Social Support as a Moderator of Suicidal Ideation and Self-Destructive Behavior

MS THESIS

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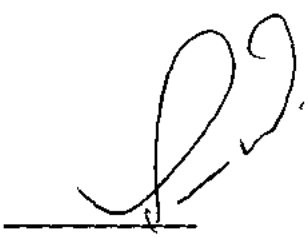

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Dedication

To the most important person in my world, now and always,

and to whom I owe everything that I have ever achieved.

To *Mrs. Razia Riaz*

My mother.

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ABSTRACT

The present study was conducted to explore the prevalence of suicidal ideation, self-destructive behavior and depression among substance abusers and patients with major depressive disorder. The study was also intended to explore the role of social support, as moderator, in relation to suicidal ideation and deliberate self-destructive behavior. For this purpose, a clinical sample of 100 respondents, 50 substance abusers and 50 patients of major depressive disorder, were approached from different psychiatric departments of hospitals and rehabilitation centers situated in twin cities. Urdu translations of Beck Scale for Suicidal Ideation (BSSI), Deliberate Self-Harm Inventory (DSHI), Provisions of Social Relations Scale (PSRS) and Beck Depression Inventory (BDI) were used to collect the data for present study. The Cronbach's alpha coefficients were found to be in the satisfactory range for all the scales. The findings of the present study revealed that there is a significantly positive relationship among suicidal ideation, self-destructive behavior, depression and social support. However, it was indicated that role of social support as moderator of suicidal ideation and self-destructive behavior was not significant. The results also revealed a significant difference between substance abusers and patients of major depressive disorder in relation to suicidal ideation, self-harm and social support. The role of demographic variables i.e. education, occupation, marital status and monthly income was also explored in relation to targeted study variables. There is a substantial need for additional research and development of specific interventions aiming to decrease suicidal ideation and self-destructive behaviors for targeted population.

CHAPTER-I

INTRODUCTION

Substance abuse and depression are most prevalent disorders in Pakistan. Depression is the most common mental disorder that disturbs the interpersonal relationships and routine lives of people. Individuals with depressive illness may report their life empty, tearful, sad, discouraged, irritable and hopeless. They may also report of loss of pleasure or interest, difficulty in sleeping, loss of self-worth, exhaustion and guilt along with para-suicidal behavior.

Depression has high rates of co-morbidity with other mental disorders and substance related disorders. When co-morbid with other mental illness, e.g. anxiety and substance abuse, depression has high risks of recurrence and severity of episode. A depressed person may turn to alcohol or other substance to alleviate the miserable condition. Similarly, it is believed that substance abuse can cause depression. Substance abuse is a chronic disease that causes compulsive drug seeking and usage. It is harmful for substance abuser and his family. Substance abuse and depression are inter-related.

Substance-induced depression is a form of depression which occurs during the course of substance use and it exceeds the expected effects of substance intoxication or withdrawal from substance used. Substance abuse and depression related problems are often associated with significant difficulties in the personal lives of the patients or of their families. These may include broken family life and personal relationships, financial

issues, poor educational achievement, and loss of employment. Suicidal ideation and self-harm are common behaviors among individuals with depression and substance abuse. Suicidal ideation is obsession with para-suicidal behaviors including suicidal thoughts and detailed planning to unsuccessful suicide attempts and it results in deliberate self-harm, which is intentional act of self-injury. There is a variety of self-harming behavior e.g. cutting, scratching, pinching skin that cause bleeding or marks on the skin, banging and hitting body parts, burning skin with cigarettes, matches and hot water, interfering the healing wounds and deliberately overdosing the medication. Individual, suffering from depression and substance abuse, needs a strong network of supportive friends and family members to buffer all these distressing effects. Social support is a function of social relations provided by members within a social network, and social networks generally relate to the number or contact frequency of family members, relatives, friends, and colleagues. Social support provides the encouragement from social network to deal with the stress effectively, better cope with depressive illness and to alleviate substance abuse. Support from members of family, friends and other individuals in society plays a positive role in reducing the feelings of self-destruction and self-harm in substance abusers and depressive patients. Therefore, this research a) reviews the various conceptual and operational definitions of suicidal ideation, self-harm and social support; b) provides an integrative and conceptual framework or model on the moderating role of social support on suicidal ideation and self-harming behavior of substance abusers and depressive patients.

Current study proposes that social support plays a role of buffer on deteriorating effects of depressive illness and substance abuse. It is presumed that help and support by

members of family, friends and social network will decrease the suicidal thoughts and self-harming behavior among patients of depression. The proposed study will also focus on the protective role of social support against self-destructive behavior and suicidal ideation among substance abusers.

The use of substances for pleasurable stimulation and sedative effects upon central nervous system has been traced back to ancient civilizations, however, in modern civilization, it has been acknowledged that excessive indulgence in any substance or drug is psychiatric as well as social problem. Initially, a substance staggers cost to individual and society socially and then psychologically and economically (Muhammad, 2003). Because these risky substances are a serious threat to the mental and physical wellbeing of individual, destroy lives and worsen human progress and breed crime in society (Isralowitz, 2004). Therefore, excessive substance use and drug abuse is an issue of increasing public concern (Sean, Jessica and Sherry, 2008).

Pakistan, 6th most populous country in the world, is also facing this social problem, even though, the possession and use of drugs in Pakistan is illegal. Drug trafficking from Afghanistan, to and through Pakistan, leads to increased ratio of drug abuse in Pakistan. Further, Pakistan is passing through serious domestic challenges and natural hazards including terrorism, earthquakes, and floods. Such conditions contribute to a higher ratio for illegal drug abuse due to losses, hardship and poverty experienced by millions of Pakistanis (Drug Use in Pakistan, 2013).

The technical summary of the Drug Use in Pakistan (2013) launched during the commission on narcotic drugs revealed that 5.8 per cent or 6.4 million adults in Pakistan

used drugs in the last 12 months and among them 4.1 million individuals are thought to be drug dependent. Substance abuse is most prevalent in Khyber-Pakhtunkhwa where 11 per cent of population is drug addict followed by Sindh 6.5 per cent, Baluchistan 5 per cent and Punjab 4.8 per cent. Cannabis (locally known as Charas) is the most frequently abused drug in Pakistan, with 3.6 per cent addicted population whereas opiates namely opium and heroin user are 1 percent of overall drug users. Non-medical use of tranquilizers and sedatives also prevails in Pakistan with a high ratio.

Substance or drug is a wider term which can be used for medical and non-medical purposes. The meaning of substance or drug varies in different contexts. For some people, substance is any prohibited and socially disapproved drug which has devastating effects on personality and performance of an individual, whereas for many other people, substance or drug means medical prescription which works as cure to pain. According to Oxford English Dictionary, a substance is *"an intoxicating, stimulating, or narcotic chemical or drug, especially an illegal one"*. However, there are many substances which can be abused for their mood altering properties. Sometimes, it is very difficult to draw a line between substance use and substance abuse. Because, in certain situations, the usage of substances with mood altering effects is normal or at least is socially approved, e.g. to start a day with a cup of coffee or tea is normal even though it has caffeine (Nevid, Rathus and Greene, 2010). There are three terminologies used commonly to distinguish between course and nature of substance-related disorders.

1. Substance Use
2. Substance Dependence
3. Substance Abuse

Substance Use

Substance use refers to *"those individuals who have tried or continue to use nicotine, alcohol, or illegal drugs and who are not dependent or addicted to the substances"* (Israiowitz, 2004). This category includes following two types of drug users:

A). Those individuals who use drugs, to feel good or because their friends are doing it.

B). Those individuals, who have been suffering from some clinical disorder like depression, schizophrenia and panic disorder, use drugs to feel better.

Both types of users use drugs periodically or infrequently to avoid dependence or addictions (Leshner, 2001).

Substance Dependence

Israiowitz (2004) defined substance dependence as *"compulsive use accompanied by craving, increased tolerance, a pattern of compulsive use and considerable impairment of health and social functioning"*. The diagnostic criteria for substance dependence demands the presence of three or more of the following symptoms: A). *tolerance;* a need to increase the amount of substance to achieve the desired effect or for a diminished effect with use of same amount, B). *Withdrawal;* a maladaptive behavioral change to avoid the physiological and cognitive consequences, C). *Dependence;* compulsive drug taking behavior or taking the drug in larger amounts or for a longer period than was intended, D). *Continuous desire and attempts* to cut down substance use, E). *Continued use of substance* despite the knowledge that it is causing serious physical and

psychological problems, F). *Spending a great deal of time* to obtain, use and recovering from its effects (American Psychiatric Association, 2000).

Substance Abuse

Substance abuse was defined by World's Health Organization (WHO) expert committee on drug dependence as *"persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice"* (WHO, 1969).

According to Diagnostic and Statistical Manual for Mental Disorders-V (DSM-V) substance abuse is a maladaptive pattern of repeated substance use that has recurrent and significant detrimental consequences including failure to fulfill obligations, repeated substance use in dangerous situations (e.g. driving) and interpersonal and socio-occupational problems (American Psychiatric Association, 2013).

Classification of Substances

There are two major classification systems, for drugs of abuse, being followed in clinical settings.

A). *The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* (American Psychological Association APA, 2013).

B). *The International Classification of Diseases (ICD-10)* (World Health Organization, 2011).

According to DSM-V, there are 10 types of drugs of abuse; alcohol; caffeine; cannabis; hallucinogen (with separate categories for phencyclidine (or similarly acting arylcyclohexylamines) and other hallucinogens); inhalants; opioids; sedatives, hypnotics,

and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances (American Psychological Association, 2013). Whereas, ICD-10 classifies drugs of abuse into 9 different categories; alcohol, opioids, barbiturates or hypnotics, cocaine, cannabis, amphetamines and other psycho stimulants, hallucinogens, tobacco, and 'others' e.g. glue and paint (World Health Organization, 2011). These all drugs of abuse are generally classified into three major groupings;

1. Depressants
2. Stimulants
3. Hallucinogens (Leshner, 2001)

Depressants

A depressant is a drug that slows down or reduces the activity of central nervous system and is taken orally. Its effects may include reduction in stress and anxiety slow movements, slurred speech, memory and concentration impairment, rapid eye movement, and sedation. This category of drugs includes alcohol, heroin, tranquillizers, morphine, opiods, narcotics, and barbiturates (Sussman and Ames, 2001). Here below are some commonly abused drugs in Pakistan from this category;

Alcohol: Alcohol is a one of most widely abused substance. It is a liquid obtained by refining various fruits, vegetables, and grains. It is classified as a depressant because it inhibits or slows down the central nervous system, causes slurred speech, and impairs motor coordination, effects judgment, vision and memory of abusers. Continuous and over-consumption of alcohol can lead to dangerous behaviors like self-harm, physical

abuse to others, and even death (Isralowitz, 2004; Nevid, et al., 2010; Edelfield and Moosa, 2012).

Heroin: Heroin, another depressant that can eliminate any thought and gives pleasure and relief to the abuser. It is a transformed form of morphine and it has heroic effects in relieving the pain. It is injected either directly beneath the skin or into a vein. It affects immediately and eradicates all feelings of guilt, anxiety and a state of well-being, satisfaction lasts from 3-5 hours after injection (Nevid, et al., 2010).

Opiods and Narcotics: Opiods and narcotics are pain relieving and sleep inducing drugs. These are derived from the juice of poppy plant (opium). Opiods produce intense feelings of pleasure and satisfaction by directly stimulating the brain's pleasure circuit (Isralowitz, 2004; Nevid, et al., 2010).

Stimulants

Stimulants are psychoactive substances which produce pleasure and alertness by increasing the activity of central nervous system (Nevid, et al., 2010). They are usually taken oral, though can be injected or smoked. This category includes cocaine, nicotine, caffeine, methamphetamine, amphetamines and ecstasy etc. (Sussman, et al., 2001). Following are most commonly abused stimulants;

Cocaine: Cocaine is a stimulant naturally derived and refined from the coca plant. It is a white powder with a bitter taste and is snorted or smoked in the form of crack. After converting it into liquid form, it can also be injected into the body directly. It causes increased heart rate, muscle tremors, seizures, and disturbance in sleeping and eating

patterns. Abuser may experience intense cravings for the drug and inability to experience pleasure in its absence (Isralowitz, 2004; Nevid, et al., 2010).

Nicotine: Nicotine is, a stimulant drug, present in tobacco products e.g. cigar, cigarettes, pipe tobacco and smokeless tobacco. Smoking causes lungs cancer and deadly diseases. Habitual use of cigarettes may lead to dependence on nicotine drug (Nevid, et al., 2010). The symptoms experienced by nicotine abuser are cough, bleeding gums, mouth sores, high blood pressure, gastric ulcer, and decreased sense of smell and taste (Isralowitz, 2004).

Caffeine: Caffeine is present in tea, coffee, soft drinks and medical drugs e.g. cough syrups etc. It affects the central nervous system and eliminates fatigue and tiredness. Excessive doses of caffeine may cause dizziness, sleep disturbance, light flashes, breathing difficulty and tense muscles (Isralowitz, 2004).

Hallucinogens

Hallucinogens are a type of drugs that produce hallucinations or sensory distortions. They are taken orally and include marijuana or cannabis, phencyclidine (PCP) and mescaline (Sussman, et al., 2001; Nevid, et al., 2010). Cannabis is the most commonly used hallucinogen used in Pakistan.

Cannabis or Marijuana: Cannabis, commonly known as marijuana, weed, pot, ganja and grass, is derived from the *cannabis sativa* plant (Isralowitz, 2004). *Hashish* is a street name of cannabis in Pakistan. It causes memory loss and can make irrationally suspicious of others (Nevid, et al., 2010). Continuous use of marijuana may damage respiratory system, cause lung cancer and breathing problems (Edelfield, et al., 2012).

Risks Factors Associated with Substance Abuse

A risk factor is any variable (behavioral, psychological, hereditary, or environmental) which significantly increases the chances of developing a disorder or disease. There are many factors which can significantly be associated with substance abuse because these increase the vulnerability of an individual towards drugs or substance abuse. We can divide risk factors of substance abuse into following domains:

Community Domain Risk Factors

Community related risk factors include availability of illicit drugs, exposure to drugs, transition and mobility, community norms and laws favorable towards drug use, community disorganization, economic deprivation, low neighborhood cohesiveness and community crime rate etc. All these factors increase the vulnerability of an individual towards drug abuse. For example, if drugs are easily accessible and community norms or laws do not control the supply and demand of illicit drugs then individuals are at a higher risk of substance abuse. A community with higher mobility and crime rates, low neighborhood cohesiveness, and extreme economic deprivation is vulnerable to drug use (Hawkins, Catalano, and Miller, 1992).

Family Domain Risk Factors

Family can influence an individual's drug use behavior in a number of ways. Including hereditary transmission of susceptibility to illicit drugs, family domain include risk factors like parental social support, parental attitude towards substance use, parental monitoring, poor parenting practices, parental conflicts and low level of bonding among family members (Brook, Brook, Gordon, Whiteman, and Cohen, 1990).

Peer or Individual Related Risk Factors

Certain individual and peer variables are examined as risk factors for the onset of drug using behavior. These variables include alienation, rebellious behavior of peer, peer attitude towards drug use, and peer delinquent behavior.

Theoretical Perspective of Substance Abuse

To better understand the phenomenon and causes of drug use, addiction and substance abuse, it is necessary to review theoretical approaches of the phenomenon. A theory of substance use or addiction will explain the causes of drug use; why individuals use drugs. There are many approaches of substance abuse or addiction. For our convenience we can divide these into following major categories:

Biological Perspective of Substance Abuse

Biological perspective postulates that there are physical mechanisms in individual that compel them either to abuse drugs or to do experiment with drugs once they are available to them. These theories view different genetic mechanisms (which are present by birth) that cause drug-using behaviors (Goode, 2012). There are two of these explanations that are as under:

1. Genetic Theories

According to genetic perspective, an individual may have predisposition for drug abuse or alcoholism due to their genetic makeup. Genes can influence the biological mechanisms such as increase the level of intoxication, decrease the stress or anxiety level when under the effects of a drug and increase the metabolic rates of chemical substance. These influences eventually make an individual susceptible to substance abuse (Goode,

2012). Research evidences of family, twins and adoption studies have suggested that tobacco and drug use behavior is influenced by genetic factors (Madden and Heath, 2002). There is strongest evidence that genetic predisposition causes significantly higher level of alcoholism in certain individuals (Health and Research world, 1995; Kolata, 1987; Shuckit, 1999).

2. *Theory of metabolic imbalance*

Theory of metabolic imbalance, developed by Vincent Dole and Marie Nyswander states that heroin addiction is a metabolic disease in which addict craves for opiate drugs after once taking in narcotics (Dole and Nyswander,1980). This craving occurs as a result of biochemical process and individual seeks drugs in the much same way as a diabetic's body seeks insulin. According to this approach, drugs/narcotics act as a stabilizer because they normalize the craving or deficiency (Goode, 2012).

Different research studies, conducted on neurological aspects of drug use, support that there are drug-specific receptors in the nervous system that affect metabolites on neurotransmitters. These biochemical or physiological actions within the brain are suggestive of addictive behaviors for all types of drugs (Ogborne, 2006).

Psychological Perspective of Substance Abuse

Psychological theories try to find out the psychological factors that may lead to substance abuse. These approaches stress upon the difference among personalities of drug abusers, mechanism of reinforcement and also view different psychological perspectives to explain the phenomenon of substance abuse. We can divide psychological theories of substance abuse into following categories;

1. Psychodynamic theory

A psychodynamic theory emphasizes on psychological factors, structures and processes as driving forces for all types of human behaviors. It also focuses on early childhood experience and conflicts that have effects of unconscious mind of an individual in later stages. Psychodynamic approach of substance abuse can be traced back to the work of Sigmund Freud and his followers. According to this approach, '*alcoholism*' is the result of '*oral fixation*' at earlier stage of life and alcoholic are unable to cope with the demands of adult life due to this fixation. Earlier fixation at stages of development (specially anal and phallic) has been proposed as best reason of alcoholism at later life (Barry, 1988). Psychodynamic perspective further postulates that substance use and abuse problems are due to unconscious motivation, unresolved interpersonal conflicts, dependency, low self-esteem and poor regulation of emotions. Freud viewed alcoholism as an expression of repressed homosexuality. He argued that when a male become disappointed with his relationship with woman, he turns to homosexual and represses his homosexual energies he chooses to drink alcohol because drinking provides him an excuse to be with other men(Ogborne, 2006).

2. Reinforcement theory

This theory emphasizes the role of reinforcement as mechanism of substance use. There are two types of reinforcement; positive reinforcement and negative reinforcement. When substance abuser seeks pleasurable sensation through taking drug and is motivated to repeat the behavior, is known as *positive reinforcement*. He becomes fixated on this pleasurable repetitive behavior (Bejerot, 1980; McAuliffe and Gordon, 1980). Whereas as a result of *negative reinforcement*, individual intakes substances to seek relief or to

avoid pain and is motivated to repeat the drug taking behavior to alleviate the pain. According to reinforcement theory, a substance abuser become physically dependent on pleasurable effects of drugs and undergoes painful withdrawal symptoms if he discontinues the use of drug. To get relief from withdrawal distress he continues the drug taking behavior (Goode, 2012).

3. Cognitive-Affective-Pharmacogenic (CAP) Control Theory of Addiction

Cognitive-Affective-Pharmacogenic Control Theory of addiction emphasizes the cognitive styles of abusers because it leads the individual to drug abuse from drug experimentation. CAP control theory of addiction views the mechanism of substance abuse as an interaction between personality style of abuser and drugs' pharmacogenic effects. According to CAP control theory, cognitive styles of abuser lead them to begin the abuse process e.g. if an individual is having difficulty in meeting the demands of society and family, they will have a conflict and the result of this conflict is anxiety. Anxiety is an uncomfortable experience and person seeks anxiety reduction through injecting drugs. The main pharmacogenic effect of drugs (especially heroine and alcohol) is anxiety reduction but a short lived effect. Thus, abuser repeats the drug taking behavior to reduce the anxiety (NIDA Research, 1980).

Substance Abuse and Co-Morbidity with Other Disorders

Co-morbidity refers to the co-existence or overlap of substance abuse with one or more psychiatric disorders. Usually a "dual diagnosis" is given to the patients who have co-morbidity of substance abuse and any other psychiatric disorder. Substance/drug abuse can have co-morbidity with a large number of psychiatric disorders specially mood and anxiety disorders. However, this phenomenon is complex as both illnesses can

intermingle and exacerbate one another. According to the United State (U.S) Department of Health and Human Services (2003), mental health disorder can lead substance abuse and withdrawal from alcohol or substance abuse can worsen the symptoms of mental illness. It was estimated that up to 7 million adults in the U.S. have at least one co-occurring mental health and substance-related disorder in any given year (U.S. Department of Health and Human Services, 1999). Findings of a survey (2001-2002) indicated that a significant number of patients have a co-morbid substance abuse and depression. Among these patients, 40 percent had alcohol use disorder and an independent mood disorder, whereas, 60 percent had co-occurrence of other substance use disorders and an independent mood disorder (Grant, Stinson, Dawson, Chou, Dufour, Compton, Pickering, Kaplan, 2006). Another research indicates that alcohol and other substance abuse may co-exist with mood disorders (Stinson, Grant, Dawson, Ruan, Huang, and Saha, 2006) especially depression (National Institute of Mental Health NIMH, 2011). It is a common tendency for a depressed individual to use substance or alcohol to alter their mood and many substance abusers may suffer from depressive illness.

Depression / Major Depressive Disorder (MDD)

Depression is a common mood disorder that presents with a low mood, loss of interest in pleasurable activities, low energy, lethargic mood, headache and muscular pain, disturbed appetite and sleep, hopelessness and feelings of guilt, feelings of worthlessness, and poor concentration. Major Depressive Disorder (MDD) is differentiated from normal mood changes by the extent of its severity, symptoms and the

duration of the disorder. Moreover, suicidal behavior also prevails in intense cases (American Psychological Association, 2000).

Diagnostic Criteria for Major Depressive Disorder

According to Diagnostic and Statistical Manual of Mental Disorders (DSM-V), major depressive disorder is an illness encompassing depressed mood, loss of interest or pleasure, disturbance in sleep pattern, sudden weight loss or weight gain, psychomotor agitation or irritability, feeling of fatigue or tiredness, poor concentration and thoughts of killing oneself. These symptoms should have been present in the 2-week period and should cause significant impairment in socio-occupational activities (American Psychological Association, 2014).

Depression and Substance Abuse

Clinical research study of substance abusers indicates a relationship between mood disorders and substance use disorders (Hovens, Cantwell and Kiriakos, 1994). Depression may increase the risks for substance abuse disorders, or depression may be developed as an outcome of pre-existing substance use disorders, it may also curb the severity of substance use disorders, or both these disorders may stem from a common susceptibility. Indeed, the co-morbidity of depressive disorders and substance abuse is prevalent in clinical sample with a range of 24-50 percent (Bukstein, Glancy and Kaminer, 1992; Kaminer, Burleston and Goldberger, 2002).

A research study conducted by Substance Abuse and Mental Health Services Administration (2007) shows that marijuana and other illicit drugs put a teen at a great risk for serious mental disorders. Further this study indicates that depressed teens are at

twice (25%) risks for using marijuana than non-depressed teens (12%). Similarly, 35 % of depressed teens used an illicit drug in the past years as compared to non-depressed teens (Fergusson, 2002). Another longitudinal study, conducted over a period of 14 years, found that marijuana use was predictor of later major depressive disorder (Brook, 2002). Co-morbidity of substance use disorders and depressive illness are a greater risk factor for suicidal behaviors, including suicidal thoughts, attempts and suicide (Bukstein, Bernet, Arnold, Shaw, Benson, Kinlan, McClellan, Stock, Ptakowski, 2005). Greenblatt's research (1998) showed that teens who abuse marijuana at least once a month in the past year are at three time greater risks to have suicidal ideation than non-abusers during the same period.

Suicidal Behavior

Suicidal behavior is a type of self-directed violence. Suicidal behavior is a broader term ranging from merely thinking about ending one's life, developing a plan to commit suicide, collecting sources to complete the action and finally attempting to kill oneself (WHO, 2002). The consequences of this plan can be successful/completed suicides or attempted suicides also known as para-suicide. Suicidal behavior represents a continuum of self-harming behavior which includes suicidal ideation, suicide attempts and completed suicide.

Suicidal behavior and self-destruction are the terms which are often mixed because both these share a common characteristic of self-injurious actions. Stengel and Cook (1958) used the term "Attempted Suicide" to delineate any self-injurious behavior intentionally aimed at self-harm. But it is very difficult to assess patient's intentions to kill himself or self-destruction because patient's self-report about the intentions to kill or

harm himself are unreliable (kreitman, 1977). Thus, Kreitman coined the term *"para-suicide"* and grouped all forms of self-destructive behavior into one category. He defined para-suicide as a "*nonfatal act in which an individual consciously caused self-harm or injects a substance in excess of any prescribed or generally recognized therapeutic dosage*" (kreitman, Philip, Greer, Bagley, 1969). The lack of consistent definitions of suicidal behavior had led to confusion in the field, so a committee meeting was held, under the Center for Study of Suicide Prevention of the National Institute of Mental Health (1970), on classification of suicidal behavior chaired by Beck. Subsequently, suicidal behaviors were categorized into three degrees; completed suicide, suicide attempts and suicidal thoughts. These constructs were categorized on the basis of degree of intent, degree of lethality and method for self-destruction (Beck, et al., 1973). According to Beck and colleagues (1973) intention to die is an important variable because if patient does not have suicidal intentions then a diagnosis of "self-injurious behavior" would be used instead of "attempted suicide".

O'Carroll and colleagues (1996) provided definitions of common suicidal behavior related terms to further build on this nomenclature. According to them, *suicide attempt* is an act of self-injury with deliberate intentions to kill himself but it has nonfatal outcome whereas "*suicidal ideation*" is self-report about thoughts of engaging in suicidal behavior.

Following table clearly offers an understanding of this classification scheme of suicidal behavior.

		Deliberate Self-destructive Behavior		
		Definite	**Uncertain/ potential**	**None**
Intentions to kill/ suicidal intent	**Definite**	Definite suicide attempt	Possible suicide attempt	Suicidal ideation
	Uncertain/ potential	Possible suicide attempt	Possible suicide attempt	Possible suicidal ideation
	None	Deliberate self-destruction without any intention to commit suicide	Deliberate self-destruction without any intention to commit suicide	

Figure 1: Classification scheme on suicidal behavior and self-destructive behavior

Suicide

Thomas Browne (1642) coined the word "suicide" basing on the Latin word 'Sui' (oneself) and 'Caedere' (to kill) (Minois, 1999). Literally suicide means killing oneself and it is considered a type of violence. Suicide is defined as "*self-inflicted death with the evidence that person intended to die*" (American Psychiatric Association, 2003).

According to World Health Organization, suicide is the 13th leading cause of death worldwide with a mortality rate of 14.5 deaths per 100,000 populations and self-directed injuries are the 4th leading cause of death among individuals age ranged 15-44 years. (WHO, 2002) Self-directed harm and suicidal behavior are not only serious threat to the person who kills himself or herself but also for other family members and friends, whose lives are intensely affected emotionally, socially and economically. Self-harm and

suicidal behavior is often not recognized as a major public health problem due to lack of statistics and the lack of research that would help in understanding of problem (Sánchez-Lacay, Parrilla-Cruz, and Pagán-Castro, 1995). Effective strategies for the prevention of these life threatening behaviors should target the statistics and risk factors.

Suicidal ideation

In definition of suicide, the intention to die is a vital element. However, it is difficult to restructure the intentions of people who commit suicide unless they have made clearly expressed their thoughts to die or left a suicide note before their death (WHO, 2002). Suicidal ideation is the thought causing one's own death. The degree of suicidal ideation may vary depending on the suicide plans and suicidal intents (American Psychiatric Association, 2003).

Suicide Attempt

Suicide attempt is defined as self-injurious behavior with a non-fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die (American Psychiatric Association, 2003). Deliberate self-harm is used either along with suicide attempt or to replace the term. Deliberate self-harm is defined as willful self-inflicting of painful, destructive, or injurious acts, but without intent to die (American Psychiatric Association, 2003).

Theoretical Perspective of Suicidal Ideation

Following are few theoretical perspectives of suicidal ideation and behavior:

1. Beck's Cognitive Theory of Suicidal Thoughts and Behavior

Beck's cognitive theory suggests that people's thinking style and interpretation of life events plays a causal role in their behavior and emotional responses to those events (Beck, 1967). He suggested that patients with depression have negative view of themselves, the world and the future. He labeled this thinking style as *the negative cognitive triad.* Later, he added an additional causal, dysfunctional belief, element to his original theory (Beck, 1987). Dysfunctional belief is the tendency to eliminate positive cognitions in favor of automatic and unrealistic negative thoughts and focus on negative outcome (Haaga, Dyck, and Ernst, 1991). According to Beck's cognitive theory, depressive patients have negative thoughts about themselves, the world and the future and such negative perception of the world appear to be associated with helplessness and suicidality (Haaga et al. 1991). As with depressed patients, patients with suicidal thoughts and behavior also have negative thoughts and dysfunctional beliefs (Beck, 1987).

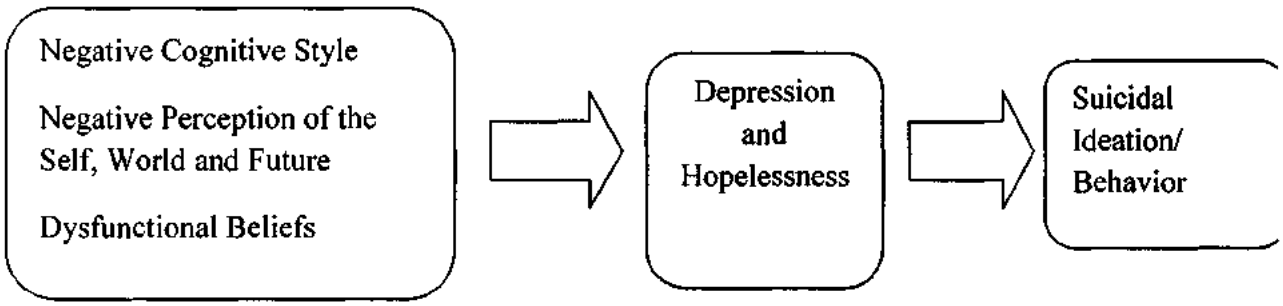

Figure 2: Beck's Cognitive Model for Suicidal Ideation and Behavior

2. Abramson, Alloy, and Metalsky's Hopelessness Theory

Beck (1967) originally proposed that hopelessness is associated with suicide risks among his patients. Later on, Abramson, Alloy, and Metalsky (1990) added more specific hypotheses in the original theory of Beck. They defined two elements of hopelessness: an expectation of negative outcome if a positive event fails to occur and feeling of hopelessness regarding to change the probability of that negative outcome. They also posit the term of *hopelessness depression*: depressive symptoms of sad mood, sleep disturbance, poor concentration and low motivation partially overlapped with suicidal ideation and behavior. Patients with hopelessness depression display the symptoms of hopelessness (suicidal thoughts and behaviors) but do not meet the full criteria of any depressive disorder (Abramson et al., 1990). Studies have shown that hopelessness plays a mediator role between the relationship of suicidality and depression (Abramson, Alloy, and Metalsky, 1998; Beck, Brown, and Steer, 1989; Salter and Platt, 1990).

3. Joiner's Interpersonal Psychological Theory of Suicide

Thomas Joiner (2006) wrote a book titles as "*Why People Die by Suicide*" outlining different emerging theories of suicide. His interpersonal-Psychological theory of suicide is related to the research under study. In this theory, Joiner theorized that people who commit suicide not only have wishes to die, they also have learned to defeat the instinct for self-preservation. According to him, death desire is composed of two psychological experiences: *Perceived Burdensomeness,* perception of being burden to others, and *Thwarted belongingness,* social disconnection from outer world. This theory also argues that a series of agonizing and proactive experiences over the long course of life can dis-inhibit the fear of pain associated with death or suicide (Joiner, 2006).

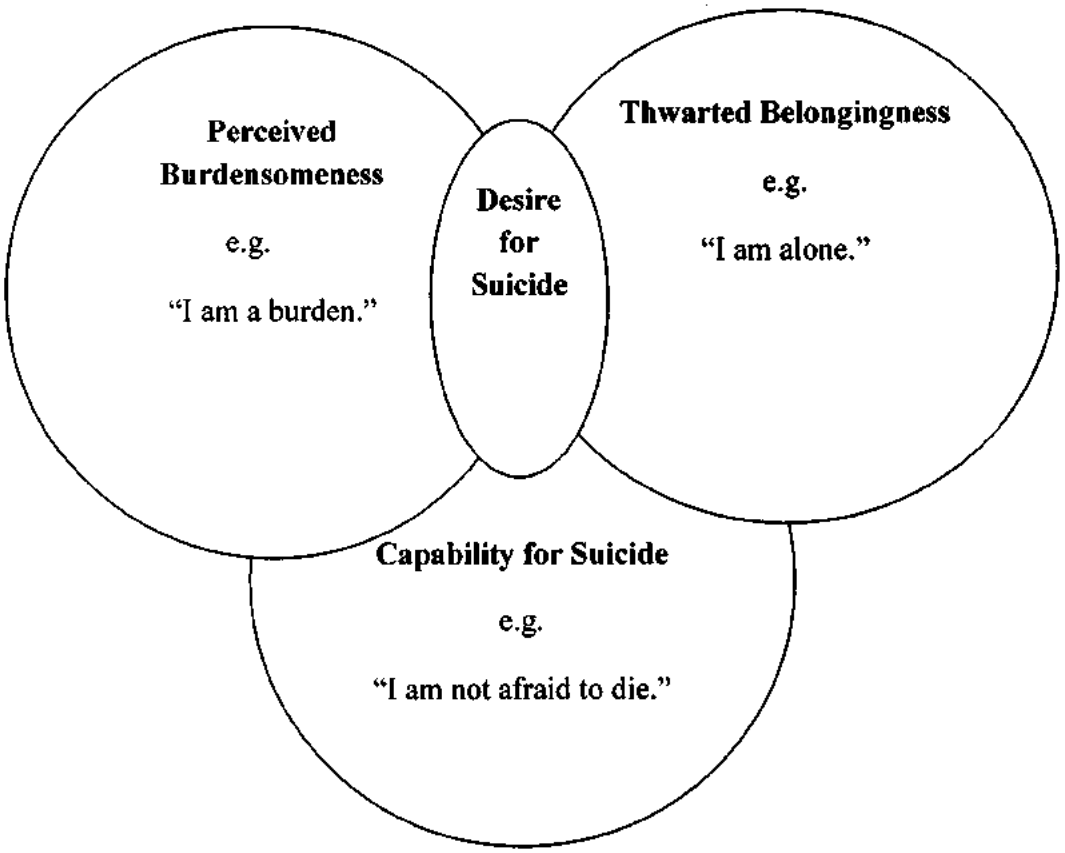

Figure 3: Joiner's Theoretical Model of Suicide

Self-Destructive Behavior/ Deliberate Self-Harm

"Self-harm is not an illness, but is more or less dangerous behavior that should alert us to an underlying problem, difficulty or disorder." (National Collaborating Centre for Mental Health, 2004: p. 16)

Self-destruction or deliberate self-harm is a phenomenon of harming oneself because the majority of case of deliberate self-harm do not come to the attention of emergency services or clinicians. This could be because deliberate self-harm is often not an attempt at deadly harm, but an attempt to inflict injury without the need for medical attention (Fox and Hawton, 2004). So there is lack of a consistent and agreed-upon

definition of deliberate self-harm because the terms self-injury, self-mutilation, self-inflicted violence and deliberate self-harm are used interchangeably in literature. However, many researches attempted to provide a detailed description of the self-harming behavior. Pattison and Kahan (1983) defined it as self-destructive behavior renowned by direct, repetitive self-harming behavior with low mortality. They further elaborated that self-destructive behavior occurs with a conscious intent to harm oneself along with personal awareness of consequences of this action. Self-destructive behavior includes reckless driving and spending, shoplifting, bingeing and purging, substance abuse, risky sexual behavior, self-mutilation and suicidal attempts in severe forms (American Psychological Association, 2006). Self -harm can be distinguished by suicidal attempt low lethality rate, because in suicidal attempt, the intent to die dominates.

In the current research, deliberate self- harm inventory developed by Kim L. Gratz (2001) is being used for measuring the prevalence of self-destructive behavior. He defined deliberate self-harm as "*the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur*" (Gratz, 2001). According to World Health Organization, Deliberate Self-harm also known as para-suicide is "*an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences*" (Kerkhof, Schmidtke and Brahe, 1994).

Sub-Types/ Forms of Deliberate Self Harm

I. Self-poisoning

II. Self-injury

III. Self-mutilation

I. Self-Poisoning

Self-poisoning is a phenomena of "*the self-exposure of an individual to an amount of substance associated with the significant potential to cause harm*" (Camidge, Wood and Bateman, 2003). Individual can poison himself by ingestion or inhalation. Self-poisoning method includes overdose of prescribed pharmaceutical medicines or developing tolerance for the substance (e.g. a heroin addict going to inject overdose of heroin) or usage of more active substance than expected (Camidge, Wood and Bateman, 2003).

Deliberate self-poisoning is a serious public health problem throughout the world especially in developing countries (Eddleston, 2000). Organophosphate poisoning is commonly used agriculture and widely used suicidal agents in Pakistan and other Asian countries (Memon, Shaikh, Kazi, and Kazi, 2012). In developing countries, these substances are a risk factor for ill health and cause death of thousands of individuals each year (Haider and Haider, 2001).

II. Self-Injury

It is the deliberate act of hurting one's own body such as cutting, burning skin and banging to the wall.

III. Self-Mutilation

Another form of deliberate self-harm is known as self-mutilation. Favazza (1999) defined self-mutilation as the direct and deliberate destruction or alteration of body parts without any conscious suicidal intention. He gave three categories of self-mutilation;

a) *Major Self-Mutilation;* It is inflicting damage to a significant amount of body tissue and it includes self-blinding, enucleating eye, facial skinning, and the amputation of fingers, hands, arms, limbs, feet or breasts (Favazza, 1999).

b) *Stereotypical Self-Mutilation;* It is repetitive and sometimes rhythmic act to harm oneself such as head banging, biting oneself, pulling hair, hitting oneself with wall, throat or eye gouging (Favazza, 1999).

c) *Superficial-to-Moderate Self-mutilation;* It is the most commonly observed type of self-mutilation including compulsive repetitive and episodic damage to the body tissues. This category includes self-harming behaviors such as cutting, scratching or burning skin, pulling hair compulsively, sticking needles into one's skin (Favazza, 1999).

Favazza, also Pattison and Kahan (1983), excluded overdose and swallowing objects from their definition of deliberate self- harming behavior, because these behaviors do not alter or affect body tissues directly.

Theoretical Perspectives of Deliberate Self-harm

1. Environmental Theory of Self-Mutilation (Self-Harm)

The environmental model of self-harm focuses on factors that have initiated and maintained the self-harming behavior. According to this model, self-harming behavior

occurs through familial modeling of abuse which leads to the feeling that self-mutilation is appropriate and there is a link between self-inflicted pain and care provided by the family members. This behavior of self-harm is strengthened by vicarious reinforcement because behavior is reinforced either internally (internal feelings of relief) or externally (care from family, peers and social network). The care and attention provided by others are powerful reinforcers of self-harm. Attention and social status among peers were found to be major reasons behind self-mutilating behavior (Offer and Barglow, 1960).

2. Affect Regulation Theory

According to this theory, self-harm or self –mutilation serves as a mediator of affect or emotions by creating a sense of control, by turning the passive pain of abandonment into active pain that can be controlled (Darche, 1990; Leibenluft, Gardner, and Cowdry, 1987; Raine, 1982). Self-mutilation is also conceptualized as a need to feel a real physical pain as opposed to just an emotional pain (Leibenluft et al., 1987). But sometime, self-mutilators report no feelings of physical pain upon self-mutilation, so it may be assumed that patients harm themselves deliberately to feel that their emotions are real (Suyemoto, 1998). Several studies have viewed self-harm as a mechanism for compensation of inappropriate effect regulation in stressful situations (Chapman, Gratz, Brown, 2006; Esposito, Spirito, Boergers, Donaldson, 2003).

Social Support

Substance abuse disorders and depressive illness are often associated with significant difficulties in interpersonal relationships e.g. broken family, familial conflicts, rejection by social networks, and staying away from friends circle. Such difficulties make the illness more chronic and prolonged, and for the treatment of such disorders, clinicians

study the role of social support and reintegration interventions. In the last few years, social support has become an immensely popular construct within clinical researches. There has been a great interest in the role of social support or interpersonal relationships in protecting individuals from possibly pathological effects of different factors like substance abuse and stressful events. In order to measure the role of social support on deleterious behaviors, e.g. suicidal ideation and deliberate self-destructiveness, there is need to understand the phenomena of social support and associated key features.

Social support is a multidimensional construct that is broadly defined as the *"psychological and material resources available to individuals through their interpersonal relationships or social network"* (Rodriguez and Cohen, 1998). Social support also refers to a social network or social relations' provision of psychological and material resources intended to benefit an individual's ability to cope with stress (Cohen, 2004).

A strong network of supportive friends and family members is an enormous buffer against life stressors. On the other side, the more loneliness and isolation, greater is the vulnerability to stress. Social support is a function of social relations provided by members within a social network, and social networks generally relate to the number or contact frequency of family members, relatives, friends, and colleagues (Golden, Conroy and Lawlor, 2009). Researchers have studied both, structural and functional, aspects of social support. *Structural support* is the existence of family, friends and other social networks within an individual's environment. *Functional support,* on the other hand deals with the quality of those relationships and covers such issues as empathic understanding (emotional support), and practical assistance or information provision and instrumental

support (Sutherland, 1997). Availability of social support within the network buffers the experience of stress (Kaniasty, Norris, 2000) and individual's social environment may influence his attempt to recover from substance use through the levels of social support available to them. Social support concerns the availability of encouragement and practical help from other people for the substance abuser trying to stop abusing the drug. Research has shown that a lack of social support increases the risks of substance abuse. For example, the social stress model of substance abuse proposes that substance abuse is a function of environmental stress e.g. extreme poverty, availability of drugs and violence, moderated by various factors, including social support (Rhodes and Jason, 1990). Social support may alleviate the impact of a stress appraisal or perception by providing solutions to the problem, by reducing the perceived importance of the problem or by tranquillizing the neuro-endocrine system so that people are less reactive to stress, or by facilitating health behaviors or coping behaviors (Cohen and Wills, 1985).

Types of Social Support

Social support is a complex and multifaceted concept, there appears to be a general agreement on the three broad categories of social support in literature.

1. ***Social Connectedness:*** It refers to the quality and quantity of social connections or interpersonal ties that one has with others. Social Connectedness could be in informal relationships (family member, friends, peers, and others) or formal relationships (formal relations with colleagues, mental health professionals, clinicians, and teachers etc.) (Lopez and Cooper, 2011). Basically researchers have focused on both, structural (number of sources available) and functional (satisfaction level with social relationships), aspect of social connectedness.

2. ***Perceived Social Support:*** It is the most studied concept of social support and it refers to cognitive appraisal of social support which ultimately promotes the coping and buffers the effects of stressful events. It is the appraisal of social support irrespective of whether individual receives the support or just perceives it. Researchers on perceived social support may differ in whether they are concerned measuring the 'an individual's appraisal of the availability' or 'the adequacy of support'. Presence of perceived social support has been related to buffer the deleterious effects of stress and psychological distress among different research populations (Lopez and Cooper, 2011).
3. ***Actual or Enacted Support:*** The last type of social support is actual or enacted social support. It refers to the support which individual receives actually (Lopez and Cooper, 2011).

Resources of Social Support

Social support can also be measured in terms of resources or common functions, which are as following:

1. ***Informational Support:*** It refers to the provisions of guidance, suggestions, and relevant information intended to help the individual for problem-solving and to cope with difficult situations (Cohen, 2004). Social support is presented in the form of information or advice which can be helpful for dealing with difficulties.
2. ***Instrumental Support:*** It refers to the provision of financial assistance, materials, services and material aids to help with daily tasks (Cohen, 2004). Instrumental

support includes the direct and concrete methods of helping others. This form is also known as *tangible social support.*

3. ***Emotional Support:*** It refers to the provision of empathy, affection, trust, love and encouragement to deal with difficulties (Cohen, 2004). Emotional support is also known as *esteem support or appraisal support.* This form of support provides the warmth and nurturance to the individual and it assures the individual that he is valued.

Theoretical Perspective of Social Support

There are two famous models of social support (Cohen, 1988; Cohen and Wills, 1985; House, 1981) and these explain the role of support, stress and psychological distress.

1. Stress-Buffering Model

The Stress-Buffering Model hypothesize that social connections provide psychological and material resources to cope with psychological distress. According to this model, social support is beneficial for those suffering from psychological distress or stress, but it may not have any role in health of those without any stress. This model is supported by an interactive role of stress and social support, because stress is considered to influence health by both, promoting coping strategies and by activating physiological systems (sympathetic nervous system and glandular system). Prolonged or repeated activation of such physiological systems put individuals at the risk of developing psychiatric disorders and physical illnesses. Stress-buffering model suggests that social support operates as a stress buffer. The perception that others will provide reliable resources may strengthen one's ability to cope with stressful situations. This will change the appraisal of situation and lower the effects of stress (Cohen, 2004).

2. Main Effect Model

The main effect model purposes that social support and social connectedness are beneficial irrespective of *"whether one is under stress or not"*. Large social networks provide individuals with regular positive experiences. Such social support can be related to overall well-being of individual by promoting positive effect. The integration effect of social network (social support) and positive effect (positive experience) may help the individual to avoid negative experiences and lesson the probability of psychological disorder (Cohen, 2004).

The interpersonal theory of suicide (Joiner, 2005) proposes that the need to belong to caring and supportive relationships is so powerful that when it is threatened, it contributes to a desire for suicide. Empirically, indices of social connectedness are related to suicidal thoughts and behavior among individuals with substance use disorders in several ways. First, living alone is associated with suicide and suicide attempts (Haw, Houston, Townsend, and Hawton, 2001). Second, low social support is associated with suicide attempts (Darke, Ross, Williamson, Mills, Havard, and Teesson, 2007). Third, perceptions of belongingness are also related to a lower likelihood of a past suicide attempt (Conner, Britton, Sworts, and Joiner, 2007).

Another research was conducted to determine the association between disrupted social connectedness and suicidal thoughts and behaviors. Participants (n = 814) were recruited from four residential substance-use treatment programs and completed self-report measures of social connectedness as well as whether they had ever thought about or attempted suicide. Multivariate results indicated that interpersonal conflict and belongingness were significant predictors of a history of suicidal ideation, and

belongingness, perceived social support, and living alone were significant predictors of suicide attempt (Sungeun You, Kimberly A. Van Orden, and Kenneth R. Conner, 2011).

Rationale of Study

Depressive illness and substance abuse seems to be an alarming issue in Pakistan. Many researches and studies conducted on the issue reveal that a major proportion of population of Pakistan is suffering from major depressive disorder and substance related disorders. Being involved in substance abuse, doesn't not only affect an individual's behavior but also risks well-being and health. Prior research suggests a variety of risk factors for suicide ideation e.g. mental illness, especially major depressive disorder and substance use disorder have been found to be associated with suicidal ideation. Social support is an influential factor that helps to alleviate the above mentioned risks. Previous researches (Deleo, Bertolote, & Lester, 2002) suggested that social support that includes help and support from members of family, friends and other individuals in society plays a positive role in reducing the feelings of self-destruction and self-harm in substance abusers .Self-directed violence encompasses a range of behaviors, ranging from non-suicidal intentional self-harm (i.e. behaviors in which the intention is not to kill oneself, as in self-mutilation) to acts of fatal and nonfatal suicidal behavior (Crosby, and Melanson, 2011).

In Pakistan, the lack of data on the extent of suicidal thoughts and behavior limits the ability of practitioners to find where the problem is the most acute. Current study proposes that individuals with low or no social support will be at high risk of self-directed violence and such behaviors will have deleterious effects on health and well-being of these individuals. Social support plays a role of buffer in environmental stress

and negative thoughts and behavior of a substance abuser and patients with major depressive disorder. It is presumed that help and support by members of family, friends and social network will buffer the association between suicidal thoughts and self-destructive behaviors. As a most convenient approach, the social support can be enhanced to reduce the self-directed violence and other risks behaviors. Recent theoretical and empirical work will significantly advance the understanding of underlying variables i.e. suicidal thoughts, self-harm and social support among depressive patients and substance abusers.

Conceptual Framework for the Current Study

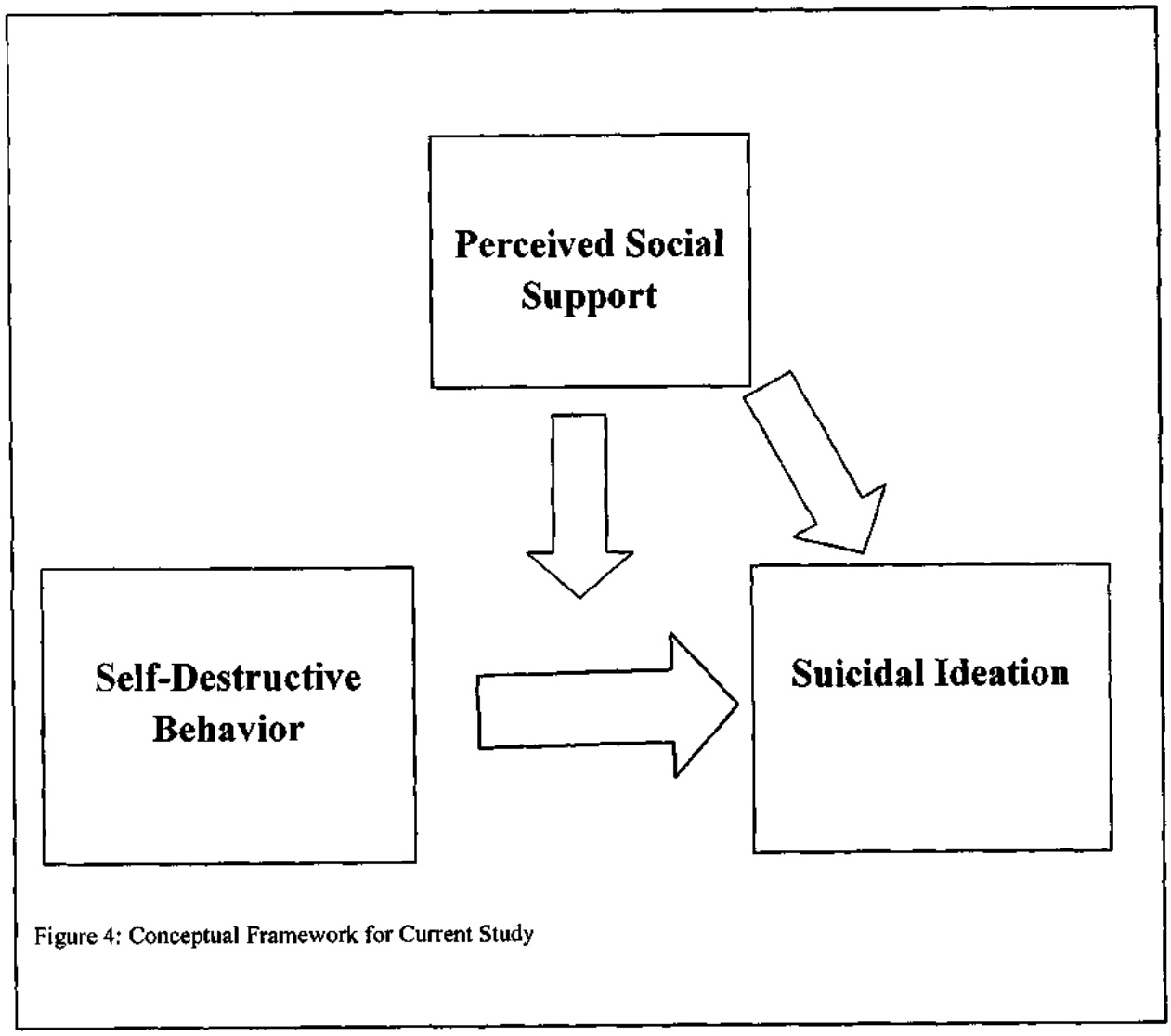

Figure 4: Conceptual Framework for Current Study

CHAPTER-II

METHOD

Chapter II discusses the objectives of research along with hypothesis, operational definitions of variables and methodology used. The psychometric properties of instruments are also discussed in this chapter. It also explains details of procedure used for data collection and analysis.

Objectives of Study

The current study focused on following major objectives:

1. To investigate the prevalence of perceived social support, suicidal ideation and self-destructive behavior among substance abusers and patients with major depressive disorder.
2. To identify the association between perceived social support, suicidal ideation and self destructive behavior among substance abusers and patients with major depressive disorder.
3. To identify how suicidal ideation and self-destructive behavior relate to each other.
4. To investigate the moderating role of perceived social support between suicidal ideation and self-destructive behavior among substance abusers and patients with major depressive disorder.
5. To compare substance abusers and patients with major depressive disorder on level of perceived social support, self-destructive behavior and suicidal ideations.

6. To investigate the role of demographic variables such as socio-economic status, educational level, and marital status in relation to suicidal ideation, self-destructive behavior, and perceived social support among individuals with substance abuse and major depressive disorder.

Hypotheses

The present study proposed that suicidal ideation, self-destructive behavior and perceived social support were distinct, but related constructs. On the basis of literature review, following hypotheses were formulated:

1. Substance abusers and patients of major depressive disorder have higher scores on scales of suicidal ideation and self destructive behavior.
2. There is a positive relationship between suicidal ideation and self-destructive behavior among substance abusers and patients with major depressive disorder.
3. Perceived social support is correlated with suicidal ideation and self-destructive behavior among substance abusers and patients with major depressive disorder.
4. Social support moderates suicidal ideation and self-destructive behavior among substance abusers and patients with major depressive disorder.
5. There is a higher level of depression among substance abusers.
6. There is a significant difference in self-destructive behavior, suicidal ideation and social support among substance abusers and patients with major depressive disorder.
7. There is a significant difference between suicidal ideation, self-destructive behavior and social support on with respect to different levels of education.

Operational Definitions of Variables

Following definitions have been adapted for current study;

Perceived Social support

For current study perceived social support has been defined as perception of "social interactions of attachment or belonging, by social integration, material, and a web of coworkers and associates" with a view to share welfare, values, and reassurance of values delivered by family, friends and colleagues (Turner, Frankel, and Levin, 1983).

Suicidal ideation

For this study suicidal ideation is defined "plans and wishes to commit suicide'' (Beck, Kovacs & Weissman, 1979).

Self-destructive behavior

Self-destructive behavior is defined as "deliberate, direct destruction or alteration in body tissue, without apparent or conscious suicidal intent but resulting in injury severe enough for tissue damage to occur" (Gratz, 2001).

Instruments

Following research instruments, along with informed consent form, were used for data collection.

A. Demographic Data Sheet

A demographic sheet containing brief description of objectives of current study along with consent form and variables such as education, profession, marital status and socio-economic status was prepared by researcher.

B. Beck Suicidal Ideation Scale (BSI) (Beck, Kovacs and Weissman, 1979)

Beck Suicidal Ideation (BSI; Beck et al., 1979) is a 19-item, interviewer-administered rating scale that measures the current intensity of patients' specific attitudes, behaviors, and plans to commit suicide. This scale quantifies various dimensions of self-destructive thoughts, wishes to die and details of suicidal plan. Each item consists of three options graded according to suicidal intensity on a 3-point scale ranging from 0 to 2. The ratings for 19 items are summed to yield a total score, ranging from 0 to 38 (Beck, Kovacs and Weissman, 1979). Individual items assess suicidal risk factors such as the duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The BSI takes approximately 10 minutes to administer. For current study, Urdu version of BSI translated by Nailah Ayub (2008) was used.

In addition to BSI, the presence of suicidal content during the major depressive disorder was investigated through the interview and psychiatric records.

C. Deliberate Self Harm Inventory (DSHI) (Gratz, 2001)

The DSHI (2001) is a 17-item, dichotomous, self-reported questionnaire that explores the direct destruction of body tissue. This scale measures direct destruction of body tissues without conscious plans for suicide. Respondents are also asked about the frequency of such events. The DSHI has internal consistency (α = .82) and adequate test-retest reliability. The participants were given "0" for "no" and "1" for "yes" on dichotomous scale of DSHI (Gratz, 2001). For current study, Urdu translation of DSHI (Riaz & Agha, 2012) was used.

D. The Provisions of Social Relations Scale (PSRS) (Turner, Frankel and Lewin, 1983)

The provisions of social relations scale (PSRS) developed by Turner, Frankel and Lewin (1983) was used to measure the social support among substance abusers and patients with major depressive disorder. This scale has 15 items which measure two aspects of perceived social support: support from family and support from friends. Friends' support is measured by items 7, 8, 10, 11, 12, 14, 15 and the second facet i.e. family support is measured by items 1, 2, 3, 4, 5, 6, 9, 13. It is a 5-point rating scale ranging from "1" (*not true*) to "5" (*very true).* The PSRS demonstrates an acceptable reliability and validity and positive correlation of two subscales (Turner et al., 1983). For current study, Urdu translation of the PSRS was used (Ayub, 2004) and it has alpha reliability coefficient 0.75.

E. Beck Depression Inventory (BDI) (Dr. Aaron T. Beck, 1961)

The Beck Depression Inventory (BDI, BDI-II), created by Dr. Aaron T. Beck, is a 21-questions, one of the most widely used instrument for measuring the severity of depression. It is a 4-point rating scale, ranging from "0" to "3", with the reliability of the BDI–II (Coefficient Alpha = .92) higher than the BDI (Coefficient Alpha = .86). For current study, the translated version of BDI-II (Farooqi, 2000) was used. The scoring range of BDI-II is from 0-63, and 0-13 is minimal range, 14-19 is mild depression, 20-28 is moderate level of depression and 29-63 indicate severe depression.

Sample

As the study targeted on the population of substance abusers and depressive patients, so the sample of the study was consisting of male participants (N=100), substance abusers (n=50) and patients of major depressive disorder (n=50). Sample was selected by utilizing convenient sampling technique. Individuals who met the sample inclusion criteria were made the part of study i.e.

a. Clinical sample of patients (already diagnosed with major depressive illness by concerned psychiatrist, in and out patients both). Specifiers with psychotic features, in partial remission, in full remission and unspecified were excluded from the sample. Patients with a diagnosis of DSM-V bipolar I or II disorder, schizoaffective disorder, schizophrenia or another non-affective psychosis, organic disorder, were also excluded from the study, even if they fulfilled the symptom criteria of current major depressive episode.
b. Substance abusers who had been involved in excessive use of a drug without a medical justification and are taking treatment or consultations at any rehabilitation center for not more than a month. Only those individuals were included who never consulted a psychiatrist for some disorder, as per informed by their family.
c. Sample also required the participants between the age ranges 20-50 years and education level should be above middle level.

Different psychiatric departments of hospitals and rehabilitation centers from Islamabad and Rawalpindi were approached for data collection. These include Benazir Bhutto General Hospital, National Institute of Rehabilitation Medicine, Salamat Clinic

and Rehabilitation Center and Wadah Clinic, Rawalpindi. Demographic variables considered for the study were socio-economic status, profession, marital status and qualification.

Procedure

Prior to data collection, approval for data collection was gained from concerned authorities of the head of psychiatric departments and rehabilitation centers. After the approval, a meeting was held with the concerned consultant and objectives of the study were discussed. With the permission of authorities, psychiatric files of patients were viewed to select the participants for study. Then the participants were informed about confidentiality and were requested to sign a written consent form to participate in the research. Then all the four scales along with demographic data sheet; Beck suicidal Ideation Scale, Beck Depression Inventory, the Provisions of Social Relations Scale, and Self-harm Inventory, were administered to participants. Proper instructions and guidance was provided to the participants about filling out the scales. On the whole participants took 35-40 minutes to complete the booklet of scales, in some cases time exceeded.

After data collection, all data was entered in Statistical Package for Social Sciences (SPSS) version 20, analysis were carried out. Scores of scales were analyzed for mean, standard deviation, correlation, regression and moderation models. Independent sample t-test was also run to check the mean difference among two samples on selected variables. After running basic and advance analysis on data, results were compiled and tables were generated according to American Psychological Association (APA) 6th edition. Then results were discussed with supporting literature and suggestions were made for further research in the targeted area.

CHAPTER III

RESULTS

The goal of the study was to investigate the prevalence and association between social support, suicidal ideation and self-destructive behavior among substance abusers and patients major depressive disorder. The study was also aimed at exploring the moderating role of social support on suicidal thoughts and self-destructive behaviors. For this purpose, data was collected from the population of substance abusers and patients of major depressive disorder in order to compare them across the targeted variables i.e. social support, suicidal ideation and self-destructive behavior. This chapter summarizes and presents the findings of study in tabular form. Each table follows an interpretation of different values and their significance level.

Table 1: *Frequencies and percentage of demographic variables i.e. sample type, marital status, education, occupation, monthly income and smoker/non-smokers (N=100)*

Demographic Variables		*f*	%
Sample Type			
	Substance Abusers	50	50
	Depressive Patients	50	50
Marital Status			
	Un-married	40	40
	Married	60	60
Education			
	Up to Metric	47	47
	Intermediate	30	30
	Graduation and Masters	23	23
Occupation			
	Unemployed	12	12
	Laborer	57	57
	Non-laborer	31	31
Monthly Income			
	No income	12	12
	10000-15000	45	45
	16000-20000	29	29
	21000-25000	11	11
	25000 above	3	3
Smokers/non-smokers			
	Smokers	78	78
	Non-Smokers	22	22

Table 1 illustrates the frequencies and percentage of demographic variables of the present study. With respect to sample type, both substance abusers and patients with major depressive disorder are equal in number. With respect to marital status, married participants are in larger proportion (n=60) as compared to unmarried participants (n=40). Further, most of the participants have up to metric level of education (n=47) and

most of the participants (n=57) are falling into laborer work with respect to occupation. With respect to monthly income, participants with a range of 10000-15000 are in higher in proportion (n=45). Most of the participants of the sample are smoker (n=78).

Table 2: *Alpha reliabilities of Beck Scale for Suicidal Ideation (BSSI), Deliberate Self-harm (DSH), Beck Depression Inventory (BDI), and Provisions of Social Relations Scale (PSRS), and its subscales i.e. Family Support, Friends Support, (N=100)*

Scale/Subscales	No. of items	*Cronbach's Reliability Coefficient*
BSSI	19	.80
DSH	17	.54
BDI	21	.80
PSRS	15	.91
Family Support Subscale	8	.83
Friends Support Subscale	7	.81

Note: BSSI= Beck Scale for Suicidal Ideation, DSH=Deliberate Self-harm, BDI= Beck Depression Inventory, PSRS= Provisions of Social Relations Scale.

Table 2 shows alpha reliabilities for study scales and subscales. The reliabilities come out to be .80, .54, .80, .91, .83, and .81 for Beck Scale for Suicidal Ideation, Deliberate Self-Harm Inventory, Beck Depression Inventory, Provisions of Social Relation Scale and its subscales i.e. Family Support Subscale and Friends Support Subscale respectively. All the scales have satisfactory reliability coefficient except for Deliberate Self-harm Inventory.

Table 3: *Descriptives, Skewness, Kurtosis, Actual and Potential Scores for Beck Scale for Suicidal Ideation (BSSI), Provisions of Social Relations Scale (PSRS), Family Support, Friends Support, Deliberate Self-harm (DSH), and Beck Depression Inventory (100)*

Scale	*M*	SD	Skewness	Kurtosis	Actual Score	Potential Score
TBSSI	10.74	5.30	.88	1.32	1-28	0-38
TPSRS	46.63	10.74	-.42	-.55	22-70	15-75
Family Support	25.0	5.96	-.41	-.54	10-38	8-40
Friends Support	21.63	5.13	-.32	-.51	10-33	7-35
TDSH	6.04	2.44	.05	-.09	1-12	0-17
BDI	20.37	7.59	.72	.62	7-44	0-63

Note: BSSI= Beck Suicidal Ideation Scale, DSH= Deliberate Self-harm, PSRS=Provisions of Social Relations Scale, BDI=Beck Depression Inventory.

Table 3 shows the mean scores, standard deviation, skewness, kurtosis, actual scores and potential scores for the scales for overall data. The table values indicate that Provisions of Social relation Scale has the highest mean value for the complete sample and the values of skewness and kurtosis show a normal distribution of the data.

Table 4: *Correlation Matrix of Scores of Deliberate Self-harm (DSH), Beck Scale for Suicidal Ideation (BSSI), Provisions of Social Relations Scale (PSRS), Family Support, friends Support and Beck Depression Inventory (BDI), (N=100)*

Scale	DSH	BSSI	PSRS	Family Support	Friends Support	BDI
DSH	-					
BSSI	.43**	-				
PSRS	.60**	.49**	-			
Family Support	.57**	.46**	.97**	-		
Friends Support	.60**	.50**	.96**	.87**	-	
BDI	.25*	.22*	.16	.09	.22*	-

Note BSSI= Beck Suicidal Ideation Scale, DSH= Deliberate Self-harm, PSRS=Provisions of Social Relations Scale, BDI=Beck Depression Inventory.

*$p<.05$, **$p<.01$

Table 4 shows that there is strong correlation between DSH and BSSI (*r= .43, p □.01),* DSH and PSRS (*r*=.60, *p<.01),* DSH and Family Support (*r=.57, p<.01),* DSH and Friends Support (*r=.60, p<.01)* and DSH and BDI (*r*=.25, *p<.05).* It also indicates a strong relationship between BSSI and PSRS *(r=.49, p<.01)*, BSSI and Family Support *(r=.46, p<.01),* BSSI and Friends Support *(r=.50, p<.01),* and BSSI and BDI *(r=.22, p<.05).* It is also observed from the table that there exist a strong correlation between PSRS and its subscales i.e. family Support and friends support *(r=.97, r=.96, p<.01).* Table values also indicate that correlation between BDI and friends support *(r=.22*, p<.05)*, whereas, correlation between BDI and PSRS (*r=.16)* and BDI and family Support *(r=.09)* is not significant.

Table 5: *Stepwise regression analysis indicating the moderating role of social support on deliberate self-harm and suicidal ideation among substance abusers and patients with major depressive disorder (N=100)*

Model	Variables	*B*	*SE*	*β*	*t*	*p*
1	(Constant)	5.137	1.290			
	DSH	.928	.198	.428	4.683	0.000
2	Constant	-.496	2.05			
	DSH	.440	.236	.203	1.864	0.06
	PSRS	.184	.054	.373	3.426	0.01
3	Constant	-2.394	5.135			
	DSH	.813	.956	.375	.851	.39
	PSRS	.226	.116	.457	1.939	.05
	Interaction	-.008	0.19	-.236	-.403	.688

Note; DSH= Deliberate Self-harm, PSRS= Provisions of Social Relations Scale, interaction= DSH*PSRS

$R=.428$, $R^2=.183$, Adjusted $R^2=.175$, $\Delta R^2=.183$ for step 1
$R=.521$, $R^2=.271$, Adjusted $R^2=.256$, $\Delta R^2=.088$ for step 2
$R=.522$, $R^{2=}272$, Adjusted $R^2=.250$, $\Delta R^2=0.001$ for step 3

Table 5 shows the regression analysis for predicting the role of social support as moderator of deliberate self-harm and suicidal ideation among the sample of substance abusers and depressive patients. It is evident from the table that only 27.1% of variance is explained towards suicidal ideation on model 2, whereas 27.2% of variance is explained towards the interaction of suicidal ideation and deliberate self-harm by social support. The findings indicate that social support does not moderate the interaction of deliberate self-harm and suicidal ideation among substance abusers and patients with major depressive disorder.

Table 6: *Mean, standard deviation and t-values on scores of BSSI, DSH, PSRS and BDI between substance abusers and patients of Major Depressive disorder (N=100)*

Scales	Sample Type: Substance Abusers (*n=50*)		Patients of MDD (*n=50*)				*95% CI*		*Cohen's d*
	M	*SD*	*M*	*SD*	*t(98)*	*p*	*LL*	*UL*	
BSSI	12.04	5.34	9.44	4.98	2.51	.01	.55	4.65	0.50
DSH	6.74	1.92	5.34	2.72	2.97	.004	.47	2.33	0.59
PSRS	49.04	10.25	44.22	10.77	2.29	.02	.65	8.99	0.46
BDI	17.36	6.58	23.38	7.40	-4.29	.000	-.8.80	-.3.24	0.86

Note BSSI= Beck Suicidal Ideation Scale, DSH= Deliberate Self-harm, PSRS=Provisions of Social Relations Scale, BDI=Beck Depression Inventory.

Table 6 shows the mean, standard deviation and t-values on the total scores of BSSI, DSH, and BDI between substance abusers and patients with major depressive disorder. Values in the table 6 show that the two groups differ significantly on the scores of BSSI, DSH, PSRS, and BDI. Substance abusers show significantly high mean and standard deviation value for BSSI (*M=12.04, SD=5.34),* DSH (*M=6.74, SD=1.92)* than patients with major depressive disorder. Whereas patients with MDD were significantly high on mean and standard deviation values of BDI (*M=23.38, SD=7.4).*

Table 7: *Mean, standard deviation and t-values on scores of BSSI, DSH, PSRS and BDI between married and un-married groups of sample (N=100)*

Scales	Marital Status								
	Married (n=60)		Un-married (n=40)				*95% CI*		*Cohen's d*
	M	*SD*	*M*	*SD*	*t(98)*	*p*	*LL*	*UL*	
BSSI	10.08	5.14	11.73	5.45	1.526	.13	-.49	3.77	0.31
DSH	5.77	2.46	6.45	2.38	1.37	.17	-.30	1.67	0.28
PSRS	45.63	12.03	48.13	8.37	1.138	.25	-1.85	6.84	0.24
BDI	19.58	6.94	21.55	8.45	1.272	.206	-1.102	5.035	0.25

Note BSSI= Beck Suicidal Ideation Scale, DSH= Deliberate Self-harm, PSRS=Provisions of Social Relations Scale, BDI=Beck Depression Inventory.

Table 7 shows the mean, standard deviation and t-values on the total scores of BSSI, DSH, and BDI between married and unmarried groups of sample. Results in the table 7 indicate that the two groups do not differ significantly on score of BSSI, DSH, PSRS and BDI. The participants do not significantly differ on the values of mean and standard deviation on all variables of study with respect to marital status.

Table 8: *Mean, standard deviation and t-values on scores of BSSI, DSH, PSRS and BDI between smokers and non-smokers groups of sample (N=100)*

Scales	Smokers (n=78)		Non-smoker (n=22)				*95% CI*		*Cohen's d*
	M	*SD*	*M*	*SD*	*t(98)*	*p*	*LL*	*UL*	
BSSI	11.03	5.30	9.73	5.28	1.01	.31	-1.24	3.83	0.24
DSH	6.27	2.202	5.23	3.08	1.78	.07	-.177	2.20	0.38
PSRS	47.18	10.46	44.68	11.72	.963	.338	-2.649	7.64	0.22
BDI	19.59	6.90	23.14	9.32	1.96	.05	-7.13	0.43	0.43

Note BSSI= Beck Suicidal Ideation Scale, DSH= Deliberate Self-harm, PSRS=Provisions of Social Relations Scale, BDI=Beck Depression Inventory.

Table 8 shows the mean, standard deviation and t-values on the total scores of BSSI, DSH, and BDI between smokers and non-smokers groups of sample. Results in the table 8 indicate that the two groups do not differ significantly on score of BSSI, DSH and PSRS. The non-smokers have relatively high scores on mean and standard deviation on BDI (*M=23.14, SD=9.32)* as compare to smokers (*M=19.59, SD=6.9).*

Table 9: *Cross tabulation between Substance abusers and patients with Major Depressive Disorder in relation to BDI with Chi-Square (N=100)*

	Substance Abusers (n=50)	Patients with MDD (n=50)		
Level of Depression	*f (%)*	*f (%)*	χ^2 (3)	*p*
Minimal Range	16 (80)	4(20)		
Mild Depression	20(69)	9(31)	23.58	0.00
Moderate Level of Depression	8(21.6)	29(78.4)		
Severe Depression	6(42.4)	37(57.1)		

Note: MDD= Major Depressive Disorder

The table 9 indicates the cross tabulation between substance abusers and patients of major depressive disorder in relation to co-morbidity on ranges of depression. In minimal range of scores on BDI substance abusers are (80%) whereas, depressive patients are (20%). On mild category of depression substance abusers are 69% and patients with MDD are 31%. Patients with MDD are high on moderate level of depression (78.4%) and severe depression (57.1%) as compared to substance abusers. The value of chi-square (χ^2 (3)=23.58, $p<.001$) is significant and results reflects that patients with MDD have higher scores in moderate and severe ranges of depression.

Table 10: *Cross tabulation between substance abusers and patients with Major Depressive Disorder in relation to social support with chi-square (N=100)*

Social Support	Substance Abusers (n=50) *f(%)*	Patients with MDD (n=50) *f(%)*	Total	χ^2 (1)	*p*
High Social Support	18(38.3)	29(61.7)	47	4.86	.02
Low Social Support	32(60.4)	21(39.6)	53		

The table 10 shows the cross tabulation between substance abusers and patients with major depressive disorder in relation to social support. Table values indicate that participants with low social support are high (n=53) as compared to participants with high social support (n=47). It is also evident from the table that patients with MDD are high in number (61.7%) as compared to substance abusers (38.3%) on high social support. Whereas, substance abusers are high (60.4%) on low social support as compared to patients with MDD (39.6%). The value of chi-square (χ^2 (1) =4.86, p<.05) is significant and results indicate that patients with MDD are higher in perceived social support.

Table 11: *One way Analysis of Variance (ANOVA) for up-to metric, intermediate, graduation & masters groups of sample on Beck Scale for Suicidal Ideation (BSSI), Deliberate Self-harm (DSH), Provisions of Social Relations Scale (PSRS), Beck Depression Inventory (BDI), (N=100)*

	1 Up-to Metric (n=47)		2 Intermediate (n=30)		3 Graduation & Masters (n=23)				
Scales	Mean	SD	Mean	SD	Mean	SD	F	*p*	Post hoc
BSSI	12.06	5.8	10.27	5.1	8.65	3.5	3.5	.03	1>2, 1>3
DSH	6.74	2.3	6.0	2.32	4.65	2.4	6.3	.003	1>2, 1>3
PSRS	48.09	11.6	47.0	9.21	43.17	10.4	1.7	.19	
BDI	20.19	7.4	22.07	7.7	18.52	7.7	1.4	.24	

df=2, 97

The table 11 shows that participants of these three different educational groups differ significantly on BSSI scores F (2, 97) = 3.5, $p < .05$, on DSH scores F (2, 97) = 6.3, $p<.01$. Whereas, these three educational groups do not differ significantly on PSRS scores F (2, 97) = 1.7, p=.19, and BDI scores F (2, 97) = 1.4, p=.24. These results indicate that the prevalence of suicidal ideation, self-harm and social support is different among these educational groups. The findings of post hoc analysis also support these results.

Table 12: *One way Analysis of Variance (ANOVA) for unemployed, laborer, and non-laborer groups of sample on Beck Scale for Suicidal Ideation (BSSI), Deliberate Self-harm (DSH), Provisions of Social Relations Scale (PSRS), Beck Depression Inventory (BDI), (N=100)*

	1 Unemployed (n=12)		2 Labourer (n=57)		3 Non-labourer (n=31)				
Scales	Mean	SD	Mean	SD	Mean	SD	F	*p*	Post hoc
BSSI	11.33	6.9	11.26	5.6	9.55	3.69	1.13	.32	
DSH	4.17	2.8	6.54	2.0	5.84	2.7	5.25	.007	2>1, 2>3
PSRS	44.25	13.1	48.02	11.1	45.00	8.91	1.13	.32	
BDI	19.50	6.1	20.65	7.3	20.19	8.7	.12	.88	

df=2,97

The table 12 shows that participants of these three groups on the basis of occupation do not differ significantly on BSSI scores $F\ (2, 97) = 1.13$, $p=.32$, on PSRS scores $F\ (2, 97) = 1.13$, $p=.32$ and on BDI scores $F(2, 97)= .12$, $p=.12$. Whereas, these three groups differ significantly on DSH scores $F\ (2, 97) = 5.25$, $p<.05$. These results indicate that the prevalence of self-harm is different among these occupational groups. The findings of post hoc analysis also support these results.

CHAPTER-IV

DISCUSSION

Suicidal ideation and deliberate self-destructive behaviors are strongest predictor of future suicide attempt among psychiatric population. Individuals with psychiatric illness, specially substance abuse disorders and depression, are at high risk for suicidal behavior and deliberate self-destruction. Research studies showed that substance dependence is related with high risk for suicidal ideation i.e. thoughts about killing oneself (Grant and Hasin, 1999) and coexistence of depression increases the risks for such behaviors. Thus, the purpose of current study was to identify the prevalence of suicidal ideation and self-harming behaviors among substance abusers and patients with depressive illness. It also focused on identification of association between self-harm and suicidal thoughts and their relation with major depressive disorder. The study further investigated the moderating role of social support and its subscales, i.e. family support and friends, support on self-harming behavior and suicidal thoughts among targeted sample. For this purpose, data was collected from different psychiatric departments of hospitals and rehabilitation centers. Findings were analyzed and presented in tabular form.

The present study employed a set of self reported measures which include Beck Scale for Suicidal Ideation (BSSI; Beck, Kovacs and Weissman, 1979), Deliberate Self-Harm Inventory (DSHI; Gratz, 2001), Provisions of Social Relations Scale (PSRS; Turner, Frankel and Lewin, 1983), and Beck Depression Inventory (BDI; Aaron T. Beck,

1961). Urdu translations of all these scales were used for current study. For hypothesis testing purpose, the data was collected from 100 respondents of Rawalpindi and Islamabad. These respondents include 50 substance abusers and 50 depressive patients.

Cronbach's alpha reliability coefficients were used to examine the reliabilities of Urdu translation of study measures. The Cronbach's alpha reliability estimates of all scales were in satisfactory range for present study. However, the reliability coefficient for Deliberate Self-harm Inventory (DSH) was found to be slightly low (.535) but it was near to accepted cutoff of reliability (i.e. .70).

After examining the reliabilities of study instruments, the main phase of current study involved hypothesis testing. It was assumed in first and second hypothesis that there will be a significant prevalence of suicidal ideation, self-destructive behavior and depression among substance abusers and patients with Major Depressive Disorder (MDD). As hypothesized, a significant level of these constructs was observed between substance abusers and patients of MDD. These findings are consistent with previous literature. A research findings show self-injurious behavior and suicidal ideation were about 13.1% and 50.7% among patients of alcohol and other drug (Al-Sharqi, Sherra, Al-Habib, & Al-Qureshi, 2012) . In another drug abuser based survey conducted by Landheim, Bakken and Vaglum (2006) higher (47%) suicide attempts were reported and multi-substance abusers were high in ratio (58%) than to alcohol abusers (38%). In Saudi Arabia, a cross-sectional study was conducted to check the prevalence of self-harming behaviors and suicide related behaviors among patients of MDD. In this study, 557 patients were assessed on Columbia suicide severity rating scale and was reported that

47.2% of participants were with suicidal thoughts and 7.7% of participants with self-harm without suicidal intent (Al-Habeeb, Sherra, Al-Sharqi, & Qureshi, 2013).

The study also assumed in third hypothesis that suicidal ideation will be positively correlated with self-destructive behavior among substance abusers and depressive patients. According to the findings of current study, a positive correlation was observed between suicidal ideation and self-destructive behavior (i.e. r=.428). Consistent researches have been reported by the literature in favor of this finding (Asarnow, Porta, Spirito, Emslie, Clarke, Wagner, et al., 2011; Glenn & Klonsky, 2009; Nock, Joiner, Gordon, Lloyd-Richardson, Prinstein, 2006). In a recent longitudinal study, 4799 participants were assessed on self-harm with suicidal intentions and without suicidal intention among adolescents. It was found that there were increased risks of major depressive disorder among individuals who harmed themselves and had suicidal thoughts. The association between self-harm and suicidal thoughts was high along with depressive illness (Mars, Heron, Crane, Hawton, Kidger, Lewis, Macleod, Tilling, & Gunnell, 2014).

Social support was also observed to be associated significantly with deliberate self-harm and suicidal ideation but only family support (a subscale of PSRS) was significantly correlated with depression. These findings are supported by a research by Stice, Ragan, and Randall (2004) conducted to identify the perspective relationship between social support and depression on a sample of adolescents girls (N=496). According to this study, arrears in familial support predict the onset of depression or increase in depressive illness whereas peer/ friends support do not significantly predict increase in depressive illness.

The core objective of this study was to explore the model which would explain the association and direction of the effects of social support towards self-destructive behavior and suicidal ideation among substance abusers and patients with major depressive disorder. The moderating model suggests that social support do not plays a moderating role between self-harming behavior and suicidal thoughts and these results are in accordance with many other research studies in which social support was reported as an important coping strategy (Caplan, 1974; Hobfoll, & London, 1986; Eskin, 1995). These findings are supported by many studies suggesting that an ample amount of social support may twirl into a "Bear Hug", reducing the perceived health and ultimately increasing stress. It may also reduce the sense of control and sense of responsibility (Rook, 1984; Ayalon, 1983; Halim, 1982), that is important in controlling suicidal thoughts and self-harming behavior. Pakistani culture encourages nuclear family system and a strong familial network which is reflected in the form of perceived social support by individuals. Social support plays a role in determining the perceived quality of health in Pakistan. Substance abusers and patients with major depressive disorder perceive that support, by family members and friends, is a source of comfort for them and it is only available to them when they are in distressful condition (mentally distressed). They communicate their mental distress by behavioral responses e.g. hurting themselves or by communicating their suicidal thoughts, to friends and family, to seek their attention and care. Hence, social support may serve as a source of potential pleasure instead of moderation resource.

To check the co-morbidity of substance abuse and major depressive disorder, it was also presumed that there will be a significant range of depression among substance

abusers. The analysis of the score of Beck Depression Inventory (BDI) depicted that a significant range of co-morbid cases of substance abusers and depressive patients. These findings accepted study hypothesis that there may exist co-morbidity between depression and substance abuse. This co-morbidity may arise through a number of possible associations between substance abuse and depression, e.g. substance abuse may proceeds depressive illness or substance abuse may be a cause for developing depression or both could arise from a common vulnerability (Hovens, Cantwell, & Kiriakos, 1994; Volkow, 2004). It was reported that almost 1/3 of patients of major depressive disorder also have substance use related disorder, and the existence of co-morbidity increases the risks suicide attempts and socio-occupational impairments (Devis, Uezato, Newell, & Frazier, 2008). Furthermore, it was hypothesized for the current study that a significant difference will exist on suicidal ideation, deliberate self-harm, social support and depression among substance abusers and patients of MDD. The study findings supported the hypothesis because all the study variables were differing significantly among substance abusers and patients of MDD. The study also explored that there is a significant difference among smokers and non-smokers on depression level. This finding is in-line with a study, conducted to check the differences between smokers and non-smokers on depression scale indicated that smokers were significantly high on the scores of depression scale as compared to non-smokers (Wise, Weidner, & Preussler, 2004).

Conclusion

The present study found out that social support, suicidal ideation, and deliberate self-destructive behavior are positively correlated with each other among substance abusers and patients of MDD. While, there is a significant difference in suicidal ideation, self-harm and social support among substance abusers and patients of MDD. Research also shows that smoker participants have higher scores on depression and self-injury scales. It was also found in this study that social support do not moderate the effects of suicidal thoughts and self-harming behaviors, rather it serves as a source of potential pleasure among substance abusers and patients of MDD.

Limitations and Suggestions

The present study may add important thoughtful information to the existing literature in relevant field, but still it has some limitations. The study sample purposely selected on the basis of suicidal ideation and self-destructive behavior from a clinical population of substance abusers and patients of major depression. So in clinical setup very individuals were approached which does not support the generalization of results to the clinical population. Secondly, no past psychiatric history of suicidal ideation or other psychiatric disorders and family history of mood disorders were obtained at the stage of data collection. Such as sample may produce skewed prevalence rates of suicidal ideation or depression.

Only those participants were included in the in present study who volunteered for their consent to participate and who completed the questionnaires. Data collected from

only two cities of Pakistan, which may also limit the generalization of findings. Inclusion of more sample from the different areas can give better results.

Implications

Besides these limitations, the findings of the present study will add to the existing literature about the moderating role of social support in suicidal ideation and self-destructive behavior among substance abusers and depressive patients in Pakistani context. The findings of the present study will also help the practitioners and psychologists, working with patients of suicidal thoughts and self-destructive behavior, to educate family and friends to enhance their understanding about the effect of social support on illness of patient. Further, there is a substantial need for additional research and development of specific interventions aiming to decrease suicidal ideation and self-destructive behaviors for targeted population. It is also advised to investigate the role of seeking attention or other reasons detected from the presence research to enhance authenticity of assumptions made.

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Annexure

Annexure E

شعبہ نفسیات، انٹرنیشنل اسلامک یونیورسٹی، اسلام آباد ایک ایسا شعبہ ہے جو تعلیم و تدریس کے علاوہ انسانی و معاشرتی نفسیات سے متعلق مختلف موضوعات اور مسائل پر تحقیق کرتا ہے۔

اس تحقیق کا مقصد یہ جاننا ہے کہ آپ کو اپنے اندر خود اذیتی اور خودکشی کی خواہشات کے بارے میں کہاں تک خود آگاہی ہے۔ اور آپ کے عزیز و اقارب، والدین اور دوستوں کے تعلقات آپ کے ساتھ کیسے ہیں۔ اس سلسلے میں ہم نے مختلف بیانات مرتب کئے ہیں۔ یہ بیانات علیحدہ حصوں پر مشتمل ہیں۔ یہ بیانات آپ کی ذات سے تعلق رکھتے ہیں۔ برائے مہربانی ان بیانات پر مشتمل حصوں کا ترتیب وار جواب دیں اور ہر حصے کے بیانات کا جواب دینے سے پہلے اس کی ہدایات کو غور سے پڑھیں۔ کسی بھی حصے کے کسی بھی بیان کو خالی نہ چھوڑیں۔

ہم آپ کو مکمل یقین دلاتے ہیں کہ آپ کی دی گئی تمام معلومات کو صیغہ راز میں رکھے جائے گا اور ان کو صرف تحقیقی مقاصد کے لئے استعمال کیا جائے گا۔

ہم آپ کے تعاون کے بے حد مشکور ہیں۔

تحقیق کنندہ

صدف ریاض

شعبہ نفسیات

انٹرنیشنل اسلامک یونیورسٹی اسلام آباد

Annexure F

نام _____ تعلیم _____

پیشہ _____ شادی شدہ/غیر شادی شدہ _____

ماہانہ آمدنی _____

کیا آپ سگریٹ نوشی کرتے ہیں۔ ہاں/نہیں

اگر ہاں تو روزانہ کتنے سگریٹ پیتے ہیں۔

دستخط _____

خودکشی کے تصور (خیال) کی جانچ کا پیمانہ (Beck Scale for Suicidal Ideation)

سوالنامے کا آخری حصہ ان سوالات پر مبنی ہے جس سے ہمیں پتہ چلے گا کہ کبھی حالات کی بنا پر آپ کو خیال آئے کہ آپ زندگی کی نسبت مر جانے کو ترجیح دیں گے تو ایسے میں آپ کے خیال کے مطابق آپ کا طرز عمل کیا ہوگا؟

ہر بیان کے لئے کسی ایک جواب پر نشان لگائیں۔ برائے مہربانی کسی بھی بیان کے لئے ایک سے زیادہ جواب کا انتخاب نہ کریں۔

۱۔ زندہ رہنے کی خواہش: ۱۔ درمیانی سے شدید ۲۔ کمزور ۳۔ نہیں ہے

۲۔ مرنے کی خواہش: ۱۔ درمیانی سے شدید ۲۔ کمزور ۳۔ نہیں ہے

۳۔ زندگی یا موت کا جواز: ۱۔ زندہ رہنا موت پر حاوی ہے ۲۔ دونوں برابر ہیں ۳۔ مرنا زندگی پر حاوی لگتا ہے

۴۔ خودکشی کرنے کی خواہش: ۱۔ نہیں ہے ۲۔ کمزور ۳۔ درمیانی سے شدید

۵۔ غیر ارادی خودکشی کی کوشش کی صورت میں: ۱۔ زندگی بچانے کے لئے احتیاطی اقدام کروں گا۔
۲۔ زندگی یا موت کو قسمت پر چھوڑ دوں گا
۳۔ زندگی بچانے یا اس کی بقا کے لئے ضروری اقدامات سے گریز کروں گا (مثلاً ذیابیطس (شوگر) میں انسولین یا دوا کا لینا ترک کر دینا)

نوٹ: اگر سوال نمبر ۴ اور ۵ دونوں کا جواب (۱) دیا ہے تو بقیہ سوالات چھوڑ دیں۔

۶۔ خودکشی کے تصور یا خواہش کا دورانیہ: ۱۔ مختصر یا سرسری (چند لمحات) ۲۔ نسبتاً طویل (کئی گھنٹے) ۳۔ مسلسل (متواتر) یا مستقل (کئی دن)

۷۔ خودکشی کے تصور یا خواہش کی کثرت: ۱۔ کبھی کبھار (بسا اوقات) یا ایک دو دفعہ خیال آنا ۲۔ وقتاً فوقتاً خیال آنا ۳۔ مستقل یا مسلسل خیال رہنا

۸۔ خودکشی کی خواہش یا تصور کی طرف رویہ: ۱۔ رد کر دینا ۲۔ غیر فیصلہ کن (لاتعلق) ۳۔ قبول کرنا

۹۔ خودکشی کی خواہش یا اقدام خودکشی پر قابو پانے کی صلاحیت: ۱۔ ضبط (کنٹرول) کا احساس ہے ۲۔ ضبط (کنٹرول) کا یقین نہیں ہے
۳۔ کوئی کنٹرول یا ضبط نہیں ہے

۱۰۔خودکشی کا عمل کرنے کی کوشش سے روکنے والی وجوہات (مثلاً خاندان، مذہب، ناکامی کی صورت میں شدید چوٹ، موت کی صورت میں ناقابل واپسی راستہ):

۱۔ان وجوہات کی بنا پر خودکشی نہیں کروں گا۔
۲۔ان وجوہات کا کچھ لحاظ ہے۔
۳۔ان وجوہات کی بہت کم یا بالکل پرواہ نہیں ہے

۱۱۔منصوبہ بندی کے تحت خودکشی کے خیال کی وجوہات: ۱۔ماحول پر اثر انداز ہونا، توجہ حاصل کرنا، انتقام ۲۔(۱) اور (۳) دونوں ۳۔فرار، مسائل کا حل، موت

۱۲۔سوچی سمجھی کوشش کے لئے منصوبہ بندی یا طریقہ کار: ۱۔سوچا نہیں ۲۔سوچا لیکن تفصیلات پر کام نہیں کیا ۳۔اچھی طرح منصوبہ بندی کر لی

۱۳۔طریقہ کار کا موجود ہونا یا موقع ملنا: ۱۔طریقہ کار موجود نہ ہونا یا موقع نہ ملنا ۲۔طریقہ پانے میں وقت لگے گا، موقع فی الحال میسر نہیں
۳۔طریقہ اور موقع دونوں میسر ہیں، یا مستقبل میں مل جائیں گے

۱۴۔خودکشی کی کوشش کرنے کی صلاحیت کا احساس: ۱۔ہمت نہیں، کمزور، خوفزدہ، قابل نہیں ۲۔حوصلے اور صلاحیت کے بارے میں یقین نہیں
۳۔حوصلے اور صلاحیت کا یقین ہے

۱۵۔عملی کوشش کرنے کا امکان یا پیش بندی: ۱۔نہیں ایسا ہرگز نہیں ہوگا ۲۔یقین نہیں، معلوم نہیں ۳۔ہاں کافی حد تک یقین ہے

۱۶۔ممکنہ کوشش کی درحقیقت تیاری: ۱۔کوئی تیاری نہیں ۲۔تھوڑی بہت (مثلاً دوا یا زہر جمع کرنا شروع کرنا) ۳۔مکمل بھرپور تیاری (دوا کا موجود ہونا، بلیڈ یا بھری ہوئی بندوق)

۱۷۔خودکشی کے بارے میں تحریر یا ڈائری لکھنا: ۱۔کوئی نہیں ۲۔شروع کی مگر مکمل نہیں کی، اس کے متعلق سوچا تھا ۳۔مکمل کی تھی

۱۸۔موت کی توقع کرتے ہوئے حتمی کام (مثلاً بیمہ، وصیت، تحائف): ۱۔کوئی نہیں ۲۔سوچا تھا یا کچھ انتظامات کئے تھے
۳۔مکمل منصوبہ بنایا تھا یا مکمل انتظامات کئے تھے (یقینی منصوبہ بندی کر لی تھی)

۱۹۔دھوکہ دہی یا سوچی سمجھی کوشش کو چھپانا (خودکشی کے خیال کو لوگوں تک پہنچانے کے حوالے سے): ۱۔کھل کر اظہار کیا ۲۔اظہار سے اجتناب کیا
۳۔دھوکہ دینے، چھپانے یا جھوٹ بولنے کی کوشش کی

ارادی خُود اَذیّتی کا سوالنامہ

یہ سوال نامہ اُن مختلف طریقوں کے مُتعلق ہے جنہیں لوگ خود کو اَذیّت دینے کیلئے کبھی کبھار استعمال کرتے ہیں۔ براہِ کرم ہر سوال کو توجہ سے پڑھیں اور ایمانداری سے اِس کا جواب دیں۔ لوگ اکثر مختلف وجوہات کی بنا پر اپنے خود اذیتی کے عمل کو راز رکھتے ہیں۔ لیکن آپ کے سچے جوابات نہ صرف ہمیں اِس عمل کو بہتر طور پر جاننے اور سمجھنے میں مدد دیں گے بلکہ اِس سے دو چار لوگوں کی بہترین مدد کرنے میں بھی مُعاون ثابت ہونگے۔ کسی بھی سوال کا جواب ''جی ہاں'' میں صرف اُس صورت میں دیں جب آپ نے وہ عمل اِرادۃً یا جانتے بُوجھتے ہوئے کیا ہو۔ اگر کوئی عمل حادثاتی طور پر آپ سے سرزد ہوا ہو (مثلاً آپ پھسل گئیں اور آپ کا سر بُری طرح سے کسی شے سے ٹکرا گیا) تو ''جی ہاں'' میں جواب نہ دیں۔ یہ اِطمینان رکھیں کہ آپ کے تمام جوابات کو راز رکھا جائے گا۔

1۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی کلائی، بازو یا جسم کے کسی اور حصے کو کاٹا ہے (اپنی جان لینے کے ارادے کے بغیر)؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر ''جی ہاں''

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

2۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) خود کو سگریٹ سے جلایا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر ''جی ہاں''

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

3۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) خود کو لائٹر یا ماچس سے جلایا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟----------

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم)----------

- آپ نے آخری بار یہ عمل کب کیا تھا؟----------

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے----------

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟----------

4۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جلد پر الفاظ تراشے ہیں؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟----------

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم)----------

- آپ نے آخری بار یہ عمل کب کیا تھا؟----------

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتی رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے----------

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟----------

5۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جلد پر تصاویر، نقش و نگار یا کوئی نشانات تراشے ہیں؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟----------

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم)----------

- آپ نے آخری بار یہ عمل کب کیا تھا؟----------

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟----------

6۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) خود کو اِس بُری طرح سے نوچا ہے کہ زخموں کے نِشان پڑ گئے یا خون بہہ نکلا؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

7۔کیا آپ نے کبھی ارادۃً (یعنی کہ جانتے بُوجھتے ہوئے) خود کو (دانتوں سے) ایسے کاٹا ہے کہ آپ کی جِلد پھٹ گئی ہو؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

8۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنے جسم پر ریگ مال رگڑا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

9۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جلد پر تیزاب ٹپکایا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

10۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جلد کو صاف کرنے کیلئے بلیچ یا اوون کلینر کا استعمال کیا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

11۔کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جلد میں تیز دھار اَشیاء جیسے سوئیاں، کھُونٹیاں یا اسٹیپلر کی پِنیں وغیرہ گھونپی ہیں؟ (اِس میں جسم پر کندہ کیے جانے والے نِشان (ٹیٹُو)، کانوں کا چھیدنا، نَشے کیلئے اِستعمال ہونے والی سوئیاں یا جسم کا چھیدنا شامل نہیں ہے)۔کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

-جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____

- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____

- آپ نے آخری بار یہ عمل کب کیا تھا؟ _____

- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

12۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی جِلد پر شیشہ رَگڑا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چُکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

13۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنی ہی ہڈّیاں توڑ ڈالیں؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چُکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

14۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنا سَر کسی شَے سے اِس شدّت سے مارا ہے کہ زَخم آ گیا ہو؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چُکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____

- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

15۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) اپنے آپ کو اِس زور سے گھُونسا مارا ہے کہ زخم آ گیا؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

16۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) زخموں کو بھرنے سے روکا ہے؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی اصل تعداد لکھئے _____
- کیا اِس عَمل کے نتیجے میں کبھی آپ کو ہسپتال میں داخل ہونا پڑا یا زخم اِتنا گہرا آیا کہ آپ کو طبّی اِمداد کی ضرورت پیش آئی؟ _____

17۔ کیا آپ نے کبھی اِرادۃً (یعنی کہ جانتے بُوجھتے ہوئے) خود کو اَذیت پہنچانے کیلئے کچھ اور کیا ہے جس کے مُتعلّق اِس سوالنامے میں نہیں پوچھا گیا؟ کسی ایک کے گرد دائرہ لگائیں:

(1) جی ہاں (2) جی نہیں

اگر "جی ہاں"

- آپ نے خُود کو اَذیّت دینے کیلئے کیا کیا؟ _____
- جب آپ نے پہلی بار ایسا کیا تو آپ کی عُمر کیا تھی؟ _____
- آپ کتنی بار ایسا کر چکے ہیں؟ براہِ کرم اصل تعداد لکھئے (مثلاً 1 بار، 5 بار، 15 بار نہ کہ کبھی کبھار، بہت دفعہ یا بہت کم) _____
- آپ نے آخری بار یہ عَمل کب کیا تھا؟ _____
- آپ کِتنے سالوں سے ایسا کر رہے ہیں؟ (اگر اب آپ ایسا نہیں کر رہے ہیں تو چھوڑنے سے قبل آپ کتنے سال تک یہ عَمل کرتے رہے ہیں؟) براہِ کرم سالوں کی

اصل تعداد لکھئے

معاشرتی تعلقات کا پیمانہ (The Provisions of Social Relations Scale)

ہدایات:

ہم جاننا چاہیں گے کہ خاندان، دوستوں اور جاننے والوں کے ساتھ آپ کے تعلقات کیسے ہیں۔ آپ سے گزارش ہے کہ ہر بیان کے لئے دیئے گئے جوابات کو استعمال کرتے ہوئے بتائیں کہ کون سا بیان آپ کے تجربے کی زیادہ بہتر طور پر وضاحت کرتا ہے۔

1 خواہ کچھ بھی ہو جائے، لیکن مجھے معلوم ہے کہ ضرورت کے وقت میرا خاندان میرے لئے موجود ہوگا۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔

۲۔ بعض اوقات مجھے یقین نہیں ہوتا کہ میں اپنے خاندان پر مکمل انحصار کر سکتا ہوں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۳۔ میرا خاندان مجھے میری قدر و قیمت کا احساس دلاتا ہے۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۴۔ میرے خاندان کے لوگ مجھ پر بھروسہ کرتے ہیں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۵۔ میرے خاندان کے لوگ میرے مسائل کے حل کا تلاش کرنے میں میری مدد کرتے ہیں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا ۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں ۔۔۔۔۔۔۔۔۔۔۔۔۔

۶۔ مجھے معلوم ہے کہ میرا خاندان ہمیشہ میرا ساتھ دے گا۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا ۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں ۔۔۔۔۔۔۔۔۔۔۔۔۔

۷۔ جب میں اپنے دوستوں کے ساتھ ہوتا ہوں تو مکمل اطمینان محسوس کرتا ہوں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا ۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں ۔۔۔۔۔۔۔۔۔۔۔۔۔

۸۔ میں زندگی کے بارے میں وہی نظریہ رکھتا ہوں جو میرے اکثر دوست رکھتے ہیں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا ۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں ۔۔۔۔۔۔۔۔۔۔۔۔۔

۹۔ جو لوگ مجھے جانتے ہیں وہ مجھ پر اعتماد کرتے ہیں اور میری عزت کرتے ہیں۔

۱۔ میرے تجربے کے عین مطابق ۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا ۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا ۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں ۔۔۔۔۔۔۔۔۔۔۔۔۔

۱۰۔ جب میں کسی کام سے باہر جاؤں تو مجھے پتہ ہے کہ میرے کئی دوست میرے ساتھ اس کام سے لطف اندوز ہوں گے۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۱۱۔ میرا کم از کم ایک دوست ایسا ہے جس کو میں کچھ بھی بتا سکتا ہوں۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۱۲۔ میں خود کو اپنے کچھ دوستوں کے کافی قریب محسوس کرتا ہوں۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۱۳۔ مجھے جاننے والوں کا خیال ہے کہ میں جو کام بھی کرتا ہوں اچھے طریقے سے کرتا ہوں۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۱۴۔ میں اپنے دوستوں کے ساتھ ہو کر بھی خود کو تنہا محسوس کرتا ہوں۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔

۱۵۔ میں جب کبھی چاہوں میرے دوست وقت نکال کر میرے مسائل پر گفتگو کرنے کیلئے تیار ہوں گے۔

۱۔ میرے تجربے کے عین مطابق۔۔۔۔۔ ۲۔ کافی حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔

۳۔ کچھ حد تک ملتا ہوا۔۔۔۔۔۔۔۔۔۔ ۴۔ کچھ زیادہ نہیں ملتا۔۔۔۔۔۔۔۔۔۔

۵۔ بالکل نہیں۔۔۔۔۔۔۔۔۔۔۔۔۔

بیک انونٹری

درج ذیل میں 21 طرح کے بیانات ہیں جو لوگوں کے احساسات اور اعتقادات سے متعلق ہیں۔ جو بیان آپ کے گزشتہ ہفتے کے احوال کو صحیح بیان کرتا ہے اس پر گول دائرہ ڈال دیں۔ ان سوالات کا جواب ہاں یا نہیں کی صورت میں دیں۔ شکریہ۔

1

0 مجھے افسردگی محسوس نہیں ہوتی۔

1 مجھے اداسی محسوس ہوتی ہے۔

2 میں ہر وقت افسردہ رہتا ہوں اور اس کیفیت سے نکل نہیں سکتا۔

3 میں اتنا افسردہ یا اتنا خوش ہوں کہ مجھ سے اپنی کیفیت برداشت بھی نہیں ہوتی۔

2

0 میں خاص طور پر مستقبل کے بارے میں مایوس نہیں۔

1 میں اپنے مستقبل کے بارے میں مایوس ہوں۔

2 میں محسوس کرتا ہوں کہ مستقبل میں میرے لئے کچھ بھی نہیں ہے۔

3 میں محسوس کرتا ہوں کہ مستقبل بھی مایوس کن ہے اور یہ صورتحال بہتر نہیں ہو سکتی۔

3

0 میں ناکام محسوس نہیں کرتا۔

1 مجھے احساس ہے کہ میں ایک عام اوسط انسان کی نسبت زیادہ کام کر رہا ہوں۔

2 جب میں اپنی گزشتہ زندگی پر نظر ڈالتا ہوں تو مجھے بہت سی ناکامیاں دکھائی دیتی ہیں۔

3 یوں محسوس ہوتا ہے کہ میں بالکل ناکام شخص ہوں۔

4

0 مجھے چیزوں میں اتنی ہی تسکین / تسلی ملتی ہے جتنی پہلے ملا کرتی تھی۔

1 مجھے جس طرح پہلے مختلف چیزوں سے مسرت حاصل ہوتی تھی اب نہیں ہوتی۔

2 اب مجھے کسی چیز سے حقیقی تسکین نہیں ملتی۔

3 میں ہر شے سے غیر مطمئن اور بیزار ہوں۔

5

0 میں خود کو خاص طور پر قصوروار نہیں سمجھتا۔

1 میں خاصا وقت خود کو قصوروار سمجھتا ہوں۔

2 میں پیشتر وقت احساس جرم کا شکار رہتا ہوں۔

3 میں ہر وقت احساس جرم کا شکار رہتا ہوں۔

6

0 میں یہ محسوس نہیں کرتا/ کرتی کہ مجھے سزا مل رہی ہے۔

1 میں یہ محسوس کرتا/ کرتی ہوں کہ شائد مجھے سزا مل رہی ہے۔

2 میں سزا دیے جانے کی توقع کرتا ہوں

3 یوں لگتا ہے کہ مجھے سزا مل رہی ہے۔

7

0 میں اپنے آپ سے مایوس نہیں ہوں۔

1 میں اپنے آپ سے مایوس ہوں

2 میں اپنے آپ سے بیزار ہوں

3 مجھے اپنے آپ سے نفرت ہے۔

8

0 میں محسوس نہیں کرتا کہ میں کسی بھی دوسرے فرد سے بدتر ہوں

1 میں اپنی کمزوریوں اور غلطیوں پر خود تنقید کرتا ہوں

2 میں ہر وقت اپنی غلطیوں کیلئے خود کو الزام دیتا ہوں اور قصوروار ٹھہراتا ہوں

3 میں اپنے ساتھ ہونیوالی ہر بری بات کا خود کو ذمہ دار/ قصوروار ٹھہراتا ہوں۔

9

0 مجھے اپنے آپ کو ختم کرنے کے کوئی کوئی خیال نہیں آتے۔

1 مجھے اپنے آپ کو ختم کرنے کا خیال تو آتا ہے لیکن مین اس پر عمل نہیں کروں گا۔

2 میں خود کو ختم کر دینا چاہتا/ چاہتی ہوں

3 اگر مجھے موقع ملتا تو میں اپنے آپ کو ختم کر ڈالتا

10

0 میں معمول سے زیادہ نہیں روتا/روتی

1 میں پہلے کی نسبت اب زیادہ روتا/روتی ہوں

2 اب میں ہر وقت روتا رہتا/ رہتی ہوں

3 مجھ میں پہلے رونے کی سکت ہوتی تھی اب میں رونا چاہوں بھی تو نہیں رو سکتا

11

0 میں معمول سے زیادہ چڑ چڑا/ جھنجھلایا ہوا نہیں ہوں۔

1 اب میں پہلے کی نسبت زیادہ جھنجھلا جاتا ہوں یا خفا ہو جاتا ہوں

2 میں اب ہر وقت چڑ چڑا تا رہتا ہوں

3 میں ان چیزوں سے تنگ نہیں آتا جن سے پہلے میں تنگ آیا کرتا تھا۔

12

0 دوسرے لوگوں میں میری دلچسپی ختم نہیں ہوئی۔

1 دوسرے لوگوں میں میری دلچسپی اب پہلے کی نسبت کم ہو گئی ہے۔

2 میں نے اب لوگوں میں دلچسپی لینا چھوڑ دیا ہے۔

3 مجھے اب لوگوں میں بالکل کوئی دلچسپی نہیں رہی۔

13

0 میں اب بھی پہلے کی طرح فیصلے کرنے کی اہلیت رکھتا ہوں

1 میں اب فیصلہ کرنے کے مرحلے کو پہلے کی نسبت زیادہ ملتوی کرتا ہوں

2 پہلے کی نسبت اب فیصلہ کرنے میں مجھے زیادہ دشواری پیش آتی ہے۔

3 اب میں مزید بالکل کوئی فیصلے نہیں کر سکتا

14

0 مجھے نہیں لگتا کہ میں پہلے سے بدتر دکھائی دیتا ہوں

1 مجھے پریشانی ہے کہ میں اب بوڑھا اور بدشکل دکھائی دینے لگا ہوں

2 میرے خیال میں میری ظاہری شکل وصورت میں مستقل تبدیلی آچکی ہے جو مجھے بدشکل اور بھدا بنا رہی ہے

3 مجھے یقین ہے کہ میں بدشکل دکھائی دیتا ہوں

15

0 میں پہلے کی طرح خوش اسلوبی سے کام کرسکتا/سکتی ہوں

1 کوئی کام شروع کرنے کیلئے مجھے اب زیادہ کوشش کرنا پڑتی ہے

2 مجھے کوئی کام کرنے کیلئے اپنے آپ کو بہت کوشش سے مائل/مجبور کرنا پڑتا ہے

3 میں بالکل کام نہیں کرسکتا۔

16

0 میں حسب معمول اچھی نیند سوسکتا ہوں

1 میری نیند اب پہلی کی طرح اچھی طرح نہیں

2 میں معمول سے 1-2 گھنٹے قبل اٹھ جاتا ہوں اور پھر دوبارہ سونے میں بہت مشکل پیش آتی ہے

3 میں پہلے کے معمول سے کئی گھنٹے پہلے جاگ جاتا ہوں اور پھر دوبارہ نہیں سوسکتا۔

17

0 میں معمول سے زیادہ نہیں تھکتا۔

1 میں پہلے کی نسبت بہت تھک جاتا ہوں

2 میں تقریباً ہر کام کرنے سے تھک جاتا ہوں

3 میں اتنا تھکا ہوا ہوں کہ کوئی کام نہیں کرسکتا

18

0 میری بھوک معمول سے خراب نہیں

1 میری بھوک اب اتنی اچھی نہیں رہی جتنی ہوا کرتی تھی

2 مجھے اب بہت ہی کم بھوک لگتی ہے

3 مجھے اب بالکل بھوک نہیں لگتی

19

0 حال ہی میرا وزن کوئی زیادہ کم نہیں ہوا

1 میرا وزن پانچ پونڈ سے زیادہ کم ہوا ہے۔

2 میرا وزن دس پونڈ سے زیادہ کم ہوا ہے

3 میرا وزن پندرہ پونڈ سے زیادہ کم ہوا ہے

4 میں جان بوجھ کر وزن کم کرنے کے لئے کم کھا رہا ہیو

20

0 میں معمول سے زیادہ اپنی صحت کے بارے میں فکرمند نہیں

1 میں جسمانی تکالیف مثلاً بدن میں دردیں، بدہضمی یا قبض وغیرہ کے بارے میں فکرمند ہوں

2 میں جسمانی تکالیف کے بارے میں بہت زیادہ فکرمند ہوں اور مجھے زیادہ کسی اور چیز کے بارے میں سوچنے کی مہلت نہیں

3 میں اپنی جسمانی صحت کے بارے میں اتنا فکرمند ہوں کہ کچھ اور سوجھتا ہی نہیں۔

21

0 میں نے حال ہی میں جنس میں اپنی دلچسپی میں کوئی تبدیلی محسوس نہیں کی

1 پہلے کی نسبت اب مجھے جنس میں کم دلچسپی ہے

2 میں اب جنس میں بہت کم دلچسپی لیتا ہو

3 جنس میں میری دلچسپی بالکل ختم ہوگئی ہے۔