Reasons for Living and Suicide Attempt in Major Depression

Vikas Malik
Rachana Pole
G.K. Vankar

Abstract

**Background:** There are known risk factors for suicide in major depression but there is lack of knowledge about what protects people against suicide.

**Aims:** To find out Reasons of living in Major Depression and to compare patents with and without suicidal ideas as regards Reasons for living, demographic and disease related characteristics, severity of depression and number of stressful life events.

**Material and Methods:** Patients with Major Depression attending medical college psychiatry OPD were screened for past suicide attempt. All patients were evaluated for severity of depression (both subjective and objective), severity of suicidal ideas, hopelessness, reasons for living and stressful life events. Suicide attempter and non-attempters were compared regarding these parameters.

**Results:** Those who had attempted suicide had more severe depression and higher suicidal ideas, and lower reasons for living inventory scores, though the stressful life events were not in excess. In on two subscales of reasons for living inventory, those who attempted suicide had significantly higher scores – Survival and coping belief as well as fear of suicide.

**Conclusions:** Clinicians should routinely interview patients regarding suicide risk factors as well as the reasons for living; the later has potential to be protective against suicide.

**(Keywords:** major depression, suicide, reasons for living)
Introduction

Various biopsychosocial factors predispose a person to suicide, however there is paucity of research on what factors protect a person with major depressive disorder against suicide. Despite of intense psychological pain, many patients want to live. During interviews, patients many a time narrate their reasons for living, mainly socio-cultural in nature. This is a first systematic study exploring reasons for living in Indian patients suffering from major depressive disorder.

Over two decades of research have suggested a positive association between stressful life events and subsequent. Loss or “exit” events (such as marital separation o death), which may have particularly strong effects on self esteem, occur more frequently among depressed than among non-depressed persons. Depressed patients have higher mean life event score as compared to non-depressed subjects. In terms of type of life events, it is seen that depressed patients experience significantly higher proportion of life events related to death of a family member, personal health related events, bereavement, interpersonal and social events. Studies in elderly also suggest that life events, especially financial problems and death in the family are as important a precipitating event for depression as they are in young adult. Studies have also reported that economic and interpersonal relationship difficulties, partner violence, sexual coercion by the partner as the common causal factors related to development of depression in general and depression during antenatal and postnatal period. It has been shown that gender of the newborn child is an important determinant of postnatal depression.

Bagadia et al. attempted to examine the relationship between unemployment and suicide and concluded that though unemployment may be an important factor in suicide it did not appear to be the causative factor. Srivatsava et al.(2004) identified unemployment, presence of a stressful life event in the last six months, suffering from physical disorders and having idiopathic pain as definite risk factors for attempting suicide. In a study on 100 female hospitalized burns patients, Venkoba Rao, et al. reported that the most common reasons for suicidal attempts were marital and interpersonal problems followed by psychiatric and physical illnesses respectively. Sethi, et al. studied patients admitted for self destructive behavior and found that Financial stress, rejection in love and strained familial relationships were the most common causes. Das, et al. n their study on subjects with intentional self harm attempts The most common reasons for the attempt were interpersonal problems with family members and spouse.
Linehan et al. (1983) suggested that reasons for not taking one’s life despite suicidal thoughts or considerations is important aspect of evaluation. A major assumption of these reasons for living instruments is that suicidal individuals are lacking in adaptive beliefs present among nonsuicidal individuals that deter suicidal behavior. The reasons for living examined through these instruments can be considered buffers or personal and environmental contingencies operating against suicide. In their original research, Linehan and colleagues (1983) found that individuals with prior suicidal behavior reported fewer reasons for living than individuals with no suicidal history. Moreover, those with suicidal histories valued reasons for living to a smaller degree. That is, they rated reasons for living as less important than individuals with no suicidal history.

Reasons for living instruments have been developed for a diverse groups and research has offered further support for the assessment of reasons for living in diverse populations (e.g., psychiatric inpatients, college students, delinquent adolescents) (Cole, 1989; Gutierrez et al., 2002; Osman et al., 1993, 1998).

Table 1 shows some selected studies on Reasons for Living.

<table>
<thead>
<tr>
<th>Researchers</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segal And Needham (2007)</td>
<td>Robust gender differences on the RFL found among younger individuals appear to diminish with advancing age, although it is unclear to what extent older men improve in the reasons for staying alive or older women decline in their reasons for staying alive.</td>
</tr>
<tr>
<td>Connel and Meyer (1991)</td>
<td>A significant difference existed between suicidal and nonsuicidal individuals on the RFL.</td>
</tr>
<tr>
<td>McLaren S. (2011)</td>
<td>The influence of age, gender, or the combination of the two varies according to the reason for living being investigated. Being female was associated with higher total, child-related concerns and fear of suicide (FS) scores, whereas increasing age was associated with higher total, responsibility to family (RF), FS, and moral objections scores.</td>
</tr>
<tr>
<td>Segal et al (2012)</td>
<td>No individual PD features or personality traits contributed significant variance in reasons for living.</td>
</tr>
<tr>
<td>Devic et al (2011)</td>
<td>In bipolar depression patients Higher score on the moral or religious objections to suicide subscale of the RFLI is associated with fewer suicidal acts in depressed bipolar patients. Patients with religious affiliation had comparatively higher scores on the moral or religious objections to suicide subscale of the RFLI.</td>
</tr>
<tr>
<td>Oquendo et al (2005)</td>
<td>explored protective factors against suicidal behavior in Latinos.. Latinos reported significantly less suicidal ideation and made less lethal attempts. On the RFLI, Latinos scored significantly higher on subscales regarding survival and coping beliefs, responsibility to family, and moral objections to suicide, possibly reflective of cultural norms endorsed by Latino groups.</td>
</tr>
<tr>
<td>Choi and Rogers (2010)</td>
<td>Validity of the CSRLI subscales was supported through significant negative relations with measures of depression and hopelessness</td>
</tr>
<tr>
<td>June et al. (2009)</td>
<td>high religiousness was associated with more reasons for living. Ethnicity alone did not meaningfully account for variance differences in reasons for living, but significant interactions indicated that the relationship between religiousness and reasons for living was stronger for African Americans.</td>
</tr>
</tbody>
</table>
Aims and Objectives

- To find out the protective factors against suicidal acts in patients suffering from major depression
- To study the demographic variables and clinical features in patients with major depression with or without suicide attempt.

Materials and Method

Patients visiting psychiatric OPD at Shree Sayaji General Hospital (SSGH) which is a medical college affiliated tertiary care general hospital in Vadodara, Gujarat. Patients who met DSM-IV-TR criteria for Major depressive disorder, Patients with psychotic features like delusions, hallucinations, grossly disorganized behavior and disorganized speech (irrelevancy, incoherence, loosening of association etc.), With mental retardation , With delirium due to any cause ,With dementia and other cognitive disorders and With altered sensorium were excluded.

Methodology
Subjects, aged 18-80 years, who met DSM-IV-TR criteria for current major depressive episode, were recruited from patients coming to Psychiatry OPD of S.S.G. Hospital, Vadodara Subjects were free of severe, unstable medical and neurologic disorders. The subjects were clinically assessed for depression and the diagnosis of a current major depressive episode was based on DSM-IV-TR.

The severity of the major depressive episode was measured objectively with the Hamilton Depression Rating Scale and subjectively with the Beck Depression Inventory. General Psychopathology was assessed by using the Brief Psychiatric Rating Scale. In addition to administrating the Reasons for Living Inventory, the quantity and severity of life events was assessed by using the Presumptive Stressful Life Event Scale. The Scale for Suicidal Ideation was administered to assess current suicidal ideation.
Instruments Used In the Study

**Hamilton Rating Scale For Depression** (Hamilton, 1960)\(^{38}\)

The Hamilton Rating Scale for Depression (HAM-D, HRSD) is the most widely utilized rating scale to assess symptoms of depression. The HAM-D is an observer-rated scale consisting of 21 items. Ratings are made on the basis of the clinical interview. The items are rated on either a 0 to 4 spectrum (0 = none/absent and 4 = most severe) or a 0 to 2 spectrum (0 = absent/none and 2 = severe). HAM-D is used to assess the severity of depression.

**Beck Depression Inventory (Abridged Version)** (Beck, 1961)\(^{39}\)

The Beck Depression Inventory (BDI), is a rating to measure the severity for depression. Unlike HAM-D, the BDI is a self rated scale, in which individuals rate their own symptoms for depression. For the present study a 13 item Gujarati Version was used (Vankar, 1994). The individuals are asked to rate themselves on a 0 to 3 spectrum (0 = least, 3 = most).

**Brief Psychiatric Rating Scale** (Overall and Graham, 1962)\(^{40}\)

The Brief Psychiatric Rating Scale (BPRS) is a relatively brief scale that measures major psychotic and non-psychotic symptoms in individuals with a major psychiatric disorder. It’s a clinician rated 18-item scale. The rating is based upon observations made by the clinician/rater during 15 to 30 minute interview and subject verbal report.

**Reasons for Living Inventory** (Linehan et al. 1983)\(^{41}\)

The Reasons for Living Inventory is a self report instrument that measures beliefs that may contribute to the inhibition of suicidal behavior. It is composed of six factors: Survival and Coping Beliefs, Responsibility to Family, Child Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections to Suicide. The scale consists of 48 statements which are rated by the individuals on a 1 to 6 spectrum (1=Not at all Important and 6=Extremely Important).

**1. Survival and coping beliefs**
Survival and Coping reasons for living combine a number of beliefs about life and living. Included are reason having to do with positive expectations about the future and coping abilities of an individual. The former set of beliefs seems to be converse versions of some of Beck’s Hopelessness Scale beliefs; the latter seem to tap general self-efficacy. A third set of beliefs included in this scale has to do with imbuing life and living with specific value. Positive beliefs about Survival and Coping appear strongly related to both prior and current suicidal behavior.

From the findings it seems warranted to conclude that suicidal individuals, when compared to both psychologically disturbed, non-suicidal individuals, and non-disturbed, non-suicidal persons, lack positive beliefs related to surviving and coping with life, beliefs shared by a large portion of the population.

2. Responsibilities to family and child related concerns
Both the importance of beliefs about one’s responsibility to a family as well as concerns about children are significantly related to whether one reports prior suicidal behavior or currently engages in suicidal behavior. Irrespective of psychiatric status, family and child related concerns are almost universal. Higher importance attached to Child-Related Concerns also differentiates current suicide ideators from current parasuicides. In addition, importance of family and children is negatively related to reported suicide ideation for the past year, prediction of the likelihood of future suicide, and ratings of suicide as a solution to life’s problems. Whether one communicates this suicide ideation, however, appears related to the importance of family but not to the importance of child related concerns.

3. Fear of suicide, fear of social disapproval, and moral objections
The Fear of Suicide Scale is the only scale that distinguishes between individuals who report actual parasuicidal behavior in the past and individuals who report having thought about it seriously at some point but not engaging in any overt suicidal behavior. In the general population, people with a history of parasuicide report less fearful expectancies than do individuals with a history of serious ideation in the absence of actually carrying out those ideas. The high negative correlation between the Fear of Suicide Scale and social desirability should be viewed with considerable caution; reports of prior suicidal activity are also related to social desirability (Linehan & Nielsen, 1981).

Presumptive Stressful Life Events Scale (Singh G., Kaur and Kaur,1984)
The Presumptive Stressful Live Event Scale (PSLES) measures stressful events specifically for the Indian population. The scale consists of 51 items. The scale consists of two time scales: Life time and Past one Year as recall of events in recent time is considered better than relatively remote events.

Beck’s Scale For Suicide Ideation (Beck,)
The Beck’s Scale for Suicide Ideation (BSS), is a self report scale to assess severity of suicide ideation in adults and adolescents. Each item on the scale contains three statements and are graded in severity from 0 to 2. The first five items are screening items that limit the length and intrusiveness of the assessment for individuals who are non-suicidal.
Data analysis
The cases were divided into two groups, suicide attempters and suicide non-attempters. Demographic characteristics of both the groups were compared, chi-square and “t”-test applied as appropriate. Similarly the scores obtained on Hamilton Depression Rating Scale, Beck Depression Inventory, Brief Psychiatric Rating Scale, Beck’s Suicide Ideation Scale and Presumptive Stressful Life Event Scale was compared and as appropriate “t”- test was applied.
The total score on the Reasons for Living Inventory was compared as well as scores for the factors, Responsibility towards family, Fear for Social Disapproval, Moral Objections, Survival and Coping Beliefs, Fear of suicide and Child Related Concerns, was also compared appropriately.
Analysis of data was done by using Epi-info. 43

Results

1. Demographic and Clinical Features of Patients with Major Depression

Table 1: Demographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Suicide Attempts present n=24</th>
<th>Suicide Attempts Absent N=46</th>
<th>t =</th>
<th>df=68, p=0.53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age years</td>
<td>22-51</td>
<td>19-62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range Mean(sd)</td>
<td>34.95(9.72)</td>
<td>36.76(12.18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12 (50)</td>
<td>24 (52.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 (50)</td>
<td>22 (47.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>17 (70.8)</td>
<td>38 (82.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>4 (16.7)</td>
<td>8 (17.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2 (8.3)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>14 (58.3)</td>
<td>19 (41.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>1 (4.2)</td>
<td>5 (10.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried Job</td>
<td>2 (8.3)</td>
<td>16 (34.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business</td>
<td>4 (16.7)</td>
<td>5 (10.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>3 (12.5)</td>
<td>1 (2.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>15 (62.5)</td>
<td>37 (80.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>9 (37.5)</td>
<td>9 (19.6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X²= 4.15, df=2, p=0.125

X²= 9.44, df=4, p=0.05

X²= 2.66, df=1,
Table 2: Comparison of various measures in suicide attempters and non-attempters

<table>
<thead>
<tr>
<th></th>
<th>Suicide Attempts present</th>
<th>Suicide Attempts Absent</th>
<th>'t' test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=24</td>
<td>N=46</td>
<td></td>
</tr>
<tr>
<td>BDI Score</td>
<td></td>
<td></td>
<td>p=0.002</td>
</tr>
<tr>
<td>Range</td>
<td>12-35</td>
<td>2-34</td>
<td>t =3.9, df=68,</td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>22.1(6.73)</td>
<td>15.1(7.23)</td>
<td>p=0.002</td>
</tr>
<tr>
<td>HDRS score</td>
<td></td>
<td></td>
<td>p=0.0005</td>
</tr>
<tr>
<td>Range</td>
<td>12-37</td>
<td>5-38</td>
<td>t =3.69, df=68,</td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>24.29(6.59)</td>
<td>17.76(7.25)</td>
<td>p=0.0005</td>
</tr>
<tr>
<td>SIS Score</td>
<td></td>
<td></td>
<td>p=0.0001</td>
</tr>
<tr>
<td>Range</td>
<td>0-17</td>
<td>2-34</td>
<td>t =7.69, df=68,</td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>15.87(8.19)</td>
<td>3.91(4.82)</td>
<td>p=0.0001</td>
</tr>
<tr>
<td>BPRS Score</td>
<td></td>
<td></td>
<td>p=0.0027</td>
</tr>
<tr>
<td>Range</td>
<td>6-31</td>
<td>2-31</td>
<td>t =3.1, df=68,</td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>14.95(6.83)</td>
<td>9.73(6.58)</td>
<td>p=0.0027</td>
</tr>
<tr>
<td>PSLES Score</td>
<td></td>
<td></td>
<td>p=0.40</td>
</tr>
<tr>
<td>Range</td>
<td>1-15</td>
<td>0-20</td>
<td>t =0.84, df=68,</td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>7.58(4.36)</td>
<td>6.65(4.70)</td>
<td>p=0.40</td>
</tr>
</tbody>
</table>

Demographic characteristics:

Patient age range was 19-62 years with mean age, 36(41.4%) were men and 34(48.6%) were women. 55(78.6%) were Hindus, 12 ((17.1 %)) Muslims and 2(0.3%) were others. Thirty three patients were unemployed, 18 (25.7%) had salaried jobs , 52(74.3%) had urban background and 18(25.7%) hailed from rural area.
Forty three (61.4%) had monthly income more than Rs.3000. Forty six (65.7%) had education upto higher secondary school, 14 (17.4%) had no formal education and 8 (11.4%) were college educated.

Of the 70 patients who participated in the study, 24 (34.3%) had attempted suicide. Most common mode of suicide was by ingestion of organo-phosphorus compound. However suicide attempters and non-attempters did not differ significantly on demographic characteristics like age, sex, religion, and income. Depressed patients who attempted suicide were more often unemployed and were better educated.

**Disease Related Characteristics:**
On both subjective and objective measures of major depression, BDI and HDRS who attempted suicide had higher mean scores. On SIS, the attempters had higher mean score, similarly on BPRS the attempters had similar higher scores compared to non-attempters. As regards duration of illness when patients sought treatment as outpatient varied from 1 month to 6 months. Most suicide attempters had a shorter duration of disease, which varied from 3 weeks to 2 months.

**Life events and suicide attempt:**
Suicide attempters and non-attempters did not differ significantly as regards mean number of stressful life events.

**Suicide intent and Suicide attempt:**
Depressed patients who attempted suicide harbored more severe suicidal ideation than those who did not. The difference was found statistically significant.

**Reasons for Living and Suicide attempt in Major Depression:**

<table>
<thead>
<tr>
<th>Measures From Reasons for Living Inventory</th>
<th>Suicide Attempt N=24</th>
<th>No Suicide Attempt N=46</th>
<th>T statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores for Factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsibility towards family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>3-18</td>
<td>0-39</td>
<td></td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>25.16(8.3)</td>
<td>27.23(6.94)</td>
<td>t= 2.64, df= 68, p= 0.275</td>
</tr>
<tr>
<td><strong>Fear of social disapproval</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>6-24</td>
<td>5-18</td>
<td></td>
</tr>
<tr>
<td>Mean(sd)</td>
<td>10.04 (4.5)</td>
<td>9.4(2.9)</td>
<td>t= 0.73, df= 68, p= 0.46</td>
</tr>
<tr>
<td><strong>Moral objections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>33-122</td>
<td>8-21</td>
<td>t= 0.63,</td>
</tr>
</tbody>
</table>
The mean of the total score on the Reasons for Living Inventory in patients who did not attempt suicide was significantly higher compared to those who attempted suicide (182.48 vs 159.29), the difference was statistically significant.

**Reasons for living Correlation with Hopelessness as well as suicide intent:**

For whole MDD patients in this study, Hopelessness score and Total RFL score correlation was significant (r = -0.255, p = 0.033). Similarly, Beck’s Suicide Intent Scale Score and Total RFL score had high negative correlation, which was statistically significant (r = -0.508, p = 0.000).

In a separate analysis for suicide attempters, the total score for reasons for living was significantly inversely correlated with the scores for hopelessness (r = -0.255, N = 70, p = 0.23), suicide Intent Scale scores (r = -0.508, N = 70, p = 0.113).

**Discussion**

This is the first Indian study to examine the association between different RFL and suicide ideation in adults with major depression. Prior western studies have shown that RFL are negatively associated with suicide ideation in younger adults, with the exception of fear of suicide which was found to have a negative association with suicide ideation in a clinical sample but a positive association in a nonclinical sample.
Our findings indicated that fear of suicide, as proposed by the authors of the RFL as an combination of the fear of death and fear of the act of killing oneself, diminishes the likelihood of suicide ideation in adults with a mood disorder. The fear of death and of killing oneself may be an important deterrent of suicide ideation in depressed adults. None of the other RFL was associated with the presence or severity of suicidal ideation. Findings of this study regarding patients with Major Depressive Disorder are consistent with results in previous studies of Major Depressive disorder by Malone et al and of Borderline Personality disorder by Lineham et al, in which more reasons for living in depressed patients protected against acting on suicidal thoughts at vulnerable times. In a Pearson correlation analysis, the total scores for reasons for living were significantly correlated with the scores for hopelessness and suicidal ideation. This means that as the reasons for living increases hopelessness decrease and similarly for suicidal ideation. Thus the study shows that the reasons for living does have a protective role in major depression and protects patient from committing suicide.

The individual scores for factors on Reasons for Living Inventory differed from the study conducted by Malone et al on western subjects. Chils et al(1989) in their comparative study of American and Chinese patients who were having difficulty with suicidal thinking or behavior found that Hopelessness, reasons for living, and suicidal efficacy showed none of the expected relationships with suicidal intent among the Chinese patients, but the two groups were similar on many variables theoretically related to suicidality. Chinese patients were less likely to communicate suicidal intent and rated suicide as less effective at solving problems. The authors emphasize possibility of different cultural approaches to suicidal behavior. Reasons for living, like hopelessness, may reflect a cultural or environmental component in the suicide threshold and may contribute to variation in suicide rates among different cultures (Malone et al, 2000). As a whole those who attempted suicide had significantly lower scores on RFLI compared to those who did not attempt suicide. In other words, those who had more reasons to live, attempted suicide less often and vice versa. Non-attempters had higher scores on Survival and Coping Beliefs as well as Fear of Suicide. Both the findings were in line with study by Malone et al.

Contrary to Malone et al, in the present study, the scores for Responsibility towards Family, Fear of Social Disapproval, Moral Objections and Child Related Concerns were similar among suicide attempters and non-attempters, the difference being not statistically significant. Depressed patients who attempted suicide had experienced similar number of stressful events comparable to those who did not attempt suicide. Thus merely presence of a stressful event may not be sufficient to lead to suicide attempt; the meaning of the event may be much more significant for such outcome. Malone also did not find excess stressful life events in MDD Patients who attempted suicide.

In general, RFL may reflect a sense of purpose and meaning, that makes people live through difficult circumstances. However RFL involving family obligations may enhance the negative effects of hopelessness. Clearly, more research on the apparently complex relations between responsibility to family, hopelessness, and suicide ideation is needed.
Implications: Clinicians while interviewing for suicide risk factors, should also explore the reasons for living. What each RFL means for each patient is important, rather than assuming that they are protective. Understanding the personal meaning of RFL may improve clinicians’ ability to evaluate whether RFL are indicative of resilience or risk. Open-ended questions about specific RFL may encourage patient elaboration and reveal critical details and insights that could improve clinicians’ ability to determine risk. This exploration may also enhance patients’ understanding of their motivation to live.

Limitations:
Small sample size and recall bias might be considered as possible drawbacks of the study.

Conclusion

This study concludes that occupation, higher education, fear of suicide, social and coping beliefs of individuals and society at large act as protective factors against suicide in patients with current Major Depressive Disorder. Severity of depression was significantly higher in suicide attempters. Life events as opposed to the conventional thought were not higher in the suicide attempters and thus made little impact.

Sources of support: None
Conflict of interest: None

References


43. Chiles JA, Strosahl KD, Ping ZY, Michael MC, Hall K, Jemelka R, Senn B, Reto C.


Sources of support: None

Conflicts of interest: None

Vikas Malik, MD, Resident, Psychiatry Dept., Medical College and SSG Hospital, Vadodara

Rachana Pole, M.B.B.S. Resident

G.K. Vankar, MD, DPM, Professor and Head
Department of Psychiatry, B.J. Medical College and Civil Hospital, Ahmedabad 380016

Correspondence:
Dr. G.K. Vankar  Professor and Head
Department of Psychiatry, Civil Hospital OPD Building, Wing 1, First Floor Asarawa, Ahmedabad 380016

e-mail: drgkvankar@gmail.com

cell: +919904160338