

UNDERSTANDING THE INTERPLAY OF DEPRESSION, ANXIETY AND GENDER IN DEVELOPING SUICIDAL IDEATION

Dr. Ambrien Ahmed

Professor,

Department of Psychology, School of Liberal Education, Galgotias University, Greater Noida

Ms. Simmran Mani

Post Graduate Student

Department of Psychology, School of Liberal Education, Galgotias University, Greater Noida

Abstract

Suicide is a significant public health concern, yet it is largely preventable through early diagnosis and timely intervention. Identifying individuals at risk of developing suicidal thoughts and providing immediate, targeted care is critical. Collaborative efforts between therapists and psychiatrists are essential to determine the best course of action for those exhibiting symptoms of suicidal ideation. This study aims to examine depression, anxiety, and suicidal ideation among adolescents. The findings of the study reveal that although females exhibited higher levels of depression and anxiety, these conditions did not significantly differ between genders in relation to the overall risk of suicide. However, gender plays a critical role in the likelihood of experiencing suicidal thoughts, with the data suggesting that males are at a greater risk of suicidal ideation.

Keywords: *Depression, Anxiety, Suicide, Adolescents*

Introduction

Suicide is a deeply tragic and complex phenomenon, defined as the intentional act of taking one's own life. According to the National Institute of Mental Health (NIH), suicide occurs when an individual harms themselves with the intent to end their life, and this act results in death. The scope of this issue is vast, with the World Health Organization (WHO) estimating that over 700,000 people die by suicide each year, equating to one suicide every 40 seconds. This makes suicide one of the leading causes of death worldwide, particularly in vulnerable populations. It is especially alarming that suicide ranks as the fourth leading cause of death among late adolescents, a critical period marked by significant psychological and social challenges.

The burden of suicide extends far beyond the individuals who take their own lives. For every suicide, there are many more attempts, often leaving survivors with severe physical injuries, psychological trauma, and a heightened risk of future attempts. A prior suicide attempt is one of the most significant risk factors for suicide in the general population. Additionally, the WHO reports that 77% of global suicides occur in low- and middle-income countries, where access to mental health care and support services is often limited, exacerbating the crisis.

The aftermath of a suicide is devastating, leaving families and communities in deep mourning, often plagued by feelings of guilt, confusion, and helplessness. The emotional toll is immense, as loved ones grapple with the question of "why" and are left to navigate their grief in a world that may not fully understand their pain. The use of terms like "successful suicide" or "failed suicide attempt"

can be particularly harmful, as they inadvertently trivialize the profound tragedy of suicide and can retraumatize those who are grieving.

Suicide does not discriminate; it affects people of all ages, genders, and ethnic backgrounds. However, certain factors can increase the risk of suicide, including a history of previous suicide attempts, mental health disorders such as depression and anxiety, chronic pain, and a family history of mental illness or substance abuse. Exposure to family violence, including physical or sexual abuse, and witnessing or being aware of suicidal behavior in others whether family members, friends, or peers also significantly elevate the risk.

It is crucial to approach the issue of suicide with sensitivity and a deep understanding of the underlying factors. Suicide prevention requires a comprehensive approach that includes early identification of risk factors, access to mental health care, support for those at risk, and postvention services for those affected by the loss. By fostering open conversations, reducing stigma, and providing robust support systems, we can work toward reducing the incidence of suicide and alleviating the profound suffering it causes. Furthermore, studies have shown that depression is the most prevalent psychological disorder among suicide victims; almost 90% of suicide victims had a psychological disorder at the time of their death (Henriksson et al., 1993, Cavanagh et al., 2003). According to the majority of psychological autopsies, depression is the primary cause of happening in two out of every three instances (Rich et al., 1986, Henriksson et al., 1993, Conwell et al., 1996, Harwood et al., 2001). The proportion of people in the strata undergoing therapy for

depression is significantly greater than in the general population. Suicide accounts for one in six deaths among people undergoing depression treatment from a psychologist or psychiatric agency (Wulsin et al., 1999). More than 25% of people who die by suicide have major depression and have contacted a mental health provider in the hopes that things will improve before they pass away. Depression is a very common disorder in the general population (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2012) According to Joyce (2012), identifying those who are suicidally at risk has become crucial, even though it might be challenging to identify those who are at higher risk. Furthermore, major depressive disorder (MDD) is the most common cause of suicide deaths among individuals. Approximately 15% of the population exhibits a high suicidal rate, ranging from 15% to 17%. Likewise, earlier research has suggested a connection between anxiety disorders and suicidal thoughts. Numerous studies have been done on the relationship between anxiety and suicide. Gender also plays a significant role in this relationship; research indicates that women attempt suicide at a higher rate than men do and that women tend to use less immediate, lethal means of death than men do, such as hanging, carbon monoxide poisoning, using firearms, etc., while women rely more on drugs and overdose on them. These days, it's impossible to tell what someone is going through in their life; it is hard to know if they are genuinely experiencing life or if they're only acting it out. In addition, people tend to communicate the opposite of how they are feeling, often to the point of exaggeration, repressing their actual sentiments and building up a mountain of emotions that affect them all at once. Emotional manipulation can also harm mental well-being in addition to physical health and emotional instability. It can cause internal turbulence that ultimately leads to an unbalanced life.

Objectives

1. To study depression, anxiety, and suicidal ideation among male and female adolescents.
2. To assess the gender difference in depression, anxiety, and suicidal ideation.

Methodology

Sample- In the present study the sample has been collected from the clinically diagnosed population. The total number of participants is 84, of which 43 are females and 41 are males. The sample was collected through Google Forms via a link from Delhi/NCR. The age group is from middle adolescence to late adolescence.

Tools- In the present study three tests have been used to measure depression, anxiety, and suicidal ideation.

Beck Depression Inventory (BDI)

The original Beck depression inventory (BDI) was developed by Beck, Ward et al. in 1961. The revised Beck depression inventory by (Beck, Rush, Shaw and Emery) was developed in 1979. BDI is a self-report questionnaire used to measure the severity of depression. The BDI consists of 21 questions each of which corresponds to symptoms of depression. BDI is used to measure the severity of depression and also works as depression screening following which BDI also monitors the course of treatment. The alpha-coefficient reliability for BDI is 0.93. In the meta-analysis of 9 psychiatric samples, Beck et.al. (1988) found that BDI had a mean coefficient alpha of 0.86 in outpatient sample. The convergent validity of the BDI was 0.93 ($p < 0.001$).

General Anxiety Disorder Scale (Gad-7)

GAD-7 scale was developed by Spritzer and his colleagues in 2006. The GAD-7 scale is used for screening and assessing the severity of anxiety. The GAD-7 scale is a self-report questionnaire that consists of 7 items. Scoring includes all the 7 questions now, each question has at least 4 possible choices of answer ranging in intensity for example, in the last 2 weeks, how often have you been bothered by the following problems? The alpha coefficient reliability was all above 0.82 at intake and post-treatment, GAD-7 demonstrates good internal consistency. And, the correlations were large with other measures of anxiety and well-being, indicating high reliability and validity.

Suicide Behaviours Questionnaire-Revised (SBQ-R)

The SBQ-R was developed by Osman, Bagge, et al in 2001. It is a self-report to measure past suicidal behavior. It is a revised version of 34-item SBQ developed by Linehan in 1981. The SBQ-R scale is a 4-item questionnaire. SBQ-R is used to measure suicidal attitude, ideation, and future possibilities of attempting suicide. Each of the items is rated on a 4, 5, 6 point scale. Each item taps a risk factor that is directly or indirectly related to suicidal behaviour. (Item 1)- life stress, (Item 2)- hopelessness, (Item-3)- Interpersonal conflict, (Item-4)- satisfaction with most recent life events. So, when the test is scored a value of 1-6 is assigned for each answer and then the total score is compared to key to determine the suicidal ideation level. Where, scores are given as; (Scores < 7) indicate non suicidal ideation, (Scores > 7) indicate significant risk of suicidal ideation. At the end, all

the scores of all 4 items are added to make interpretation and to obtain the total score of samples. SBQ-R has high internal consistency, the

composite reliability and average variance extracted were 0.87 and 0.63, respectively.

Result

Table 1: Level of Depression among Male and Female Adolescents in Percentage

Level of Depression	Total	Female	Male	Female % tage	Male % tage
Normal	38	18	20	21.4	23.8
Mild	15	6	9	7.1	10.7
Border Line	8	6	2	7.1	2.4
Moderate	14	8	6	9.5	7.1
Extreme	1	1	0	1.2	0.0
Severe	8	5	3	6.0	3.6
G.Total	84	44	40	52.4	47.6

Table 1 presents data on the prevalence of depression among male and female participants, categorized into normal, mild, borderline, moderate, extreme, and severe levels. Comprising 52.4% females and 47.6% males. The results indicate that out of the total sample of 38 individuals, 18 are girls and 20 are men, all of whom exhibit normal levels of depression. This corresponds to a proportion of 21.4% females and 23.8% males. 15 adolescents have exhibited mild depression, in which 7.1% of females have mild depression, whereas 10.7% of males experience mild depression. 8 individuals exhibit symptoms of borderline depression among females and males

representing percentages of 7.1% and 2.4% respectively. 14 of the participants exhibit moderate depression. Among these participants, 8 are females and 6 are males, accounting for 9.5% and 7.1% of the total, respectively. Just one individual, who is female, exhibited extreme depression. The prevalence of extreme depression among females was 1.2%, whereas no males showed extreme depression, representing a prevalence of 0%. Out of the 8 individuals with severe depression, 5 are females and 3 are males. This means that 6.0% of the total population are females with severe depression, while 3.6% are males with severe depression.

Table 2: Anxiety Level among Male and Female Adolescents in Percentage

Level of Anxiety	Total	Female	Male	Female % tage	Male % tage
Minimal	35	13	22	15.5	26.2
Mild	32	20	12	23.8	14.3
Moderate	14	9	5	10.7	6.0
Severe	3	2	1	2.4	1.2
G.Total	84	44	40	52.4	47.6

Table 2 displays the count of male and female adolescents categorized by the levels of anxiety they experience, namely low, mild, moderate, and severe. The population consists of 52.4% females and 47.6% males. Out of a total of 35 adolescents, there are 13 females and 22 males who experience minimal anxiety. This means that 15.5% of the total are females and 26.2% are males. Further, 32

adolescents had exhibited mild anxiety where 23.8% of females have mild anxiety, whereas 14.3% of males experience light anxiety. However, 14 adolescents exhibit moderate anxiety of which 10.7% are females and 6.0% are males. Lastly, 2.4% of females and 1.2% of males showed severe anxiety.

Table 3: Suicidal Ideation among Male and Female Adolescents in Percentage

Suicidal Ideation	Total	Female	Male	Female % tage	Male % tage
Non Suicidal	61	27	34	32.1	40.5
Suicidal Ideation	23	17	6	20.2	7.1
Total	84	44	40	52.4	47.6

Table 3 shows the number of male and female participants having suicidal and non-suicidal thoughts. Among the 61 adolescents with non-suicidal thoughts, 27 are female and 34 are male—that corresponding to 32.1% and 40.6%

respectively. Of the 84 adolescents overall, 23 showed suicidal thoughts; of these, 17 were female and 6 were male, therefore accounting for 20.2% of females and 7.1% of males.

Table 4: Group Mean and Standard Deviation of the Measured Variables among Male and Female Adolescents (n=84)

Variables	Mean	Standard Deviation
Depression	14.21	10.80
Anxiety	5.89	4.87
Suicide	6.20	4.35

Table 4 demonstrates the mean and standard deviation of the measured variables among the male and female adolescents. The mean of depression among adolescents is 14.21 with a standard deviation of 10.80. The mean score of

anxiety among adolescents is 5.89 with a standard deviation of 4.87. Further, the mean of suicidal ideation among adolescents is 6.20 with a standard deviation of 4.35.

Table 5: Mean and Standard Deviation of Depression, Anxiety and Suicidal Ideation among Male and Female Adolescents

Variables	Gender	Mean	Standard Deviation
Depression	Female	15.34	10.99
	Male	13.02	10.60
Anxiety	Female	6.51	4.46
	Male	5.24	5.24
Suicidal Ideation	Female	7.18	4.42
	Male	5.17	4.07

Table 5 shows the measured variables mean and standard deviation for both male and female adolescents. The mean for male and female adolescents with depression are 13.02 and 15.34, with standard deviations for both genders of 10.60 and 10.99 respectively. The mean score of anxiety

in male and female adolescents are 6.51 and 5.24, with a standard deviation of 4.46 and 5.24 respectively. In suicidal ideation the mean among male and female adolescents are 5.17 and 7.18 with standard deviation of are 4.07 and 4.42 respectively.

Table 6: T-test to see Male and Female Differences in Depression, Anxiety and Suicidal Ideation

Variables	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Depression	.557	.985	82	.327	2.32	2.35
Anxiety	.456	1.195	82	.236	1.26	1.06
Suicidal Ideation	.124	2.169	82	.033	2.01	.929

Table 6 presents the t-test values for the measured variables among male and female adolescents. In depression, the calculated t-value is 0.985, indicating that the t-test is not significant with a minor mean difference of 2.32. This means that there are no significant differences between males and females in depression. Similarly, in anxiety, the calculated t-value is 1.195, showing a non-significant result with a minor mean difference of 1.26. Thus, no significant differences among males and females in anxiety. However, for suicidal ideation, the calculated t-value is 2.169, which is significant at <0.01 level of significance. The mean score of the males is 7.18 whereas, the mean score of females is 5.17. it reflects that males have higher suicidal ideation as compared to their counterparts.

Discussion

The findings from this study underscore the complex relationship between depression, anxiety,

and suicidal ideation among adolescents, with notable gender-specific trends. The data reveals that although depression levels are slightly higher than anxiety levels among the participants, the small difference suggests a strong interrelationship between the two. This pattern indicates that an increase in depression is likely to be accompanied by a rise in anxiety, consistent with previous research that highlights the frequent comorbidity of these conditions (Kessler et al., 2003). While depression and anxiety are distinct, their co-occurrence is common, though severe manifestations of both simultaneously are relatively rare.

The study further identifies a significant gender disparity in mental health outcomes, with female participants exhibiting higher levels of depression compared to males. This finding is supported by prior research, which consistently shows that women are more susceptible to depression due to a

combination of biological, psychological, and social factors (Nolen-Hoeksema, 2001). The participants in this study were clinically diagnosed with depression and were receiving ongoing therapy, which is crucial given the well-documented link between untreated depression and an elevated risk of suicidal ideation. Indeed, the results indicate that female participants, who generally experience higher levels of depression, also face a greater risk of suicidal ideation compared to males. This aligns with studies by Henriksson et al. (1993) and Cavanagh et al. (2003), which found that depression is a significant risk factor for suicide, occurring in a substantial proportion of cases. Additionally, research by Wulsin et al. (1999) and Isometsa et al. (1994) has shown that active treatment can mitigate this risk.

Similarly, the analysis indicates that female participants exhibit higher levels of anxiety than their male counterparts. Among those diagnosed with anxiety disorders, females reported more severe symptoms and a heightened risk of suicidal ideation. These findings are consistent with research indicating that anxiety disorders are more prevalent in women and are strongly associated with suicidal behavior (McLean et al., 2011). The heightened anxiety and associated risks in females highlight the need for gender-sensitive approaches in mental health interventions.

Moreover, the results demonstrate that while there is no significant gender difference in the statistical relationship between depression and anxiety, there is a positive correlation between these conditions. This suggests that increases in depression are likely to coincide with increases in anxiety and suicidal ideation, emphasizing the interrelated nature of these mental health issues. This correlation is well-supported by existing literature, such as studies by Brown et al. (1998) and Tiller (2013), which have shown that anxiety often exacerbates depressive symptoms and contributes to the overall severity of the condition.

References

1. Barraclough, B.M., Pallis, D.J., (1975). Depression followed by suicide: a comparison of depressed suicides with living depressives. *Psychological Medicine* 5, 55–61.
2. Black, D.W., Winokur, G., Nasrallah, A., (1988). Effect of psychosis on suicide risk in 1,593 patients with unipolar and bipolar affective disorders. *American Journal of Psychiatry* 145, 849–852.
3. Brown, C., Schulberg, H. C., & Madonia, M. J. (1998). Clinical presentations of major depression by level of anxiety among primary care patients. *Journal of Affective Disorders*, 49(2), 117-123.
4. Cavanagh, J. T., Carson, A. J., Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine*, 33(3), 395-405.
5. Goldberg D, Hillier V (1979) A scaled version of the General Health Questionnaire. *Psychol Med* 9:139–145
6. Henger G (1990) A biologic perspective on comorbidity of major depressive disorder and panic disorder. In: Maser J, Cloninger C (eds) *Comorbidity of mood and anxiety disorders*. American Psychiatric Press, Washington, DC
7. Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627.
8. Maser J, Cloninger C (eds) (1990) *Comorbidity of mood and anxiety disorders*. American Psychiatric Press, Washington, D
9. McLean, C. P., Asnaani, A., Litz, B. T., & Hofmann, S. G. (2011). Gender differences in anxiety disorders: Prevalence, course of illness, comorbidity, and burden of illness. *Journal of Psychiatric Research*, 45(8), 1027-1035.
10. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006. *Avoidable deaths: five-year report of the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness*.
11. National Confidential Inquiry into Suicide and Homicides by People with Mental Illness, 2012. *Annual Report: England, Wales, Scotland, and Northern Ireland*. University of Manchester, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
12. Nolen-Hoeksema, S. (2001). Gender differences in depression. *Current Directions in Psychological Science*, 10(5), 173-176.
13. Tiller, J. W. (2013). Depression and anxiety. *Medical Journal of Australia*, 199(6), S28-S31.
14. Wulsin, L. R., Vaillant, G. E., & Wells, V. E. (1999). A systematic review of the mortality of depression. *Psychosomatic Medicine*, 61(1), 6-17.