support in case of participants high on hopelessness than participants low on hopelessness.

These two hypotheses derived their rationale from the following sets of observations:

1. Defined as a negative expectation toward the future, hopelessness as a symptom has been found to be a strong predictor of completed suicide, Beck, Steer, Kovacs, & Garrison (1985) found that hopelessness predicted eventual suicide in patients hospitalized for depression; especially, in predicting future suicide among suicide ideators.
2. In earlier researches the criteria for hopelessness focused on dysfunction, with little or no attention given to healthy functioning. Consequently if the study of hopelessness is limited to the prediction of psychopathology, application of the results would also be limited. On the other hand the positive effect of a lack of hopelessness has not been explored. Kashani et al. (1989) found that in the no hopelessness group there were no suicidal children and in contrast one-third (33.3%) of the suicidal children in the high hopelessness group.