CORRELATES OF SUICIDE IDEATION AMONG EMPLOYED UNMARRIED ADULTS AT TWO AGE LEVELS

V.V. Upmanyu*, Manmohan Singh*, Amit Kumar Dwivedi* and Roshan Lal**

ABSTRACT

The present study was designed to predict the significant predictors of suicide ideation among employed unmarried adults. Eighty men in younger age group (22-28 years), 58 men in older age group (29-36 years), 92 women in younger age group (22-28 years) and 61 women in older age group (29-36 years) were administered Beck scale for Suicide Ideation, Beck Depression Inventory, Beck Hopelessness Scale, Automatic Thought Questionnaire, Carver’s Scale for Coping Strategies and Sarason’s Social Support Questionnaire. The results revealed a differential trend for the four different groups. Depression and various detrimental coping strategies were the significant predictors of suicide ideation. The study failed to show the relevance of social support and negative automatic thoughts.

Key Words: Suicide Ideation, Depression, Social Support and Negative Automatic thoughts

Depression is a serious disorder involving high personal emotional and economic cost. The problem of suicide has long been of interest to scientists, sociologists, psychologists and clinicians, but the last 15 years have witnessed a sharp increase in research efforts. Suicide is per definition always preceded by ideation and rather frequently by attempt. The variation of suicide potential from a more innocent to a more dangerous behaviour has been postulated as the

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suicidal process. Thus, suicide as a process comprises of different stages, starting with thoughts of death and suicide (suicide ideation) and ending in self-afflicted death. Conceptualizing suicide in this way is important when considering prevention. Most efforts to prevent suicide have been directed at people who are on the verge of making a suicide attempt (secondary prevention) or who have already made an attempt tertiary prevention, (Lester, 1989). Primary prevention involves preventing suicidal thoughts and intentions in the first place. Such prevention should probably emphasize helping the individual cope with serious financial and family events and difficulties by enhancing self-esteem, mastery and support (if needed) and by offering treatment if alcohol abuse or serious distress present (Vilhjalmsson, Kristjansdottir, & Sveinbjarnardottir, 1998). The different ways of combating suicidal process develops in a variety of unbearable circumstances within a complex biopsychosocial context. Health professionals intending to provide secondary and tertiary suicide prevention are faced with a challenge of distinguishing between transitory suicidal ideas and the more persistent and serious ideas resulting in suicide attempts.

Although the study of suicide has primarily examined three types of behaviours: suicide ideation, attempt and completion, the researches on suicidal ‘attempts’ and ‘completions’ have gained the lion’s share of research and clinical attention. Therefore, less is known about the factors influencing the initial steps in the process of suicide ideation. Available studies of suicide ideation suggest a variety of risk factors, most of which have been identified in previous research on suicidal behaviour and deaths. Thoughts of suicide appear to be unrelated to gender (Sorenson & Rutter, 1991; Friedman, Asnis, Boech & Difiore, 1987) and educational attainment (Vilhjalmsson et. al., 1998, Sorenson & Rutter, 1991), but may be more prevalent among non-married and younger individuals (Zimmerman, Lish, Lush, Farber, Plescia, & Kuzma, 1995; Sorenson & Rutter, 1991), and individuals who have low self-esteem (Vilhjalmsson et. al., 1998), and limited problem-solving ability are more likely to be high on suicide ideation, although the latter relationship may be indirect. Those who are depressed, dissatisfied, pessimistic and hopeless (Breslau, 1992; Sorenson & Rutter, 1991; Kandel, Raveis, & Davies, 1991; experience frequent pains such as stomach pain or headache or migraine (Ingersoll, Grizzle, & Beiter, 1993; Bresalu, 1992), or abuse alcohol or drugs or engage in illegal activities (Kandel et. al., 1991) are also more likely to think about suicide.

Axis -I psychiatric disorders associated with suicidality include mood, substance use, and anxiety disorders (Suominen, Henriksson, Suokas, Isometsa, Ostanio, & Lonnuquist, 1996), among others. Mood disorders are among the most prevalently diagnosed in adult suicide attempters and completers (Beautrais, Joyce, Mulder et. al., 1996; Suominen et. al., 1996). In fact, Beautrais et. al. (1996) found suicide attempters to be approximately 33 times more likely to
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have mood disorder than non suicidal adults. Although not as strongly related to suicidal behaviour, substance use disorder have also been found to increase the risk for suicidal behaviour in adult populations (Beautrais et al., 1996; Suominen et al., 1996).

Similar to the diagnostis literature, psychological factors have also been consistently related to suicidality. Chief among these are negative life stress (Adams & Adams, 1996; Adams, Overholser, & Spirito, 1994), low levels of social support (D’Allirio et al., 1992; deMann & Labreche-Gauthier, 1991), and poor problem solving skills (Clum & Febbraro, 1994; Rudd, Rajeb, & Dahm, 1994; Dixon, Heppner, & Anderson, 1991).

The above mentioned findings reveal that a host of Axis-1 psychiatric diagnoses and psychosocial variables have been linked to suicidality in adulthood. However, in overwhelming number of studies, these key variables have been studied in isolation with a consequent neglect of other variables. The current research attempts to identify the significant predictors of suicide ideation, by partialling out the influence of the other set of variables measured concurrently in different groups of employed unmarried adults. Unmarried men and women were selected since marital status is valued and helps in maintaining self esteem and confidence. In contrast non-marital status is detrimental in the context of societal norms and may lead to different types of psychopathology.

METHOD

Sample

Four hundred unmarried respondents, comprising of 100 men and 100 women on the age range of 22 to 28 years (younger age group) and 100 men and 100 women in the age range of 29 to 36 years (older age group) were selected from different colleges and banking organization. The final sample, however, comprised of 80 men in the younger age group (G1), 58 men in the older age group (G2), 92 women in the younger age group (G3) and 61 women in the older age group (G4) since the remaining participants did not fill up all the questionnaires. Inclusion criteria for the participants were:

(a) No evidence of drug addiction or alcoholism, and
(b) Not being treated for a diagnosed psychiatric disorder.

Tools

Six standardized scales were used each of which have been described briefly.

Scale For Suicide Ideation (SSI: Beck et al., 1979): The scale consists of 19 items. Each item has three alternative statements graded in intensity from 0 to 2. The possible range of scores is 0 to 38. The scale posseses adequate psychometric characteristics.
Beck Depression Inventory (BDI: Beck et. al., 1961): BDI measures the cognitive, behavioural, affective and somatic components of depression. It is a frequently used 21 item self-report measure of the severity of depressive symptomatology. Each item contains 4 responses ranked from 0 to 3. The total score ranges from 0 to 63.

Although there has been some controversy concerning the use of BDI, a large number of studies demonstrate the reliability and validity of this measure and have provided evidence of discriminant validity in college student sample. BDI has now been used in more than 1000 different studies. The inventory has been shown to be reliable and valid when used with both clinical and non clinical samples of adolescents.

Hopelessness Scale (HS: Beck, Weissman, Lester, & Trexler, 1974): The hopelessness scale is a 20- item, true/false self-report measure intended to tap the degree of respondents’ negative expectations about the future. Those statements were selected which seemed to reflect different facets of the spectrum of negative attitudes about the future and which recurred frequently in the patients verbalizations. For every statement, each response is assigned a score of 0 or 1 (9 items are keyed false and 11 are keyed true). The “total hopelessness scores” is the sum of the scores on the individual items. Thus, the possible range of scores is from 0 to 20, with higher scores indicating more hopelessness. The reliability and validity data presented for the hopelessness scale are deemed sufficient to justify its use on a continuing basis.

The hopelessness scale is an instrument that may be used by both clinician and researcher involved in the assessment of hopelessness as an important variable in many psychopathological processes.

Automatic Thought Questionnaire (ATQ: Hollon & Kendall, 1980): The automatic thought questionnaire is a self-report questionnaire that asks subjects to rate on a 5 point scale how often they have experienced depression related cognitions during the past week (Hollon & Kendall, 1980). Factor analysis has indicated a four factor solution: Personal maladjustment and desire to change (e.g., What’s the matter with me?), negative self-concept and negative expectation (e.g. My future is bleak), low self-esteem (e.g. I am worthless) and giving up/hopelessness (e.g. It’s just not worth it) (Hollon & Kendall, 1980).

Scores on the 30 items are summed to give total scores for ATQ negative. It yields a score ranging from 30 to 150, with higher scores indicating more frequent negative thoughts. The questionnaire has been administered to a sample of employed women in Indian set up and demonstrated to possess adequate psychometric characteristics.

Scale for Coping Strategies (Carver, Scheier, & Weintraub, 1980): The instrument developed by Carver et. al., (1989) incorporates 13 conceptually distinct scales. Several of them are based on specific theoretical arguments about functional and potentially less functional properties of coping strategies.
Other scales were included because previous research indicates that the coping tendencies they reflect either may be of value or may impede adaptive coping.

The 13 conceptually distinct scales refer to ‘active coping’; ‘planning’; suppression of competing activities; restraint coping, support for instrumental reasons; positive reinterpretation and growth; acceptance; turning to religion; focus on and venting of emotions; denial; behavioural disengagement; and mental disengagement.

Social Support Questionnaire (SSQ: Sarason, Levine, Basham, & Sarason, 1983): Social Support Questionnaire (SSQ) consists [Cronbach’s alpha coefficients of 13 scales ranged from .53 to .92] of 27 items. Each item asks a question to which a two part answer is requested. The item asks the subject (a) to list the people to whom they can turn and on whom they can rely in given sets of circumstances, and (b) indicate how satisfied they are with these social supports on a 6-point Likert Scale (Very satisfied, fairly satisfied, a little satisfied, a little dissatisfied, fairly dissatisfied, very dissatisfied). The SSQ yields two scores: (a) perceived availability of the number of supportive persons listed (SSQ-N) and (b) satisfaction with available support (SSQ-S). The number (N) score for each item of the SSQ is the number of support persons listed. The social support available to deal with a given problem is rated on a scale ranging from “very satisfied” to very dissatisfied”. This yields a satisfaction (S) score for each item that ranges between 1 and 6. The overall N and S scores are also obtained by dividing the sum of N or S scores for all items by 27, the number of items included in the social support questionnaire.

Very high SSQ-N/SSQ-S correlation observed in India culture, raised some doubt about the cross-cultural generalizability. Sarason et. al. (1983) claim that social support is not a unitary concept when assessed by the questionnaire and that perceived availability of support and satisfaction with support that is available are worthy of study and separate analysis.

Procedure

The six tests were administered to subjects in a random order in groups of 8-12 subjects. The general testing conditions were satisfactory. Sincere efforts were made to establish rapport with the subjects in order to elicit reliable and authentic information. All of them were assured that the information given by them would be kept confidential and be used for research purpose only.

RESULTS AND DISCUSSION

The data were analyzed to obtain the following information.

(a) Frequency distributions, mean, median, standard deviation, skewness and kurtosis for different measures.

(b) Hierarchical multiple regression analysis to identify the most effective predictors of suicide ideation included in the current study.
Keeping in view the focal theme of the study, the criterion ‘suicide ideation’ was regressed on a series of measures involving depression, hopelessness, negative automatic thoughts, social support and coping strategies via hierarchical multiple regression equation and the regression analysis shows the change in $R^2$ at entry for each variable.

**Younger Males (22 to 28 Years, n = 80)**

As reflected, for the younger males group (Table 1), $R^2$ for behavioural disengagement (reducing efforts to deal with the stressors or giving up efforts to attain the goal with which the stressor is interfering) was .289 ($F=31.8$, $p<01$), while social support (qualitative) raised $R^2$ to .367 resulting in $R^2$ change of .078($F=4.62$, $p<0.1$).

Thus behavioural disengagement (reducing efforts to deal with the stressors or giving up efforts to attain the goal with which the stressors are interfering) accounted for substantial 29 percent of the total variance in suicide ideation while social support (qualitative) and social support (quantitative) contributed only 7 percent and 3 percent of the variance. Thus the use of behavioural disengagement as a coping strategy emerged to be the most salient positive correlate of suicide ideation in younger employed unmarried males.

**TABLE 1**

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>$R^2$</th>
<th>$R^2$ (Change)</th>
<th>$F$ Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural engagement</td>
<td>.289</td>
<td>.289</td>
<td>31.8 (P&lt;.01)</td>
</tr>
<tr>
<td>Social Support (Qualitative)</td>
<td>.367</td>
<td>.078</td>
<td>4.62 (P&lt;.01)</td>
</tr>
<tr>
<td>Social Support (Quantitative)</td>
<td>.399</td>
<td>.032</td>
<td>2.30 (P&lt;.01)</td>
</tr>
</tbody>
</table>

D.V. Suicide ideation $R^2=.415$, $F=13.31$

The results further revealed that for the younger male group, the regression of suicide ideation, as dependent variable, on the foregoing stock of variables revealed significant effects for behavioural disengagement ($t=.56$, $p<.005$, $\beta=.50$), social support quantitative ($t=.19$, $p<.01$, $\beta=-.16$) and social support (qualitative) ($t=.19$, $p<.005$, $\beta=-.18$). Together these three predictors account for about 40% of the variance in suicide ideation [$F(4,75)=15.54$, $p<.01$]. Thus the reported use of behavioural disengagement emerged to be most salient way of coping underlying higher experience of suicide ideation in the case of younger employed unmarried males. Thus, when adjusting for the effects of other non significant predictors the regression weights suggest that suicide ideation was markedly related positively to behavioural disengagement and negatively related (weakly) to qualitative and quantitative social support.
Older Males (29 to 36 years, n = 58)

TABLE 2

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>R²</th>
<th>R² (change)</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active coping</td>
<td>.184</td>
<td>.84</td>
<td>12.5</td>
<td>(.01)</td>
</tr>
<tr>
<td>2. Acceptance</td>
<td>.239</td>
<td>.055</td>
<td>1.45</td>
<td>(ns)</td>
</tr>
<tr>
<td>3. Suppression of activities</td>
<td>.353</td>
<td>.114</td>
<td>1.80</td>
<td>(.01)</td>
</tr>
<tr>
<td>4. Denial</td>
<td>.387</td>
<td>.034</td>
<td>2.47</td>
<td>(.01)</td>
</tr>
</tbody>
</table>

D.V.: Suicide ideation, R² =.42, F (4,75)=1.554, p<.01

For the older males group the results are shown in R² for active coping was .184 (F=12.5, p<.01), while the use of acceptance as a coping strategy raised the R² to .239 resulting in a change of .055 (F=1.45, ns). Subsequent addition of suppression of competing activities increased R² to .353 resulting in R² change of .144 (F=1.80, p<.01) and denial as a coping strategy further raised R² to 387 with R² change of .034 (F=2.47, p<.01).

Thus active coping contributed 18 percent of the variance in suicide ideation, while suppression of competing activities, and denial contributed 1 percent and 3 percent of the variance in suicide ideation.

For the older age group of unmarried employed men, hierarchical regression of suicide ideation as a dependent variable, on the foregoing stock of variables further revealed significant effects for active coping (t=20, p<.005, β =−.29), acceptance (t=18, p<.010, β =.19), suppression of competing activities (t=.27, p<.005, β =.31), and denial (t=.24, p<.005, β =.28).

Together as shown in Table 2 the predictors account for about 40% of the variance in suicide ideation [F (6.57)= 57.29, P<.01]. Thus when controlling of the other predictors, suicide ideation was related positively to denial (α=.28, p<.005) suppression of competing activities (α=.31, p<.005) acceptance (β =.19, p<.01) and negatively to active coping (α=−.29 p<.005).

Younger Females (22 to 28 years, n = 92)

As reflected for the younger females, R² for depression was .277 (F=34.4, p<.01), while behavioural disengagement, restraint coping, social support (number of persons), mental disengagement and planning raised R² to .345, .391, .426, .452 and .472 simultaneously resulting in R² change of .068 (F=4.44, p<.01), .046 (F=3.54p<.0), .035(F=3.25, p<.01) .026 (F=2.66, p<.01) and .020 (F=2.242, p<.01). Thus depression accounted for 28 percent of the variance in suicide ideation while behavioural disengagement accounted for a substantial 7 percent of the variance, restraint coping for 4 percent of the variance and mental disengagement and planning accounted for 3 percent and 3 percent of the variance in suicide ideation.
TABLE 3
Multiple R at different successive steps younger age group
(Females 22 to 28 years)

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>$R^2$</th>
<th>$R^2$ change</th>
<th>$F$</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td>.277</td>
<td>.277</td>
<td>34.4</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>2. Behavioural Disengagement</td>
<td>.345</td>
<td>.068</td>
<td>4.44</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>3. Restraint coping</td>
<td>.391</td>
<td>.046</td>
<td>3.54</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>4. Social support (quantitative)</td>
<td>.426</td>
<td>.035</td>
<td>3.25</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>5. Mental disengagement</td>
<td>.452</td>
<td>.026</td>
<td>2.66</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>6. Planning</td>
<td>.472</td>
<td>.020</td>
<td>2.42</td>
<td>(p&lt;.01)</td>
</tr>
</tbody>
</table>

D.V.: Suicide ideation $R^2 = .47, F=12.69$

The results of multiple regression with other variables used to predict suicide ideation are shown for the younger females in Table 3. For the younger female group with suicide ideation as dependent measure, depression ($t=.39, p<.005, \beta=.35$), behavioural disengagement ($t=.33, p<.005, \beta=.28$) social support (satisfaction) ($t=.29, p<.005, \beta=-.24$), mental disengagement ($t=.22, p < .005 \beta=-.18$) and planning as well as restraint coping ($t=.19, p < .005, \beta=-.16$) ($t=0.18, p < .010, \beta=-.16$) contributed significantly to regression equation and together they accounted for 47% of the variance in suicide ideation, $[F(6, 85) = 12.68, p < .01)]$.

Thus when controlling for other predictors, suicide ideation was positively related to depression ($\beta =.35, p< .005$) and behavioural disengagement ($\beta=.28, p< .005$) and was negatively related to quantitative social support ($\beta=-.24, p< .005$), mental disengagement ($\beta=-.18,p<.005$) and restraint coping ($\beta = -.16, p<.005$) and planning ($\beta = -.16, p<.01$)

Older Females (29 to 36 Years, n = 61)

It was found (Table 4) that for the older females, $R^2$ for depression was .107 ($F=7.04$, p < .01) while the addition of other variables such as denial turning to religion, and behavioural disengagement, raised $R^2$ to .183, .225, .253, simultaneously resulting in $R^2$ change equal to .076 ($F = 1.40$, NS), .042 ($F = 1.14$), .028 ($F = .83$, NS). Thus depression alone contributing to 11 percent of the variance in suicide ideation emerged as a significant predictor of suicide ideation in older females.

For the older females age group represents that with suicide ideation as dependent measure, depression ($t = .28 p< .005, \beta = .33$), denial ($t = .25, p < .005, \beta = -30$), turning to religion ($t=.16, p<.010, \beta=-.19$), and behavioural disengagement ($t = .18, p<.010, \beta = -.21$) contributed significantly to regression equation, and together they accounted for 31 percent of the suicide ideation variance, $F(6.54) = 41.22, p < .01$. Thus, when controlling for other predictors,
suicide ideation was positively related to depression ($\beta = .33$, $p < .005$), behavioural disengagement ($\beta = .21$, $p < .10$) whereas suicide ideation was negatively related to denial ($\beta = -.30$, $p < .005$) and turning to religion ($\beta = -.19$, $p < .010$).

**TABLE 4**

Multiple R at different successive step (old females)

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>$R^2$</th>
<th>$R^2$ (Change)</th>
<th>$F$</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td>.107</td>
<td>.107</td>
<td>1.04</td>
<td>(p&lt;.01)</td>
</tr>
<tr>
<td>2. Denial</td>
<td>.183</td>
<td>.076</td>
<td>1.04</td>
<td>(NS)</td>
</tr>
<tr>
<td>3. Turning to religion</td>
<td>.225</td>
<td>.042</td>
<td>1.14</td>
<td>(NS)</td>
</tr>
<tr>
<td>4. Behavioural disengagement</td>
<td>.253</td>
<td>.028</td>
<td>.83</td>
<td>(NS)</td>
</tr>
</tbody>
</table>

D.V.; Suicide ideation, $R^2 .31, F 16, 54 = 41.22, p<.01$

Studies of adults from several countries have emphatically documented that women have 1.5 to 3 times more current and life time unipolar depression than men (Lowenthal, Goldblatt, Rorton, et al., 1995; Blazer, Kessler, McGongle & Swartz, 1994; Weissman, Blaud, Joyce, Newman et. al., 1993; Wilhelm & Parker, 1993; Kessler et. al., 1993; Wittchen, 1992; Wells, Golding & Burnan, 1989; Hwu, Yen & Chang et. al., 1989; Cheng, 1989; Weissman & Klerman, 1977). The sex ratio is maintained in all western societies and in some non-western studies and recent cohort studies do not reveal much change. In recent studies the same phenomenon has been found in South America (Andrade, Lolio, Gentil et. al., 1996; Posada & Torres, 1998). Babbington, Dunn, Jenkins et al (1998) has remarked: “One of the major unsolved problems in psychiatric epidemiology is the extremely consistent finding that women suffer from higher rates of depression than men”, (p. 9).

The results of the present study have clearly revealed that unmarried employed females scored quantitatively higher on suicide ideation than unmarried employed males regardless of age. Although majority of participants expressed minimal to moderate levels of suicide ideation, it was found that a considerable number of males and females scored in the severe range of suicide ideation (12.5% to 25%). The predominance of females at the moderate to severe levels of suicide ideation was clearly revealed in the analysis of the data. The results corroborate some of the earlier studies which have found female preponderance in suicide ideation.

Several possible explanations could be offered for women’s higher scores on suicide ideation than men. One possible explanation can be derived from the present data referring to scores on different measures of perceived social support and coping strategies. The results have shown that men have scored higher than women on perceived social support and six coping strategies, namely active coping, planning, suppression of competing activities, acceptance, and positive
reinterpretation and growth. The higher scores of men on perceived social support and different coping strategies mostly involving problem-focused approach could be the reason for lower scores of men on suicide ideation than women.

Interestingly women scored higher in the use of denial as a coping strategy. The role of denial in the development of psychopathology is controversial. Valliant (1976) reports neurotic denial (dissociation) to be correlated with immature defence mechanisms, and to be the only neurotic defence related to poor adjustment. Similar results have been found by Perry and Cooper (1989) who combined denial with projection and rationalization into disavowal defences and found it to be correlated negatively with symptoms rated by the interviewer, but not by the subject. Thus gender differences in suicide ideation could be explained on the basis of gender differences in perceived social support and some important coping strategies related to adjustment.

Depression and Suicide Ideation

The results revealed that depression is a robust predictor of suicide ideation only in females at both age levels. The absence of depression as a correlate of suicide ideation among males is intriguing. The findings suggest that depression was more effective in explaining the variance in suicide ideation scores in females regardless of age.

From the results one cannot be sure of the directionality of the relationship, but it makes sense that women high on depression will be more prone to suicide ideation. Conversely, women low on depression tend to have lower suicide ideation.

This finding concerning depression as a significant and positive predictor of suicide ideation in case of females is theoretically consistent. One potential explanation for this phenomenon is that the highly depressed women are not as perceptive of stimuli in their surroundings as low depressives. The behavioural patterns of highly depressed people reduce sensory acuity, resulting in decreased self-awareness. This may be more true in case of women. Thus, the highly depressed women must turn to more suicide ideation as a way to compensate stress.

Social Support and Suicide Ideation

During the past decade, there has been a great deal of interest in social support, a term that has been widely used to refer to the mechanisms by which interpersonal relationships presumably protect people from the deleterious effects of stress. This interest was triggered by a series of influential review papers published in the mid 1970s. These studies reviewed literature demonstrating associations between psychiatric disorder and such factors as marital status, geographic mobility and social disintegration. They argued that a theme present in all of these associations is the absence of adequate social ties or supports and
disruption of social networks. Although, highly inferential in their arguments, and not always clear about their definition of the concept, these early reviews generated a great deal of scientific interest in the possibility that social support can protect health.

The results of this study failed to reveal convincingly and consistently the relevance of perceived social support in suicide ideation. This finding is unexpected. Social support emerged to be a buffering predictor (although weak) of suicide ideation only in case of younger males. In contrast social support did not turn out to be relevant predictor of suicide ideation in the other three groups, namely older males, younger females, and older females.

For the present unexpected finding regarding the role of social support, one can argue from the viewpoint of conceptualization of the construct of social support in the present study. In the present investigation the overall quantitative and qualitative score (global measure) on social support scale has been used as an index of perceived social support, thus treating social support as a homogenous construct. However, there is sufficient evidence in the literature which emphasize the utility of several distinct types or components of social support (structural aspect of relationships, frequency of social contact, participation in social activities or involvement in a social network, social isolation, impairment of interpersonal communication). These distinct types or components of social support may serve different functions. Thus greatest specificity in the conceptualization and measurement of the construct may provide more valuable information with respect to suicidal behaviour.

Coping and Suicide Ideation

The coping styles that differentiated males and females were suppression of competing activities positively (relevant for males), denial positively (relevant for both males and females), turning to religion, seeking social support for instrumental reasons, and restraint coping negatively (relevant for females). The coping style of behavioural disengagement was positively associated with suicide ideation in females at both age levels and at younger age level in males. It appears that reducing one’s efforts to deal with the stressor serve to argument suicide ideation. The common feature of this coping style is basic avoidance or bypassing of the real problem, and in the long-run this coping style is maladaptive. It is equally not surprising that the prolonged overuse of behavioural disengagement may lead to the accumulation of unsolved problems. This may in turn increases the sense of emotional impasse and may eventually lead to suicide ideation as a compensatory mechanism to deal with the stressor. Interestingly, the coping style of denial was positively correlated with suicide ideation for older males and negatively correlated with suicide ideation for older females. The role of denial as a healthy coping is not clear in the literature. The present findings, however, revealed that for males, minimization leads to more of suicide ideation whereas
for older females the coping styles of denial (minimization), turning to religion, seeking social support for instrumental reasons were relatively correlated with suicide ideation. Minimizing the severity of the problem, turning to religion and seeking advice, assistance and information decrease suicide ideation risk, thus functioning as attenuators. In contrast the role of denial in case of males need attention because it is responsible for higher suicide ideation. The results are consistent with a number of other reports. Denial has been found to be associated with maladaptive disorder (Kandel et. al., 1991; Carver et. al., 1989). Vaillant (1976) reports neurotic denial (dissociation) to be correlated with immature defence mechanisms, and to be only neurotic defences to relate to poor adjustment. Similar results have been found by Perry and Cooper (1989) who combined denial with projection and rationalization into ‘disavowal’ defences, and found it to be correlated negatively with mature defences. Disavowal defences are associated with symptoms (including anxiety and depression) rated by the interviewer, but not by the subject.

The role of denial and suppression of competing activities in suicide ideation needs replication on a larger sample. Denial may have a salubrious effect on the emotional response, at least in some populations and in some context. The extent to which these effects are context specific, developmental in origin, and / or interesting in the coping strategy is not clear as yet. A full understanding of the differential effects of different coping strategies on suicide ideation is especially important if we are to make progress in developing effective coping— related interventions.

REFERENCES


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