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Original Article

Psychiatry/Mental Health Section

A Cross-sectional Study on Coping Styles and Suicidal Intent among Young Adult Suicide Attempters at a Tertiary Care Centre in Kerala, India

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ABSTRACT

Introduction: Suicide attempts in young adults have grown exponentially across the globe in the last three decades. Suicide is one of the most common cause of death among young adults worldwide. The studies on the coping styles influencing suicidal intent among young adult suicide attempters are few from the Indian context. Young adults are of utmost importance in any nation and interventions for suicide prevention have to be undertaken at different levels.

Aim: To estimate the coping styles and suicidal intent among young adult suicide attempters and to assess the various coping styles associated with the suicidal intent.

Materials and Methods: This was a descriptive cross-sectional study, which was carried out at the Suicide Prevention Clinic of the Department of Psychiatry at a Tertiary Care Centre in Kerala, India over a period of one year from October 2015 to September 2016. The consecutive 160 young adult suicide attempters were interviewed. Beck's Suicide Intent Scale was used to assess the severity of suicide attempts. The coping styles of the participants were assessed using the Ways of Coping Questionnaire-Revised (WCQ-R) Scale. Statistical significance of socio-demographic factors, suicidal intent and coping styles were assessed by Independent Student t-test and One-way Analysis of variance (ANOVA). The correlation between the severity of suicidal intent and the coping styles were assessed using Pearson's correlation coefficient.

Results: The mean age of the participants were 21.75±2.69 years. The sample consisted of 72 (45%) males and 88 (55%) females. Out of the 160 participants, 50 (31.2%) had low suicidal intent, 71 (44.4%) had medium suicidal intent and 39 (24.4%) had high suicidal intent. The present study found that all the coping strategies except the escape avoidance and positive reappraisal are having significant association with the severity of suicidal intent with $p<0.05$. This study also found that seeking social support ($r=-0.284$, $p<0.001$), accepting responsibility ($r=-0.344$, $p<0.001$) and planned problem solving ($r=-0.333$, $p<0.001$) were coping styles which have a protective role in preventing suicidal behaviour by reducing the suicidal intent.

Conclusion: This study had found significant correlation between the various coping styles and suicidal intent among the young adult suicide attempters in Kerala. The present study also found significant association between previous suicide attempt and co-morbid psychiatric diagnosis with the coping scores.

Keywords: Psychiatry, Self harm, Suicide prevention clinic

INTRODUCTION

Suicide attempts among young adults are growing exponentially across the globe in the last three decades. Suicide was the fourth leading cause of death in young people aged 15-29 years for both sexes, after road injury, tuberculosis and interpersonal violence [1]. Suicide among youth is a significant public health problem and a systematic review provided preliminary support for the implementation of universal and targeted interventions using a diverse range of psychosocial approaches for suicide prevention among young adults [2]. Globally, among young adults of 15-29 age group, suicide accounts for 8.5% of all deaths [3]. Suicide is one of the leading cause of death in young adults and non fatal suicidal behaviour is more prevalent in younger people [4,5]. An attempted suicide or Deliberate Self Harm (DSH) is described as an act with non fatal outcome, in which an individual deliberately initiates a non habitual behaviour which, without intervention from others, will cause self harm, or the individual deliberately ingests a substance in excess of the prescribed or generally acceptable therapeutic dosage [6]. Suicidal intent is defined as "an individual's desire to bring about his or her own death" [7], specifically excluding the motives for DSH. A recent study from United States have found that at ages 15-19 years, the rate of suicides was 11.8 per 100,000 (17.9 per 100,000 in males and 5.4 per 100,000 in females) [8]. An Indian study has shown that the suicide rate was highest in the 15-29 years age group (38 per 100,000 population) followed by the 30-44 years group (34 per 100,000 population) [9]. Young adults in the age group 15-29 years accounted for the largest proportion (34.5%) of suicides followed by individuals in the age group 30-44 years (34.2%). A psychological autopsy study from India found that the young adults are at increased risk of suicide with ages 20-24 years followed by 25-29 years showing the highest rates of suicide [10]. Various psychosocial interventions can play a crucial role in prevention of suicides [11]. A study from Kerala has found over representation of young females, married and housewives among the victims of completed suicides [12].

Adolescence and young adulthood are the periods with major physiological, psychological and behavioural changes with changing patterns of social interactions and relations. These changes may be accompanied by significant stress for young adults and those who interact with them. It is also a period of impulsivity and also of changes in perception and practice. It is the time to develop decision making skills, along with acquisition of new emotional, cognitive and social skills. Many factors including biological, socio-cultural and personality traits can modify the complex suicidal behaviour in young

adults [13]. Coping styles are operationally defined as the responses to external life stressors that serve to prevent, avoid, reduce or control stress and emotional distress among individuals [14].

Knowledge of the risk factors for suicidal behaviour in young adults has improved over the past 20 years. Converging evidence points to psychiatric or mental disorders as well as a history of suicidal behaviour as the strongest predictors of suicidal behaviour and death by suicide. Existing researchers have examined various coping strategies affecting suicidal behaviours [15] and analysed gender specific coping strategies associated with suicidal ideation in students [16]. Various studies have found that ineffective coping styles along with stress and negative emotions in young adults contribute to higher risk of suicidality [17-21].

Although there are many studies regarding the suicidal behaviour among young adults and the associated factors in the literature, studies on the coping styles influencing suicidal intent among young adult suicide attempters are few from the Indian context and young adult group is of utmost importance so that intervention at different levels has to be taken into consideration. Assessment of suicidal intent is important as it is a strong predictor for a repeated attempt later in the life. Considering the paucity of such work from the Indian context, this study was aimed to estimate the coping styles and suicidal intent among young adult suicide attempters in Kerela, India.

MATERIALS AND METHODS

This was a descriptive cross-sectional study, which was carried out at the Suicide Prevention Clinic of the Department of Psychiatry at a Tertiary Care Centre in Kerala, India over a period of one year from October 2015 to September 2016. The study was approved by the Scientific Review Committee and the Institutional Review Board (120/2015).

Individuals admitted to the hospital with alleged history of attempted suicide were referred to the Psychiatry Department by the concerned specialties. These individuals were registered at the Suicide Prevention Clinic and were evaluated in detail by the Psychiatrists once their physical condition is stable.

Sample size calculation: Optimum sample size was calculated using the formula $\frac{z^2_{1-\alpha/2} \times p \times q}{d^2}$ (p=40%) with a precision of 20%

where, 'z' is confidence level at 95%, Alpha is significance level (0.05), 'p' is prevalence, 'q' is 100-p, 'd' is the precision level. The sample size thus calculated was 144. Extra recruitment was done to make the sample 160.

Inclusion criteria: The young adults with suicide attempts cases attending the Suicide Prevention Clinic, Department of Psychiatry between 18-25 years of age who gave written informed consent were recruited for the study.

Exclusion criteria: Young adults with intellectual disability and cognitive impairment were excluded from the sample.

Study Procedure

The individuals recruited in the study were interviewed by the principal investigator and the details were collected in the specially designed semi-structured proforma for collecting and documenting socio-demographic variables and details of the current suicide attempt. The socio-demographic variables included age, gender, educational level, occupation, religion, marital status, type of family and socio-economic status. The history of previous suicide attempts, mode of attempt, psychiatric diagnosis and the caregiver were the variables included in the details of current DSH. The diagnosis of psychiatric disorder was done by a qualified psychiatrist as per ICD-10 criteria [22]. Modified Beck's Suicide Intent Scale was used to assess the severity of suicide attempts [23]. The scale consists of 20 questions which measures both the logistics of the suicide attempt as well as the intent. Repeated attempters will have higher scores than those who only attempted once. The suicide intent scores are classified as low intent (15-19 points), medium intent (20-28 points) and high intent (29 points or more).

The coping styles of the participants were assessed using the Ways of Coping Questionnaire- Revised (WCQ-R) Scale [24]. The participant was asked to keep a specific stressful situation in mind which the individual may had experienced in the past week. The specific situation which the participant recollects may have involved one's family, job, friends, or something else important to the person. This instrument consisted of 66 items where each item has a brief description of a cognitive and behavioural strategy for coping with stressful events. The 66 items are grouped into eight coping subscales which include confrontive coping, distancing, self controlling, seeking social support, accepting responsibility, escape avoidance, planful problem solving and positive reappraisal. Confrontive coping is where the individual takes aggressive efforts to change the situation to the point of being risky and antagonistic. Distancing is where the participants detach themselves from the situation and try to minimise its significance. Self controlling is where the individual tries to control own feelings in response to the stress. Seeking social support means the participant look to friends for emotional and other types of support. Accepting responsibility shows that the individuals acknowledge their role in the problem and they want to make it better. Escape avoidance is where we are trying to avoid dealing with the problem. Planful problem solving is the coping style where the individual tries to resolve the situation through analysis and planning. Positive reappraisal indicates the method by which an individual tries to grow from the experience of dealing with the stress. There were two methods of scoring the questionnaire, raw and relative. Raw score describes the coping effort for each one of the eight types of coping, whereas relative score describes the proportion of effort represented by each type of coping. In both methods of scoring, individuals respond to each item on a 4-point Likert scale ("1 indicates "used somewhat", 2 indicates "used quite a bit" and 3 indicates "used a great deal"). In the raw scoring, the raw scores are the sum of the individual's responses to the items that comprises a given type of coping, which was used in a particular encounter [25,26].

STATISTICAL ANALYSIS

Variables and scores obtained were electronically entered into Microsoft Excel. Descriptive statistics of variables were expressed as frequency and percentages. Statistical significance of socio-demographic factors and Coping Style score was assessed using Independent Student t-test and One-way ANOVA. The correlation between the severity of suicidal intent and the coping styles were assessed using Pearson's correlation and p-value of less than 0.05 is considered as significant. The statistical analysis was done using R software for Windows version 4.1.0.

RESULTS

During the study period, 568 suicide attempters were referred to the Department of Psychiatry and registered in the Suicide Prevention Clinic. Of the 568 attempted suicide cases, 198 (34.9%) were young adults in the age group of 18-25 years. Among the 198 young adult suicide attempters, 80 (40.4%) were males and 118 (59.4%) were females. From the 198 individuals, 160 (80.8%) were consecutive young adult suicide attempters. Out of the 160 participants, 72 (45%) were males and 88 (55%) were females. The mean age of the participants was 21.75±2.69 years. The mean score of suicidal intent among the participants was 23.59±6.332. The mean score of the WCQ-R raw scale of young adults was 13.625±2.536.

The frequency and percentages of young adult suicide attempters with respect to the socio-demographic variables and association with WCQ-R raw scores are given in [Table/Fig-1]. There was no significant association between the suicidal intent and socio-economic status (p=0.529). Depressive disorder was contributing to 60 (37.5%) of the suicidal attempts followed by Personality Disorder in 30 (18.8%) individuals. Majority of the participants 71 (44.4%) had medium suicidal intent [Table/Fig-1].

Variables	Total (n=160)			Mean±SD	Statistical value	p-value
	Parameters	n	%			
Gender*	Males	72	45	13.755±2.603	t=0.589	0.557
	Females	88	55	13.518±2.490		
Education†	School education	121	75.6	13.483±2.563	F=0.117	0.890
	Degree education	24	15	13.857±2.029		
	Professional	15	9.4	13.587±3.143		
Occupation†	Unemployed	66	41.2	13.457±2.471	F=0.871	0.421
	Student	44	27.6	14.055±2.644		
	Employed	50	31.2	13.467±2.531		
Religion†	Hindu	109	68.1	13.433±2.441	F=2.641	0.074
	Christian	45	28.1	13.801±2.774		
	Muslim	6	3.8	15.780±1.224		
Marital status*	Unmarried	112	70	13.195±2.620	t=-1.405	0.162
	Married	48	30	13.809±2.489		
Family type*	Nuclear	158	98.8	13.644±2.542	t=0.843	0.400
	Joint	2	1.2	12.120±1.994		
Caregiver†	Husband	26	16.2	13.078±2.443	F=0.762	0.517
	Wife	8	5	12.998±2.946		
	Father	16	10	13.999±2.505		
	Mother	110	68.8	13.745±2.541		
Mode of attempt†	High dose of medications	78	48.8	13.801±2.448	F=0.385	0.764
	Partial hanging	4	2.5	13.630±2.448		
	Poisoning	70	43.8	13.385±2.720		
	Cutting body parts	8	5	13.991±1.902		
Previous attempt*	Absent	141	88.1	13.797±2.530	t=-2.383	0.018
	Present	19	11.9	12.342±2.253		
Psychiatric diagnosis†	Impulsive act	45	28.1	13.747±2.384	F=3.346	0.012
	Depressive disorder	60	37.5	12.831±2.466		
	Anxiety disorder	13	8.1	14.504±2.034		
	Personality disorder	30	18.8	14.041±2.496		
	Psychotic disorder	12	7.5	15.141±3.049		

[Table/Fig-1]: Socio-demographic characteristics and Ways of Coping Questionnaire-Revised (WCQ-R) raw scores.
*Independent student t-test; †One-way ANOVA test; p-value of less than 0.05 is considered as significant

Comparison of mean and standard deviation of the eight Coping styles and the raw score of the WCQ-R between young adult suicide attempters with low, medium and high suicidal intent showed that all the coping strategies except the escape avoidance and positive reappraisal had significant association with the severity of suicidal intent. The WCQ-R raw score also showed a strong association with the suicidal intent [Table/Fig-2].

WCQ-R coping styles	Low suicidal intent (n=50) Mean±SD	Medium suicidal intent (n=71) Mean±SD	High suicidal intent (n=39) Mean±SD	F value	p-value
Confrontive coping	5.500±3.772	6.844±4.242	8.497±5.183	5.191	0.007
Distancing	7.267±3.614	7.958±4.066	10.359±4.333	7.094	0.001
Self controlling	7.532±3.002	9.549±3.686	10.910±3.850	10.496	<0.001
Seeking social support	13.597±4.413	12.214±4.951	9.764±5.440	6.730	0.002
Accepting responsibility	18.912±3.618	16.968±4.816	14.758±4.555	9.737	<0.001
Escape avoidance	9.756±7.261	9.050±5.396	10.076±5.169	0.425	0.654
Planned problem solving	19.070±4.020	18.663±4.527	15.329±3.804	10.367	<0.001
Positive reappraisal	19.081±3.716	19.377±4.056	18.892±3.970	0.208	0.813
WCQ-R raw score	14.707±2.181	13.089±2.312	13.213±2.946	7.164	0.001

[Table/Fig-2]: Association of Ways of Coping Questionnaire- Revised score with severity of suicidal intent by one way ANOVA test.
p-value of less than 0.05 is considered as significant

On assessing the Pearson's Correlation coefficient of the different coping styles and the raw score of WCQ-R with the severity of suicidal intent, it was found that seeking social support, accepting responsibility, planned problem solving are coping styles which have a protective role in preventing suicidal behaviour by reducing the suicidal intent [Table/Fig-3].

WCQ-R coping styles	Pearson's correlation coefficient	p-value
Confrontive coping	0.288	<0.001
Distancing	0.293	<0.001
Self controlling	0.375	<0.001
Seeking social support	-0.284	<0.001
Accepting responsibility	-0.344	<0.001
Escape avoidance	0.027	0.734
Planned problem solving	-0.333	<0.001
Positive reappraisal	-0.057	0.476
WCQ-R raw score	-0.182	0.021

[Table/Fig-3]: Correlation of ways of Coping Questionnaire- Revised score with severity of suicidal intent.
p-value of less than 0.05 is considered as significant

DISCUSSION

This study was aimed to understand the association between specific coping styles and suicidal intent using the WCQ-R Scale and Modified Beck's Suicidal Intent Scale in a sample of young adult suicide attempters in Kerala. The young adulthood period of life is characterised by changes and transitions from one state into another and each suicide and attempt is caused by highly unique, dynamic and complex interplay of genetic, biological, psychological and social factors [27].

Coping styles are important factors which influence suicidal behaviour among all individuals. A recent study using brief COPE Questionnaire found that having a meaning of life is a protective factor, while self-distraction and self-blame are risk factors for suicidal behaviour in college students [17]. Another prospective study among college students using COPE Questionnaire, Chou WP et al., reported that the ineffective coping skills along with persistence stress and negative emotions in students could generate higher risk of suicidality [18]. Studies from India found that social support, positive coping behaviours, and Quality of Life (QOL) are significantly lower in suicide attempters and concluded that it is difficult to pinpoint a single factor responsible for suicidal behaviour [19-21]. This implies that the young adult suicide attempters with high suicidal intent are having lower scores on the problem focussed coping strategies. The young adult suicide attempters who used emotion focussed coping styles are more likely to have higher suicidal intent in this study. These findings are consistent with other studies in the literature. An Indian study found that the healthy coping styles such as self controlling, seeking social support and accepting responsibility are more commonly used by controls than suicidal attempters [19]. Another Indian study have found that healthy coping behaviours like minimisation, replacement and mapping were more commonly used by non suicidal individuals compared to suicide attempters [20]. A study regarding the coping strategies among impulsive

suicide attempters has shown that the problem focused coping styles were used less commonly and emotion focused strategies more commonly by the impulsive suicide attempters [21]. One of the recent studies from China suggested that active coping and positive reframing, both adaptive coping skills, could be beneficial in reducing the suicidal behaviour among university students and the use of instrumental support, planning, and acceptance may also be helpful in reducing suicidality in young people. Using active coping skills for solving problems and developing a positive self-appraisal are the preferable methods shown for the young people to reduce stress during stressful events [28].

Limitation(s)

The study was conducted only in the suicide prevention clinic of a tertiary care level hospital and hence cannot be generalised to general population. The study could have given rise to a Berksonian bias as only referred cases were studied. Further research with a control group can give more valid results.

CONCLUSION(S)

This study had found significant correlation between the various coping styles and suicidal intent among the young adult suicide attempters in Kerala. This study also found significant association between previous suicide attempt and co-morbid psychiatric diagnosis with the coping scores. The problem focussed coping styles like seeking social support, accepting responsibility planned problem solving and positive reappraisal are protective against higher suicidal intent. The suicidal rates among the young adults are on the rise and there is a need to support young people to develop adaptive and effective coping strategies so as to reduce suicidal ideation and attempts among young adults. It is important to encourage help seeking from families, peers, and professionals when having suicidal thoughts. Life skills education, mindfulness training to manage stress, routine counselling and screening to identify young adults who mainly uses emotion focussed coping styles can be made an integral part of young adult suicide prevention.

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