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Research Paper

A Correlation Study between Suicidal Ideation, Psychological Wellbeing, Perceived Physical Health and Spiritual Involvement During the Covid-19 Pandemic

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ABSTRACT

"Suicidal ideation" is a major concern for us today. With changing world dynamics, it is important to re-study it again and again. The aim of this research study was to analyze the suicidal ideation of young people in the age group of 20-30 and understand the relation it has to one's psychological wellbeing, perceived physical health and their spiritual involvement. With current scenario of lockdown it became highly relevant to understand suicidal ideation among people. Covid-19 pandemic had affected every individual globally on some level may it be economic, social, psychological or physical. During 2020, the cases of suicides and mental health issues were also reported higher than usual. Hence this study was undertaken to analyze suicidal ideation among people if any and their psychological well-being, perceived physical health and spiritual involvement. Study was applied on 122 people and four tests were used to analyze all suicidal ideation. perceived physical health, spiritual involvement and psychological wellbeing. The study has been supported with relevant literature and statistics.

Keywords: *Suicidal ideation, perceived physical health, Psychological wellbeing, Spiritual involvement, COVID-19*

Thought – "There must exist relationship between an individuals lack of well-being and suicidal ideation, well-being being mental, emotional, spiritual, psychological, social etc. To understand that relationship is to understand suicidal ideation in a deeper sense."

Every 4 minutes we lose one person to suicide worldwide. It is time to work on better prevention and care and to understand the roots of suicidal ideation in the first place. To think something is to act someday. Every year, we lose around eight lakh people to suicide and it is a major concern from developing countries to developed countries. But to understand suicide is to understand the very thought or idea that encompasses it. And therefore, understanding suicidal ideation plays a very important role. And equally challenging situation is faced by the world right now is of Covid-19 pandemic. In times like

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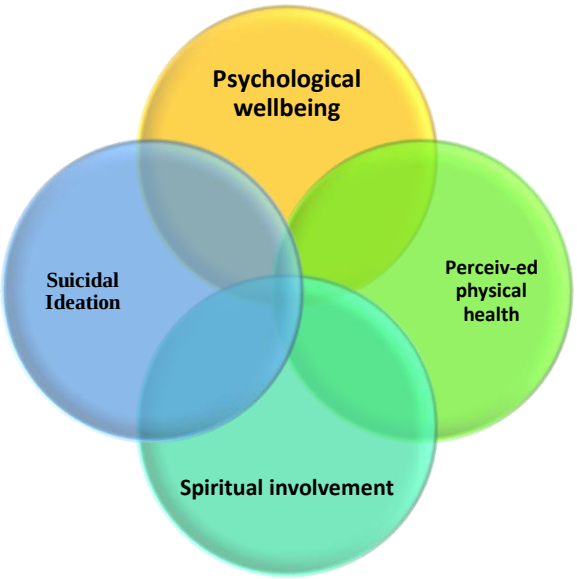
these, not only people suffer physically but they also undergo a lot of mental and emotional distress. And a prolonged distress could not only make a person dysfunctional but also highly prone to suicidal ideation or actual suicides. During times like these of complete lockdown, it is much more difficult to deal with our own wellbeing and hence it becomes a larger part of this study. WHO recognizes suicide as a public health priority. The first WHO World Suicide Report "Preventing suicide: a global imperative", published in 2014, aims to increase the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a high priority on the global public health agenda.

It has always been a topic of debate as to whether a spiritual person is less prone to suicide, or someone who is mentally fit or someone who is physically well doing. Sometimes studying the causes are not enough, studying certain angles and relationships to the particular topic becomes inevitable. Also, how each wellbeing affects another leads us to understand a person in holisitic manner.



A Diagram to Study the Relationship Between Psychological Wellbeing, Suicidal Ideation, Spiritual Involvement and Perceived Physical Health.

In this study, the correlation between these four variables will be evaluated.

India alone accounts for approximately 30 percent of the world's deaths resulting from suicide. In 2013, suicide claimed the lives of more than a quarter of a million Indians. That's five times greater than all global deaths due to war and natural disasters combined. In the last three decades (from 1975 to 2005), the suicide rate increased by 43%. With increasing urbanization and the breaking down of traditional family system, social isolation has increased. Relationship problems and feelings of loneliness render particularly the migrant population vulnerable to high suicide risk. Individuals who report having more friends and less subjective loneliness are less likely to have suicidal ideation or engage in suicidal behaviors, in spite of living alone. People at greater risk should be encouraged to receive support from family members, friends, community, mental health professionals, self-help organizations, and or religious groups.

The same social changes and loneliness can cause depression and significant anxiety, and the resulting insomnia and hopelessness are closely linked to suicide. Early recognition of mental health issues and their management is of paramount importance. Alcohol and substance abuse have increased at an alarming rate in the younger generation in India. Changing cultural values and weaker supportive bonds are leading to initiation into substance use. An ecological study showed a high correlation between levels of alcohol consumption and suicide rates in India. Suicide mortality rates for people with greater use of alcohol have been found to be approximately six times those of the general population. Alcohol and substance abuse may be the second most frequent psychiatric precursor to suicide. Substance use disorders are particularly common among adolescents and young adults who die by suicide. In addition to the increased suicide risk posed by alcohol abuse or dependence, alcohol intoxication itself appears to play a role. Hence, the availability and consumption of alcohol and other substances needs to be controlled. People already dependent on alcohol and other substances need to be treated with the help of medicines as well as psychosocial support. Competition in the context of academics and professional achievements, and even extra-curricular achievements is increasing day by day.

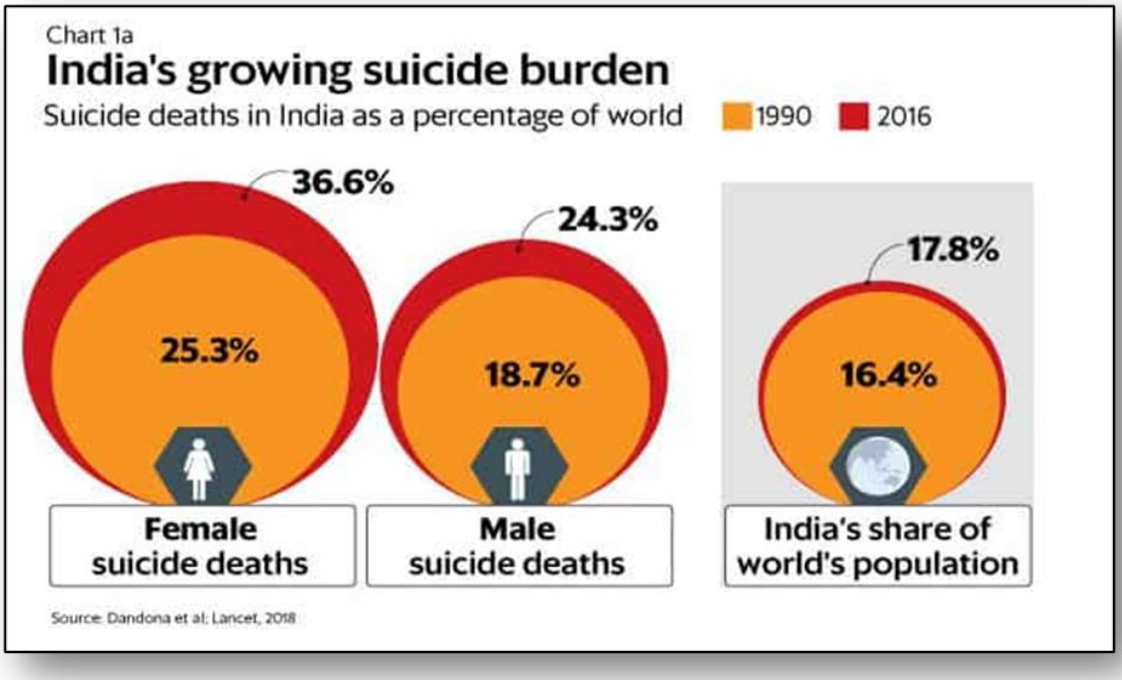
The adolescent population in India has shown an alarming increase in manifestations of stress, anxiety related disorders, and suicides in recent times. In 2013 alone, 2,471 suicides were attributed to "failure in examination", and it was one of the main causes of suicides among children below 18 years of age. The board exams of 10th and 12th standards fall during this period of adolescence. There are also sharp peaks in emergencies around the time of competitive examinations.

A common cause for concern is the pressure from parents to do well in these examinations, as scores in these exams often determine college admissions and subsequent employment opportunities. This brings an undue level of anxiety in parents which is then translated onto their children. Students aged 16-18 are often subjected to undue pressure at home to succeed. When they don't, suicide becomes a way out. Assessment of aptitudes and interests, and career counselling can give students and their families more knowledge about a wider range of career options. This could reduce the anxiety related to failure on one or a few particular examinations. Psychotherapy for children and adolescents as well as parents, and family therapy can also help with managing anxiety. These can also help parents motivate their children to realize their potential without causing excessive pressure which could lead to attempted or completed suicides by students.

Media holds the power to help gain significant support from government as well as the general public. Informed and sensitive discussions regarding suicide by the media are likely to help to drive suicide prevention higher on the public health agenda. The involvement of the media in suicide prevention can not only move beyond the “toning down” of reports, but can focus on the positive contributions that can be made. The media can be a source of information for the general public about how to and where from to seek help and support. Hence, media can play a key role in enhancing awareness regarding suicide. Stigma is one of the primary barriers to help-seeking behaviour in vulnerable individuals, and a public discussion of suicide and mental illness by the media can help in de-stigmatizing mental illness and suicide, and in normalizing help-seeking behaviour.

Some lethal means of suicide, such as pesticides and insect killer sprays are too easily available in our society. Easy access to such means, including sometimes even sleeping pills

and antidepressant medication naturally heightens the suicide risk. Restricting access to the same could reduce suicide rates. More and more pharmacies being strict about not selling these and related material without prescriptions, and selling only in limited amounts in spite of prescriptions, could prevent suicide cases due to overdose. Doctors can continue to be careful about the amount of medication prescribed as well, in addition to following up on patients on a regular basis.



A Chart Showing the Increase in Number Of Suicides From 1990 To 2016.

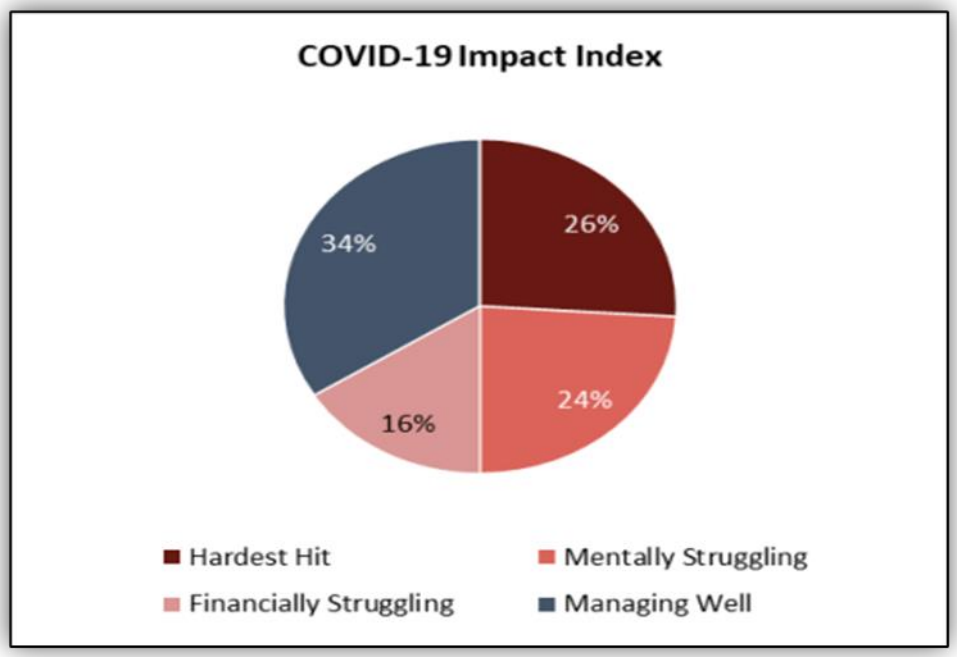
The Mental Healthcare Bill 2016 that was recently passed in Lok Sabha decriminalises attempted suicide and thereby, appears to be a significant step towards an effective suicide prevention strategy in India. This is because those attempting suicide will be seen as suffering from some form of mental illness, once this bill becomes a law.

Gatekeeper training to community members can go a long way in assuring greater vigilance and care in our country, where the number of mental health professionals is significantly low as compared to the general population that requires their services. Gatekeeper training focuses on skill development to enable community members such as teachers, coaches and others to identify suicide risk factors and warning signs, such as sudden social withdrawal. It encourages individuals to maintain a high index of suspicion, and to inquire directly about distress, persuade suicidal individuals to accept help, and provide appropriate referrals.

A more specialized form of gatekeeper training can be imparted to all health care professionals besides mental health professionals, and school professionals, as these professionals regularly come in contact with individuals, such as patients and school children, who may be at risk of suicidal ideation. Pearson Academy India has launched such a training, 'Read the Signs' for health care and school professionals that aims at creating the required sensitization among these professionals, in service of suicide prevention.

The changing times have brought newer challenges to our mental health and well-being. The

new challenges require more creative solutions and more concerted efforts from all concerned in preventing suicides. The journey starts from greater awareness, removal of barriers such as stigma, and mutual understanding and support for those at risk of suicide or recovering from attempted suicide.



A Pie Chart Showing How Covid-19 Affected People In 2020 Globally.

Concepts Used in Current Study

Spiritual involvement

Spirituality can mean different things to different people. For some, it's primarily about participation in organized religion. For others, it's a non-religious experience that involves getting in touch with their spiritual selves through private prayer, yoga, meditation, quiet reflection, or time in nature. An instinct toward spirituality appears to be deeply ingrained in humans. People can't help but ask big questions—research shows that even declared skeptics can't stifle a sense that there is something greater than the physical world they see. As the brain processes sensory experiences, it naturally looks for patterns—and people's conscious selves often seek meaning in those patterns. This can lead to the phenomenon known as "cognitive dissonance," which describes how, once one believes in something, one is strongly inclined to try to explain away anything that conflicts with it. Cognitive dissonance is not unique to religion or spirituality, but often occurs in the context of such beliefs. Some people define “spirituality” as going to church and believing in a monotheistic God. Others may define spirituality along the lines of one of the Eastern non-theistic traditions such as Buddhism, Taoism or Hinduism. Others still, may define spirituality simply as becoming a better person, quiet reflection, meditating or going for a walk in the woods.

However, you define “spirituality”, the vast majority of people in the world either believe there is something more which goes beyond our immediate experience of the world, or at the very least are seeking some way to grow as a person and to become the “best”, and the happiest, they can become in their careers, hobbies or relationships. **Studies have also shown that higher levels of spirituality or religiosity are strongly associated with a**

greater sense of meaning in life as well as higher levels of psychological and emotional well-being.

In other words, people who hold a belief in some form of "higher power", something "bigger" than who and what we are, whether defined as "God", "Energy", "Source", "Collective Consciousness" or "Spirit", tend to be happier, healthier and even live longer. For example, spirituality has been described as "the way in which people understand and live their lives in view of their ultimate meaning and value" (Muldoon and King 1995, p. 336), as "a subjective experience of the sacred" (Vaughan 1991, p. 105), and as "a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good." (Murray and Zenter, 1989). It seems almost impossible to find a description with which the majority of people would agree.

Although overall belief in God, church attendance and traditional religious affiliations have been declining steadily for years, there has been a corresponding increase in people seeking out non-traditional, "New Age" or alternative paths to personal and spiritual growth. Some of these include yoga, Tai Chi, Shamanic practices, meditation and mindfulness, energy practices, dance, music, art and even the use of entheogens (ayahuasca retreats etc). What all of these practices share in common from a psychological standpoint is that people are motivated to seek meaning and value in their lives and to transform themselves into the person they wish to become and to attain their highest potential as a human being. With this growing global interest in seeking personal growth and spiritual development, a field of psychology began to develop over 50 years ago which grew out of the works of Carl Jung, Abraham Maslow and Stanislav Grof and is called Transpersonal Psychology, which can be succinctly defined as the "psychology of spirituality" or "spiritual psychology".

A Diagram Showing the Various Elements of Spirituality.

But what is Spiritual Involvement?

The word spirituality comes from the Latin root 'spiritus', which means "breath"--referring to the breath of life. It involves opening our hearts and cultivating our capacity to experience awe, reverence and gratitude: Gratitude is getting a great deal of attention as an aspect of positive psychology: It is the ability to see the sacred in the ordinary, to feel the poignancy

of life, to know the passion of existence and to give ourselves over to which is greater than ourselves. The term spiritual Involvement means people who have certain beliefs which they find solace in and who believe in a higher power and are involved in acts which show that they are spiritual and it is a sense of strength for them.

Perceived Physical Healthiness

Traditional definitions of physical health prior to the onset of modern medicine would have considered someone physically healthy if he or she was not stricken with a serious illness. With modern medical innovations came longer life spans, which changed the way we define physical health. Today's definition can consider everything ranging from the absence of disease to fitness level. Health and physical fitness have a vital role in the life of men from time immemorial. The progress of the Nation lies in the hands of the people, who are healthy and physically fit. Every individual should develop physical fitness for a happy and effective living. Most authors define 'physical fitness's the capacity to carry out every day activities without excessive fatigue and with enough energy in reserve for emergencies. Emphatically this definition is inadequate for a modern way of life. By such a definition almost anyone can classify himself as physically fit (Gatchell 1977). According to Clarke (1971) Physical fitness is the ability to carry out daily task with vigor and alertness without undue fatigue and ample energy to enjoy leisure time pursuits and to meet unforeseen emergencies.

People who have experienced mental illness can have compromised physical health for a number of reasons. They are less likely to receive appropriate health care compared with those without mental illness, and it is an indictment of our mental health care system that people who have been involved with mental health services have often had their physical health needs overlooked. Furthermore, behavioural factors such as smoking, harmful alcohol and other drug use, obesity, poor diet, inadequate living situations (such as homelessness), and poor self-care as a consequence of illness symptoms, can make people with mental illness vulnerable to physical health problems. Perceived health is a subjective measure of overall health status. Individuals' self-assessment of their health may include aspects that are difficult to capture clinically, such as incipient disease, disease severity, physiological and psychological reserves, and social function. Studies have demonstrated that this is a reliable and valid measure, associated with functional decline, morbidity and mortality. As well, perceived health is often more effective than clinical measures for predicting help-seeking behaviours and health service use. It is important here that the perceived physical health is considered because the analysis is on how people feel healthy are they and how happy or satisfied are they with their bodies.

A Diagram Showing the Aspects of Physical Wellbeing

Psychological Well-being

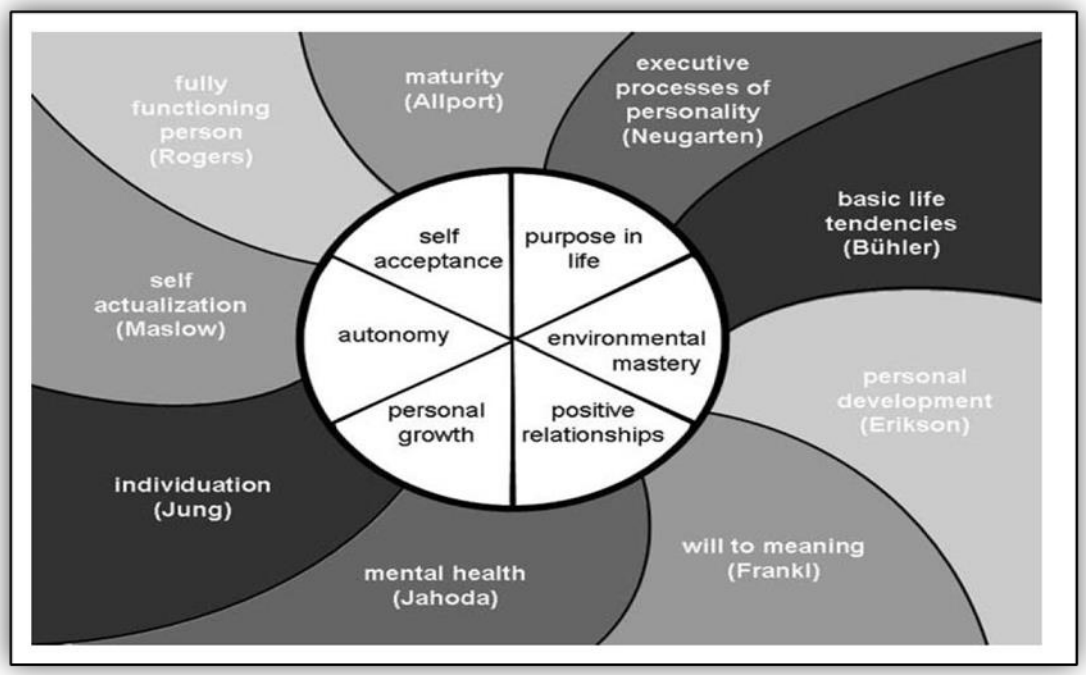
At the most basic level, psychological wellbeing (PWB) is quite similar to other terms that refer to positive mental states, such as happiness or satisfaction, and in many ways it is not necessary, or helpful to worry about fine distinctions between such terms. If I say that I am happy, or very satisfied with my life you can be pretty sure that my psychological wellbeing is quite high!

Psychological Wellbeing has two important facets.
The first of these refers to the extent to which people experience positive emotions and feelings of happiness. Sometimes this aspect of psychological wellbeing is referred to as subjective wellbeing (Diener, 2000). **Subjective wellbeing** is a necessary part of overall PWB but on its own it is not enough. The two important ingredients in PWB are the subjective happy feelings brought on by something we enjoy AND the feeling that what we are doing with our lives has some meaning and purpose.

Types of psychological wellbeing –
The term **"Hedonic"** wellbeing is normally used to refer to the subjective feelings of happiness. It comprises of two components, an affective component (high positive affect and low negative affect) and a cognitive component (satisfaction with life). It is proposed that an individual experiences happiness when positive affect and satisfaction with life are both high (Carruthers & Hood, 2004). The less well-known term**, "Eudaimonic"** wellbeing is used to refer to the purposeful aspect of PWB.

Theories of psychological wellbeing

Theories about PWB generally focus on understanding the structure of psychological wellbeing or the dynamics (i.e. the causes and consequences of PWB). The breakdown of psychological wellbeing into hedonic and eudaimonic components and Carol Ryff's model are widely accepted theories of the structure of PWB. As far as the dynamics of PWB are concerned it's important to recognise that, to some extent, PWB is relatively stable and will have been influenced by both previous experience (including, for example, early upbringing) and underlying personality. Stressful experiences can predispose people to subsequent mood and anxiety disorders (Gladstone, Parker and Mitchell, 2004); but, on the other hand exposure to extremely traumatic events can help to build resilience and actually protect PWB. For example children exposed to moderately stressful events seem better able to cope with subsequent stressors (Khobasa & Maddi, 1999). The same "inoculating" impact of stressful events has also been observed in working adults (Soloman, Berger and Ginsberg, 2007). Although baseline psychological wellbeing may be fairly stable, day to day events and experiences also exert an impact. For example, even the most resilient person may eventually become very low, or depressed, if his or her daily experiences are constantly troubling. There is strong evidence to show that exposure to work-related stressors over long periods of time will have a negative impact on PWB, so, although as mentioned above, short periods of adversity may be helpful in building resilience, long-term stress is not good for PWB. In turn, this lower level of PWB may well lead to serious illness, including cardiovascular disease, problems with blood sugar control, such as diabetes and immune system malfunctions (Chandola et al, 2008). **In summary, PWB theory proposes that early experience and underlying personality create a platform for PWB but everyday experiences can help to maintain a good level of PWB (if they are positive) or, if they are negative, reduce levels of PWB, leading, in turn, to poor health outcomes.**



A Diagram Covering the Facets Of Psychological Wellbeing By Ryff.

Suicidal Ideation

Suicidal ideation, also known as suicidal thoughts, is thinking about, considering, or planning suicide. The range of suicidal ideation varies from fleeting thoughts, to extensive thoughts, to detailed planning. **Suicide is "a self-inflicted death in which one makes an intentional, direct and conscious effort to end one's life"** (Comer, 1995, p. 345). In considering suicide, attention must be directed to suicide ideation. Suicide ideation generally exists prior to suicide, although not all suicide ideation leads to attempted or completed suicide. Suicide ideation refers to current plans and wishes to commit suicide in the absence of any recent overt suicide attempts (Ranieri, Steer, Lavrence, Rissmiller, Piper and Beck, 1987). Beck, Steer, and Ranieri (1988) define the suicide ideator to be "the individual at the earliest stage of suicidal risk" (p. 968). Thus, any investigation of suicidality must logically be extended to include suicide ideation as well. Strictly speaking, suicidal ideation means wanting to take your own life or thinking about suicide. However, there are two kinds of suicidal ideation: passive and active.

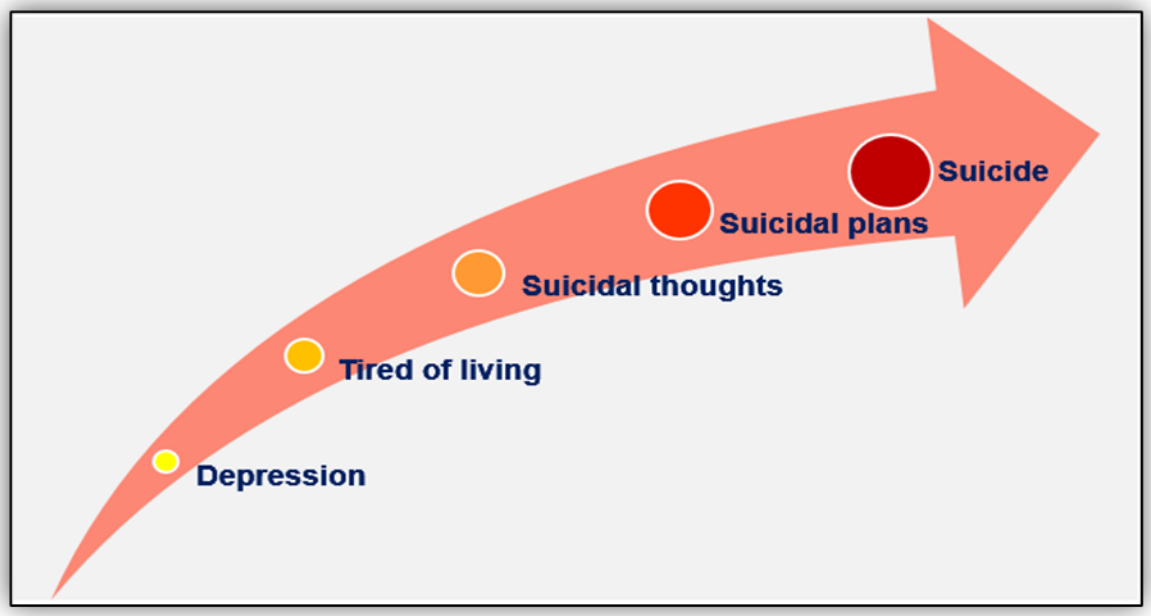
Passive suicidal ideation occurs when you wish you were dead or that you could die, but you don't actually have any plans to commit suicide.

Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to commit suicide, including planning how to do it.

The lifetime prevalence of suicidal ideation for the general world population is about 9% and about 2% within a 12-month period. Many different factors can contribute to suicidal ideation. Often these thoughts strike when you are feeling hopeless and out of control in your life and/or like it has no meaning or purpose. These feelings may be due to circumstances like relationship problems, trauma, substance use, a crisis of some sort, pressure at work, a physical health issue, or financial difficulties. Having any mental health

disorder such as depression, bipolar disorder, post-traumatic stress disorder (PTSD), or anxiety can also contribute. Suicidal Behavior Disorder is a proposed DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, fifth edition), diagnosis which would be assigned to individuals who have made a suicide attempt within the past two years. A suicide attempt is defined, as a self-destructive act deliberately carried out where there is a clear expectation of death. Considering suicidal behavior as a condition independent of depression or other mental disorders is a paradigm shift, as suicidal ideation, attempts, and successful attempts were defined as behaviors associated with mood disorders, and other mental disorders. It is noted that about 10% of people who commit suicide do not have a mental illness, and "Most people" who have depression or another mood disorder do not attempt suicide (Reardon, 2013). The previous finding are very debatable, and must be considered critically. To state that 10% of people who commit suicide do not have a mental illness assumes that the individual was properly diagnosed, or that a potential mental illness was never self-reported to a health care provider or associate- e.g., family or friend. It is also a major assumption to state that most people with a mood disorder have not attempted suicide, as attempts may be denied or hidden. Differences in neuroanatomy have also been noted in post-mortems of individuals who have committed suicide specifically in the prefrontal cortex, which is associated with inhibition, self-regulation, impulse control and consideration of long-term consequences, as well as altered serotonergic function (Courtet, Gottesman, Jollant, & Gould, 2011.; Reardon, 2013). However, causality has not been established, and is most likely much more complex than the observed neuroanatomical variations. Men tend to commit suicide at a higher rather than women, as it has long been established that men are likely to use more lethal and reliable means, such as a firearm or jumping for a height, while women are more likely to use unreliable, less lethal means such as cutting or taking an overdose of medication (Schrijvers, Bollen and Sabbe, 2011).

Suicidal Ideation is a major concern and it needs to be analysed on every basis.



A Diagram Showing the Progression of Suicidal Thoughts to Action.

Problem Statement

To understand various well-beings namely spiritual, psychological and physical and to determine how they affect suicidal ideation among people if any and also how they affect each other.

Objectives

Firstly, the data collection from a valid sample along with their demographic details to suit the study and evaluate the following -

1. To understand the spiritual involvement of adults and how it is related to suicidal ideation.
2. To understand the perceived physical healthiness of individual adults and how is it related to suicidal ideation.
3. To know the psychological well-being, measure it and understand its relationship to suicidal ideation.
4. To evaluate the relationship between spiritual involvement, psychological well-being, physical healthiness to each other respectively.
5. Predicting suicidal ideation, psychological wellbeing and spiritual involvement with collected data by regression analysis.

Summary

This chapter focused on all the terminologies that may be used in the entire research. Relevant pictorial data or statistics are also presented wherever deemed important. The problem statement was carefully determined and based on it the significance and objectives were also discussed with relevant references.

REVIEW OF LITERATURE

This chapter is of utmost importance to the study and covers researches done on spiritual involvement, psychological wellbeing, perceived physical health and suicidal ideation with respect to each other.

Spiritual involvement and physical health, psychological wellbeing and suicidal ideation

Spirituality is an important theme in health research, since a spiritual orientation can help people to cope with the consequences of a serious disease. The relationship between spirituality and health has received increasing attention in recent decades; the rate of publications on spirituality and health has increased by 68% in the last 30 years (Weaver et al. 2006).

Many people experience spirituality as an important support aid while trying to cope with a chronic or life-threatening disease (Stefanek et al. 2005). Spiritual orientation has been shown to be associated with mental health (Sawatzky et al. 2005; Koenig et al. 2001), and the association is especially strong among people facing stressful life events, such as a chronic or life-threatening disease (Smith et al. 2003). Thus, it is fair to understand spiritual involvement in greater depth as it contributes to understanding wellbeing which in turn helps to study suicidal ideation.

Nevertheless, knowledge on the role of spirituality among patients and their caregivers is in a certain sense limited, as most research is based on measures of religiosity rather than spirituality (George et al. 2000; Baldacchino and Draper 2001). Spirituality is a complex multidimensional concept (Cook 2004; Hill et al. 2000; George et al. 2000; Moberg 2002).

The concept defies clear-cut boundaries, which also applies to other latent constructs that are often used, such as character, well-being and health (Miller and Thoresen 2003).

Zinnbauer et al. (1999) described five studies in which various groups of people were asked to define spirituality. They concluded that differences in the responses of the participants outweighed by far the similarities. McSherry and Cash (2004) even stated that we should accept that the word 'spirituality' has different meanings.

Rew and Wong reviewed the association between religiosity/spirituality and adolescent health attitude and behavior. The review showed that although roughly half of the studies indicated that religiosity/spirituality had positive effect on adolescent health attitude and behavior, there were theoretical and methodological limitations of the studies. In a review of research on adolescent religiosity and mental health, Wong et al. found that most studies showed a positive relationship between religiosity/spirituality and adolescent mental health. Cotton et al. reviewed religiosity/spirituality and health outcomes. They differentiated distal domains (service attendance, frequency of prayers and meditation, self-rated religiosity) and proximal domains (meaning and peace, religious coping, church support) and reviewed the related studies on adolescent developmental outcomes. While studies showed negative relationship between religiosity/spirituality and adolescent health risk, positive relationships between religiosity/spirituality and physical/mental health were reported. Reviews showed that spiritual well-being is positively related to health outcomes, although there are possible confounding effects in the reported relationships.

Regarding the relationship between spirituality and physical health, Powell et al. tested nine hypotheses with reference to mediated models (evaluation of the impact of religion or spirituality on health, regardless of whether or not such a relationship was mediated by established risk/protective factors) and independent models (evaluated religion or spirituality as an independent protective factor after controlling other effects) and concluded that church/service attendance protects healthy people against death. Meanwhile, the authors also pointed out the need for more methodologically sound studies in the field.

In the model proposed by Benson, there are 40 developmental assets in adolescent development, where life meaning and positive beliefs are important internal assets that influence adolescent development. Dowling et al. proposed a model in which spirituality was hypothesized to influence thriving with religiosity as a mediating factor. In a review of 77 positive youth development programs in the United States, Catalano et al. concluded that positive youth development constructs are intrinsic to the successful programs, with spirituality as one of the constructs identified which is defined as the development of purpose and meaning in life, hope, or beliefs in a higher power. There are many recent publications highlighting the relationship between positive youth development and spirituality.

There are theoretical accounts suggesting that spirituality is an antecedent of quality of life (i.e., first possibility). In the theory of logotherapy proposed by Frankl, it is asserted that when there is existential vacuum (i.e., loss of meaning in life), mental problems come in to fill the vacuum. Frankl's conceptualization about human nature is based on the premise of "will to meaning". When a person fails to find meaning in life and a state of vacuum of perceived meaning in personal existence (i.e., existential vacuum) is present, he or she is confronted by "existential frustration", which is characterized by the feeling of boredom.

Although the occurrence of existential vacuum does not necessarily lead to neuroses, it was contended that existential vacuum is an etiological factor of psychopathology. Based on the above reasoning, it could be assumed that purpose in life is causally related to adolescent developmental outcomes. In a review of the relationships among meaning in life and well-being, psychopathology, and spirituality, research shows that people experiencing greater life meaning report greater well-being, less psychopathology, and more positive experience of spirituality. Emmons also argued that religion provides goals and value system contributes to life meaning which would eventually shape different aspects of a person's life. The whole discussion is on the aspect of a person being spiritual and how that helps the person in his wellbeing. Even though there have been numerous studies on spiritual involvement or spirituality, we for sure cannot say that spirituality has been directly established to affect suicidal ideation, but it does have been stated that spirituality leads to good mental and physical health which in turn are related to suicidal ideation. More research needs to be conducted in this area to analyze how the relationship between spiritual involvement and suicidal ideation works, nonetheless we have gathered data to uphold its importance while assessing a person's overall wellbeing.

Physical health and psychological wellbeing and suicidal ideation

Physical health (even though this study uses perceived physical health, the subjective part of one's health) status affects the ongoing mental health and wellbeing of people with mental illness (Kisley & Goldberg, 1997). Furthermore, mental illness has been shown to profoundly affect physical health status. A large study from Western Australia (*Coghlan et al 2001b)*, revealed that death rates from all main causes were higher for people with mental illness and the overall death rate was 2.5 time higher than the general population of Western Australia. The benefits of physical fitness are numerous. The person who is physically fit has greater amount of strength, energy and stamina an improved sense of wellbeing better protection from injury because strong well developed muscles safeguard bones, internal organs and joints and keep moving parts limbers and improved cardio respiratory function (Bucher and Prentice, 1985). It is necessary for every individual to be physically fit to perform their daily work with ease and to take part in various activities effectively. The old saying 'Fit or Perish' was present in Sparta and Athens – during the Golden Era of Greek history and again in the early centuries of the Roman Empire Nixon and Jewett (1969). The Nation is quite simple. The world's renowned thinkers have emphasized the importance of physical fitness in human beings to ensure a productive and meaningful life. It is from memorabilia of Xenophon, we come to know of Socrates emphasis on the necessity of physical fitness and possession of a robust physique for the Greek citizen.

Research has shown that psychological well-being is a diverse multidimensional concept (MacLeod & Moore, 2000; Ryff, 1989b; Wissing & Van Eeden, 2002), which develops through a combination of emotional regulation, personality characteristics, identity and life experience (Helson & Srivastava, 2001). Psychological well-being can increase with age, education, extraversion and consciousness and decreases with neuroticism (Keyes et all., 2002). In terms of gender, research has suggested that there is no significant difference between men and women on measures of psychological well-being (Roothman, Kirsten & Wissing, 2003).

Furthermore, the perception of physical health and spirituality can mediate the relationship between context and psychological wellbeing (Temane & Wissing, 2006a, 2006b). Psychological well-being has undergone extensive empirical review and theoretical

evaluation (Wissing & Van Eeden, 1998). There is currently no single consensual conceptual understanding of psychological well-being. Bradburn's (1969) initial understanding of psychological well-being provided a depiction of the difference between positive and negative affect. Preliminary research was mainly concerned with the experiences of positive and negative affect, subjective well-being and life satisfaction that were formed around the Greek word 'eudemonia', which was translated as 'happiness' (Ryff, 1989b). Despite extensive evaluation and assessments, experts have indicated that psychological well-being is a diverse multidimensional concept, with exact components still unknown (MacLeod & Moore, 2000; Ryff, 1989b; Wissing & Van Eeden, 2002). Ryff has extensively researched the objective understanding of psychological well-being.

A study from Bangor University in Wales, the United Kingdom, had participants ride a stationary bike until they reached the point of exhaustion. They defined exhaustion as the inability to keep up with a pace of 60 revolutions per minute for five or more seconds. Participants performed the test in two different situations. In one situation, they rode the bike like usual. In the second setup, participants first engaged in a 90-minute task with elements drawing on memory, fast reactions and inhibiting impulsive responses to stimuli. After participants engaged in the mental challenge, they reported feeling tired and a little listless. Most importantly, the participants reached the point of exhaustion 15 percent earlier. Mental illness is closely linked with fatigue, and that persistent tiredness can easily lead to declines in physical health. When someone is chronically depressed or anxious, they are less likely to engage in exercise and to quit early when they do. Fatigue from mental illness can also interfere with basic hygiene, increasing vulnerability to disease.

An analysis of data from eight health care systems confirmed that many physical health conditions are associated with risk of suicide death. A comparison of individuals who died by suicide with randomly selected, matched controls revealed that traumatic brain injury (TBI) increased suicide risk nearly ninefold, and HIV/AIDS and sleep disorders more than doubled it. While hypertension and back pain were associated with smaller increases in risk, they were the most common conditions among those who died by suicide. After controlling for age, sex, and the presence of mental health and substance use disorders, nine physical conditions were linked to risk of death by suicide: back pain, brain injury, cancer, congestive heart failure, chronic obstructive pulmonary disease, epilepsy, HIV/AIDS, migraine, and sleep disorders. Risk increased substantially for people with two or more conditions.

According to the authors, (Ahmedani, B K., Peterson, E. L., Hu, Y., Rossom, R. C., Lynch, F., Lu, C. Y., Simon, G. E. (2017). Major physical health conditions and risk of suicide. American Journal of Preventive Medicine, 53(3), 308–315.) these findings provide evidence that suicide prevention efforts should target patients with chronic physical health conditions in addition to patients with more well-known risk factors for suicide, such as mental health and substance use disorders and suicidal ideation. They suggested using this information to develop electronic medical record algorithms to improve detection of suicide risk in health care settings.

Suicide behavior is an extensive array of psychopathological occurrences expressed in terms of thinking (suicidal ideation and planning, thoughts and wishes to be dead), gestures (aborted action to end one's life), to attempts (self-destructive behavior with at least some resolve to kill oneself) (Pawlak et al., 2016). **Studies have identified personality traits, sociocultural, biological, physical, and genetic factors, and mental illnesses as risk**

factors for suicide behavior (Nagra, Lin, & Upthegrove, 2016). For young adults, poor social support, substance use disorders, family conflict, feelings of hopelessness, and mood disorders were all noted to be risk factors for suicide. Additionally, there were numerous risk factors appearing in higher magnitudes among those who had previous attempts (Kyle, 2013). These risk factors may have varied personal effects on a person depending on their susceptibility and resilience (Pawlak et al., 2016). On the other hand, resilience, also known as a moderating, buffering, or protective factor, refers to resources that lessen the probability of developing suicide behavior in the presence of risk factors (Kleiman, Miller, & Riskind, 2012). Protective factors known to reduce suicide risk for young adults also include their gender, adaptive coping styles, and spiritual faith (Kyle, 2013). Mościcki (2001) proposed that suicide risk is a result of the complicated constellation of risk factors and limited or lack of access to protective factors such as family cohesion, sufficient social support, availability of mental health services, and enriched coping skills, as well as the presence of intrapersonal protective factors such as religiousness and spirituality (Kyle, 2013; Meadows, Kaslow, Thompson, & Jurkovic, 2005). It is important that researchers dedicate studies on identifying different risk and protective factors for suicide behavior in order to advance how interventions are developed and implemented on the general population and at-risk populations (Kleiman & Liu, 2013; Whitaker, Shapiro, & Shields, 2016).

Psychological well-being and suicidal Ideation

Recker, Peacock and Wong (1987) examined three hundred men and women at five developmental stages from young adulthood to the old-old completed measures of life attitudes and well-being.

Significant age differences were found on five life attitude dimensions: Life Purpose (LP), Death Acceptance (DA), Goal Seeking (GS), Future Meaning (FM), and Existential Vacuum (EV). Women viewed life as more under their control and expressed a stronger will to find meaning as compared with males. Future Meaning, Life Purpose, and Life Control were found to predict psychological and physical wellbeing.

Zika and Chamberlain (1992) examined the relation between meaning in life and psychological well-being using several meaning measures and both positive and negative well-being dimensions and concluded that meaning in life had a stronger association with positive than with negative well-being dimensions, suggesting the value of taking a salutogenic approach to mental health research.

Ryff and Keyes (1995) found strong positive correlations between the variables "purpose in life" and several indicators of psychological well-being, as well as negative correlations with indicators of psychological distress among 1108 adults.

Simmons and Nelson (2001) examined the relationship between eustress, the positive response to work demands and health among 158 hospital nurses. The positive psychological states hope, positive affect and meaningfulness were used as indicators of eustress, and the psychological state negative affect was used as an indicator of distress. Results indicated that hope had a significant positive relationship with the perception of health in hospital nurses.

Ardelt (2003) examined that purpose in life was positively related to elders' subjective well-being. Rathi and Rastogi (2007) examined meaning in life and psychological well-being in

male and female students of pre- adolescence and adolescence periods. A total of 104 students were randomly selected from various schools. Of these, 54 students were from class 12 and 50 students from class 9. Two questioinnaires, one Personal Meaning Profile (PMP) and another Well-Being Manifestation Measure Scale (WBMMS) were administered on the subjects. Results showed that meaning in life is highly correlated with psychological well-being which shows that if a person perceives his or her life to be meaningful then he or she will feel more psychologically well off than those who do not perceive their life to be meaningful.

A study by Huff (1999) identified factors that related to adolescent stress and predicted suicide ideation in these individuals. These factors included depression, family disruption, poor grades and drug and alcohol abuse. These findings are consistent with theory that speaks about the individual being interconnected with their environment and it is a combination of many internal and external factors that bring about stress for the developing adolescent. Although the link between hopelessness, depression and suicide has been stressed above, it is important to be aware, that the common psychological assumption that depression causes suicide, is more complex than this one-to-one association. Zhang and Jin (1996) speak about a model that integrates individual characteristics (depression and attitudes toward suicide) and social structural characteristics (including gender and family cohesion). It is evident that risk factors leading to suicide ideation and ultimately suicide, take the form of both individual and environmental factors. It is impossible to isolate one group of factors. The risk factors for suicide ideation among adolescents must rather be seen as an interplay of many factors within different areas. In a recent multivariate study of 120 adolescents, discriminant function analyses indicated that high levels of depression and anger expression predicted self-reported wish to die (Boergers, Spirito, & Donaldson, 1998). In a similar study of 374 high school students, social support and depression were significantly related to suicidal ideation levels one-year later (Mazza & Reynolds, 1998). The research regarding family relationships has generally focused on social support. Peer relationships have often been overlooked except for the use of loneliness as a variable. In one study, suicidal thinking was found to be related to greater loneliness (Martin, Rozanes, Pearce & Allison, 1995). In that study, as in many studies, depression was the strongest factor to emerge in the regression analyses. In fact, in one study, when the effect of depression was removed, the relationships between suicidal ideation and other correlates weakened or disappeared (De Man, 1999). In longitudinal studies, depression has been found to be the most frequent predictor of subsequent suicidal ideation and attempts, with suicidal ideation and attempts, in turn, being predictors of subsequent depression (Fisher, 1999).

Hypothesis

To undertake the research and study the objectives properly, following hypotheses were formulated –

- There will be negative correlation between spiritual involvement and suicidal ideation in times of covid-19 pandemic.
- There will be negative correlation between perceived physical healthiness and suicidal ideation in times of covid-19 pandemic.
- There will be negative correlation between and psychological well-being and suicidal ideation in times of covid-19 pandemic.

- There will be positive correlation between psychological well-being and perceived physical health in times of covid-19 pandemic.
- There will be a positive correlation between spiritual involvement and psychological well-being in times of covid-19 pandemic.
- There will be a positive correlation between spiritual involvement and perceived physical health in times of covid-19 pandemic.

Summary

This chapter talks about existing study and validated literature with respect to all the variables that are a part of this study. Various studies showing the relationship of psychological well-being, physical well-being and spiritual involvement to suicidal ideation and their interrelation was shown through recent studies.

Rationale Of the Study

Suicides have always been a major concern for the psychological field and also a topic of research frequently. But the occurrence of suicides begins with its Ideation first and to study what might reduce the chances of it is the core of this study. There are various parameters of well- being which enhance the life of an individual. But mainly studying the spiritual involvement of adults, their psychological wellbeing and physical healthiness and how they together or individually interact with suicidal ideation serves us a great deal of understanding for future interventions in Suicide prevention. Also owing to the hard and difficult phase of covid-19 pandemic in the world and complete lockdown in India with so much of anxiety created by the media surrounding health to how difficult it is for a normal person to function well in such times, this study becomes much more relevant. And with growing concerns for physical and mental health also their relation to suicidal ideation is not unknown.

Though many studies have established a certain relationship between psychological well-being and suicidal Ideation, the importance of physical healthiness and spiritual understanding of adults are not highlighted. It is not just one factor or one aspect of well-being that affects Suicidal ideation and this study tries to understand the relationship among them. Equally understanding Suicidal ideation and how it is related to each variable gives us a much larger picture of the issue itself.

Not only this, psychological well-being and physical health are closely related which makes this study more elaborative. Understanding the spiritual involvement and it's affect on not only suicidal ideation but also mental and physical health makes this study a better correlation. And understanding the spiritual involvement in this study among adults also opens a new discussion on the the domain of positive psychology. Also this study will not only help evaluate the suicidal ideation among adults but also ways in which it can be anaylsed and will further help to shed light on various domains of well-being like physical, psychological and spiritual and how they independently as well as together might have a positive impact, if any on suicidal ideation. Spiritual well-being is connected to psychological well-being which is again connected to physical well-being and a physically and mentally sound person can practice spiritual well-being which thereby gives us a clear picture that well-being is not confined to a single domain but is actually an interaction of all. To study this interaction, to anaylse its effect on suicidal ideation and how reciprocally suicidal ideation might affect the individual if it does, physically and mentally remains the core of this study.

In times like world pandemics when it is extremely difficult for people to deal with certain issues especially depression, hoplelessness and suicides, this study will benefit to understand suicidal ideation on a deeper level and will also focus on various aspects of well-being.

METHODOLOGY

Research Variables

In the descriptive study, following are the variables –

- Spiritual involvement
- Perceived physical healthiness
- Psychological well-being
- Suicidal ideation

Research Design

This project is a correlation study to understand the relationship between four variables namely spiritual involvement, perceived physical healthiness, psychological well-being and suicidal ideation. This project is a quantitative study that used Descriptive Statistical Design. Data was collected using self- administered standard questionnaires.

Research Setting

As this study consists of random population from age group 20-30, no specific location or category was required. Due to the pandemic, test was made available online and the data was collected through google forms. The data was collected by standard questionnaires and participants were given an overview online as to what was their role in this study.

Operational Definition

Spiritual Involvement –

In this study, spiritual Involvement is defined as an individual's understanding of the self, a connection to his inner sense and the beliefs or values they possess that give the meaning to life in a positive healthy way.

Perceived physical healthiness –

In this study of research, perceived physical healthiness is how healthy a person perceives himself to herself to be healthy in order to feel good about their bodies and be able to function well in life.

Psychological well-being –

Psychological well-being refers to inter- and intra -individual levels of positive functioning that can include one’s relatedness with others and self-referent attitudes that include one’s sense of mastery and personal growth. Subjective well-being reflects dimensions of affect judgments of life satisfaction.

Suicidal ideation –

Suicidal ideation, also known as suicidal thoughts, is thinking about, considering, or planning suicide. The range of suicidal ideation varies from fleeting thoughts, to extensive thoughts, to detailed planning.

Sampling Requirements

- Sampling technique – Convenient and Snowball sampling methods are used.
- Sampling size and nature – All people for sample are from various backgrounds including working and non-working, government employees as well as private workers, married as well as unmarried people. A sample of around 120 is taken.
- Sampling criteria – Age group of 20 – 30 years will be included. Extraneous variables such as occupation, marital status were not tried to control.

Methods Of Data Collection Procedure

Firstly, proper test of standardized measures was selected and google form was created so that the data collection procedure could be carried out with no social contact due to Corona pandemic. Accordingly, people from age groups 20-30 were sent the google forms through snowball sampling and a maximum target of 120 samples was collected.

While forwarding the google forms, people were informed of the goal of the research study in short and an email id for any queries if arises was provided. Participants were well informed of the confidentiality of the study. To make sure that the form reaches a wide population, use of social media was initiated. After the samples was collected, the responses were stored with excel sheets for the latter calculations.

Tests Used for Assessment

Spiritual Involvement-

Spiritual Involvement and Beliefs Scale, widely applicable across religious traditions, to assess actions as well as beliefs to address key components not assessed in other available measures, and to be easily administered and scored will be used in this study to access the spiritual involvement of adults. The instrument is a questionnaire containing 26 items in a modified Likert-type format.

Validity and Reliability -

The Spiritual Involvement and Beliefs Scale (SIBS) appears to have good reliability and validity. By several measures, instrument reliability and validity are very good, with high internal consistency (Cronbach's alpha = .92); strong test-retest reliability (r = .92); a clear four-factor structure; and a high correlation (r = .80) with another established measure of spirituality, the Spiritual Well-Being Scale.

The Spiritual Involvement and Beliefs Scale (SIBS) appears to have good reliability and validity. Compared with other instruments that assess spirituality, the SIBS has several theoretical advantages, including broader scope, use of terms that avoid cultural-religious bias, and assessment of both beliefs and actions. More testing is underway to further assess its uses.

Perceived Physical Healthiness-

Perceived health competence scale Smith et al. (1995) provides a measure of perceived competence. It is a domain-specific measure in that it measures the degree to which an individual feels capable of reasonably managing his or her health outcomes. The PHCS is an 8-item measure that uses a 5-point Likert scale. Containing both outcome and behavioral expectations, the PHCS was developed to fill a void between existing behavior-specific self-efficacy measures and global perceived competence measures. It can be easily and quickly administrated.

Validity and Reliability

Construct validity A factor analysis confirmed the single factor structure underlying the PHCS scale, explaining a total of 56% of the variance (factor loadings are provided in Table 1). Cronbach's alpha was high (0.91). Concurrent validity As self-efficacy has been shown to be strongly, positively and consistently related to health status, evidence for the concurrent validity of the PHCS was found in the form of moderate to high correlations between the PHCS and each of the scales from the SF-36. The PHCS had the strongest relationship with the SF-36 General Health scale (r = .71) and the weakest relationship with the Role Limitations due to Physical Problems (r = .55) and Role Limitations due to Emotional Problems (r = .54) scales. All correlations were significant at the .001 level; other coefficients were PHCS x Physical Functioning = .62, PHCS x Bodily Pain = .58, PHCS x Vitality = .65, PHCS x Social Functioning = .65, PHCS x Mental Health = .62

Given the sound psychometric properties of the PHCS and the evidence to suggest its importance as a predictor of health-related behaviour and outcomes, it is surprising that this instrument is not more widely used and there continues to be a reliance on global measures such as the Generalised Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), regardless of the level of specificity of the outcome under Examination.

Psychological well-being -

Psychological well-being Scale Developed by psychologist Carol D. Ryff, the 42-item Psychological Wellbeing (PWB) Scale measures six aspects of wellbeing and happiness: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff et al., 2007; adapted from Ryff, 1989). Carol Ryff has conceptualized psychological well-being as consisting of 6 dimensions: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance. She has designed self-report scales to assess individual's well-being at a particular moment in time within each of these 6 dimensions. Three- to 12- item per scale validated versions exist of the measure for use in survey research or other data collection. Individuals respond to various statements and indicate on a 6-point Likert scale how true each statement is of them. Higher scores on each on scale indicate greater well-being on that dimension.

Validity and Reliability -

The test-retest reliability coefficient of RPWBS was 0.82. The subscales of Self-acceptance, Positive Relation with Others, Autonomy, Environmental Mastery, Purpose in Life, and Personal Growth were found to be 0.71, 0.77, 0.78, 0.77, 0.70, and 0.78 respectively, which were statistically significant ($p<0.001$). The correlation coefficient of RPWBS with Satisfaction with Life, Happiness, and Self-esteem were also found to be: 0.47, 0.58, and 0.46 respectively which were also significant ($P<0.001$).

Suicidal ideation-

The Beck Scale for Suicide Ideation (SSI; Beck, et al., 1979) is a brief 21-item scale that assesses the person's current intensity of attitudes, plans, and behaviors to commit suicide. The Beck Scale for Suicide Ideation (BSS) is the self-report version of the interviewer-administered SSI and is one of the most widely used self-report instruments for the assessment of suicidal thinking. It helps to identify suicidal individuals provided that they are willing to acknowledge and share their thoughts. The BSS serves as a routine screening for existent suicidal thinking (BSS-Screen) and can also aid in a more extensive exploration of the severity of such thoughts (total BSS score). It can be administered in various settings

(e.g., psychiatric-psychotherapeutic care, general medical services, and forensic psychiatry) and the routine screening, consisting only of five items, can be regarded as very time-efficient.

Validity and Reliability

The BSS has proven to be a reliable measure across many different settings and samples, showing good internal consistencies e.g., $\alpha = .87$ in an outpatient sample, $\alpha = .89$ in a risk sample, and $\alpha = .88$ in a non-clinical student sample. One-week retest reliabilities of $r_{tt} = .54$ and $r_{tt} = .88$ have been found. Suicidal ideation as measured by the BSS has been shown to be strongly associated with hopelessness and depression. High correlations between the BSS and other instruments for the measurement of suicidality have also been found, for example with the Suicide Probability Scale, the Adult Suicidal Ideation Questionnaire, and the Ratings of Suicidal Thoughts, providing support for convergent validity.

Data Analysis Method

Descriptive as well as inferential statistics was used for data analysis in the proposed study.The term "descriptive statistics" refers to the analysis, summary, and presentation of findings related to a data set derived from a sample or entire population. Descriptive statistics comprises three main categories – Frequency Distribution, Measures of Central Tendency, and Measures of Variability.

Measures of central tendency –
*Mean
*Median
*Mode

Measures of variability –
*Range
*Standard deviation
* Skewness and Kurtosis

Statistics used – SPSS means Statistical Package for Social Sciences.
Test used – Pearson Correlation Coefficient - Pearson's correlation coefficient is the test statistics that measures the statistical relationship, or association, between two continuous variables. It is known as the best method of measuring the association between variables of interest because it is based on the method of covariance.

SPSS

SPSS is the abbreviation of Statistical Package for Social Sciences and it is used by researchers to perform statistical analysis. As the name suggests, SPSS statistics software is used to perform only statistical operations. SPSS is most often used in social science fields such as psychology, where statistical techniques are involved at a large scale. In the field of psychology, techniques such as cross tabulation, t-test, chi-sqaure etc., are available in the "analyze" menu of the software. The major limitation of SPSS is that it cannot be used to analyze a very large data set. A researcher often gets a large data set in the field of medicine and nursing, so in those fields, the researcher generally uses other softwares instead of SPSS to analyze the clinical data.

Pearson Correlation Coefficient

Correlation is a bivariate analysis that measures the strength of association between two variables and the direction of the relationship. In terms of the strength of relationship, the value of the correlation coefficient varies between +1 and -1. A value of ± 1 indicates a perfect degree of association between the two variables. As the correlation coefficient value goes towards 0, the relationship between the two variables will be weaker. The direction of the relationship is indicated by the sign of the coefficient; a + sign indicates a positive relationship and a – sign indicates a negative relationship. Usually, in statistics, we measure four types of correlations: Pearson Correlation, Kendall rank correlation, Spearman correlation, and the Point-Biserial correlation. The software below allows you to very easily conduct a correlation.

Pearson r correlation: Pearson r correlation is the most widely used correlation statistic to measure the degree of the relationship between linearly related variables. For example, in the stock market, if we want to measure how two stocks are related to each other, Pearson r correlation is used to measure the degree of relationship between the two. The point-biserial correlation is conducted with the Pearson correlation formula except that one of the variables is dichotomous.

Summary

This chapter discussed the research methodology used in this study and also the various tests used along with their psychometric properties. Also the tools such as SPSS and Pearson Correlation Coefficient was described in detail and the sampling technique was presented.

RESULTS AND DISCUSSION

With the use of Descriptive analysis, we found out the mean, median and mode of the data. Also we found the standard deviation, skewness and kurtosis.

Table Of Descriptive Statistics

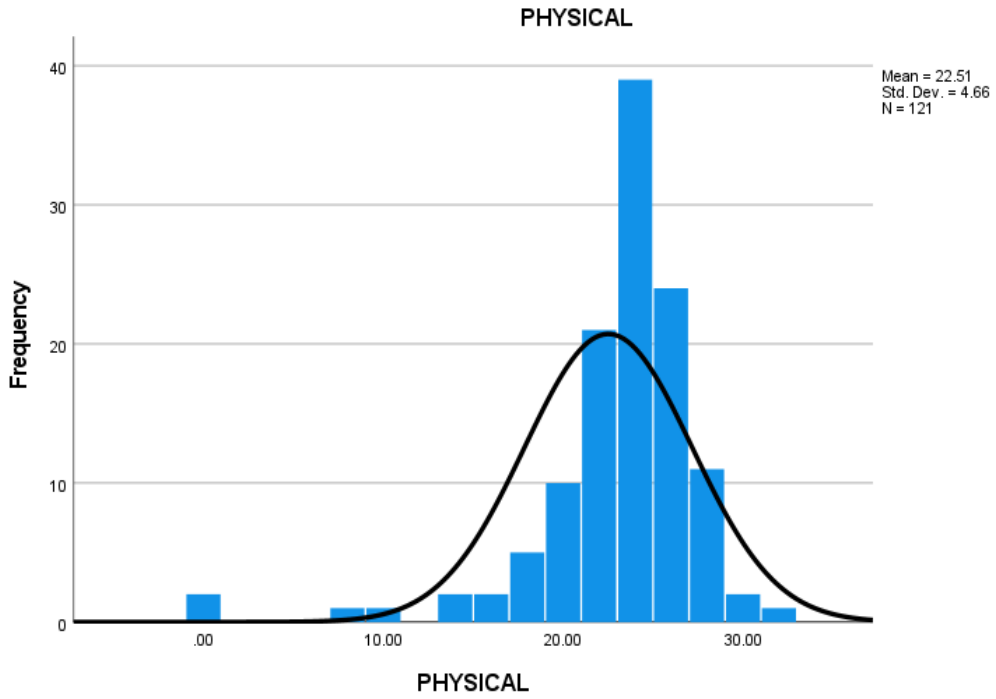
Statistics	Perceived physical health	Psychological wellbeing	Spiritual involvement	Suicidal ideation
Mean	22.512	134.20	55.702	4.446
Median	23.00	143.00	64.000	4.000
Mode	23.00	155.00	.00	.00
Standard deviation	4.660	35.293	23.882	4.006
Skewness	-2.328	-2.262	-1.669	.757
Standard error of skewness	.220	.220	.220	.220
Kurtosis	8.696	5.713	1.470	-.203
Standard error of kurtosis	.437	.437	.437	.437

The results show descriptive statistics for a data of 122 samples.

- The **mean** for perceived physical health is 22.51, for psychological wellbeing it is 134.2, for spiritual involvement mean scores are 55.70 and for suicidal ideation the scores are 4.446.

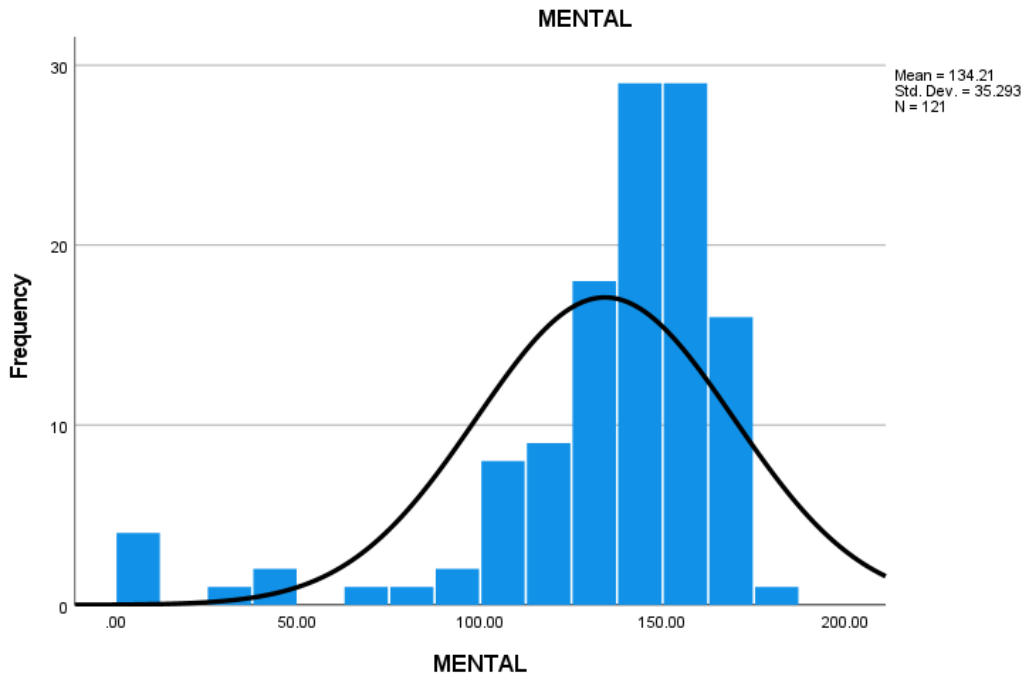
- The **median** scores perceived physical health is 23, for psychological wellbeing it is 143, for spiritual involvement it is 64 and for suicidal ideation the score is 4.00.
- The **mode** for perceived physical health is 23, for psychological wellbeing it is 155, for spiritual involvement it is 0.00 and for suicidal ideation the mode is 0.00.
- The **standard deviation** for perceived physical health is 4.66, for psychological wellbeing it is 35.29, for spiritual involvement it is 23.88 and for suicidal ideation the mode is 4.006.
- The **skewness** for perceived physical health is -2.32, for psychological wellbeing it is -2.262, for spiritual involvement it is -1.669 and for suicidal ideation it is .757 with standard error of skewness being .220.
- The **kurtosis** for perceived physical health is 8.696, for psychological wellbeing it is 5.713, for spiritual involvement it is 1.470 and for suicidal ideation it is -.203 with standard error of kurtosis being .437.

Here, to understand the distribution in a better way, histograms will be used.
Perceived physical health



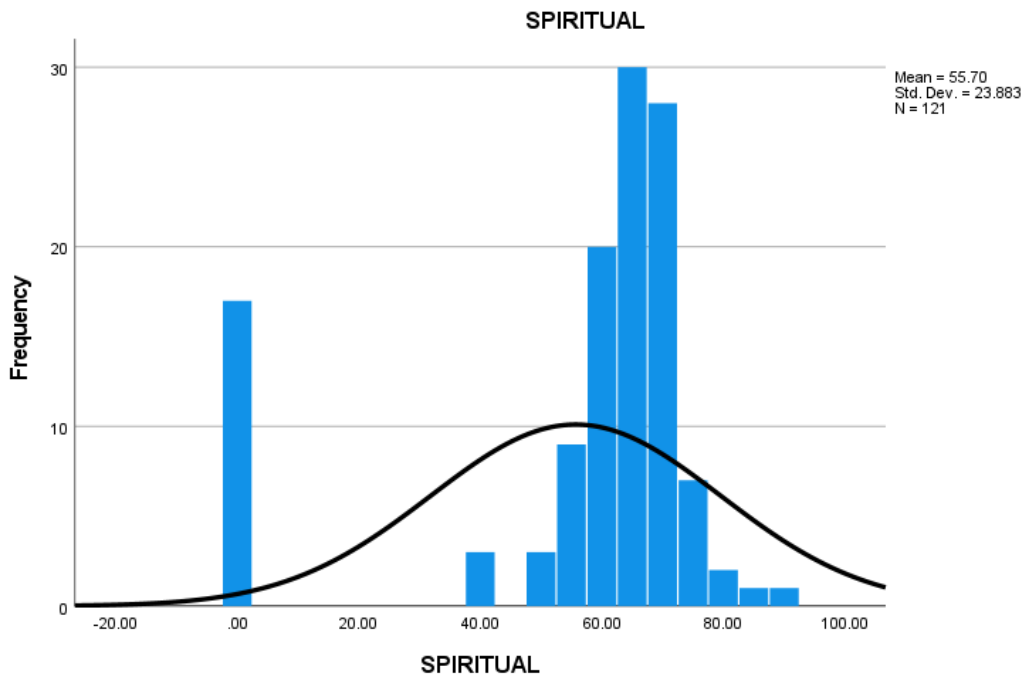
Here, the data represents a left-skewed distribution.

Psychological wellbeing –



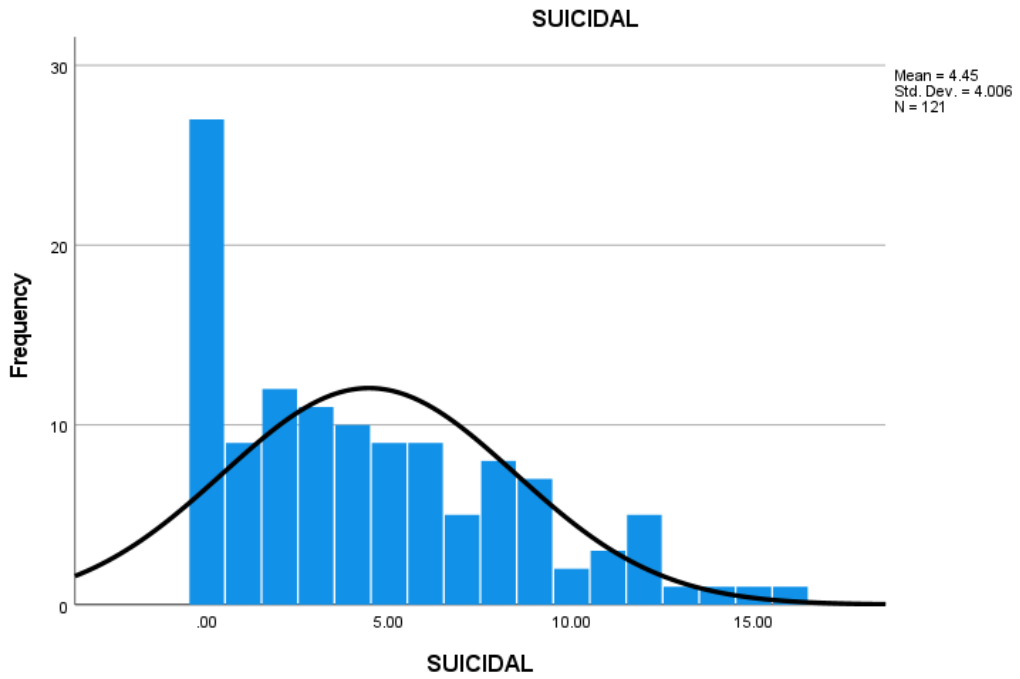
Here, again the data shows left- skewed distribution.

Spiritual involvement –



Here, distribution is bi-modal or double-peaked.

Suicidal ideation –



Here, the data distribution looks rightly-skewed.

Correlational Analysis

Variables	Perceived physical health	Psychological wellbeing	Spiritual involvement	Suicidal ideation
Perceived physical health	1	**.544****	**.159***	.099
Sig. (1-tailed)		.00	.040	.141
Psychological wellbeing	**.544****	1	**.511****	.149
Sig. (1-tailed)	.00		.00	.051
Spiritual involvement	**.159***	**.511****	1	**.359****
Sig. (1-tailed)	.040	.00		.00
Suicidal ideation Sig. (1-tailed)	.099 .141	.149 .051	**.359**** .00	1

Table Of Correlation

Note:
**Correlation is significant at 0.01 level.
*Correlation is significant at 0.05 level.

Here, table shows us various correlations.

- Perceived physical health shows positive correlation to psychological wellbeing with coefficient of .544 with 0.01 level of confidence.
- Perceived physical health shows positive correlation to spiritual involvement with coefficient of .159 with 0.05 level of confidence.

- Psychological wellbeing shows positive correlation with spiritual involvement with coefficient of .511 with 0.01 level of confidence.
- Spiritual involvement and suicidal ideation show a positive correlation of .359 with 0.01 level of confidence.

Regression Analysis

Along with studying the correlation study between Spiritual involvement, Psychological wellbeing, Perceived physical competence to Suicidal Ideation, this study also predicts how one variable could affect the other.

DV: Suicidal Ideation

Predictor variable	Adjusted R square	Beta	Sig.	dF	F	Sig.
Spiritual involvement	.121	.359	.00	1	17.589	.00

DV: Psychological wellbeing

Predictor variable	Adjusted R square	Beta	Sig.	dF	F	Sig.
Perceived physical health	.290	.544	.00	1	50.060	.00
Spiritual involvement	.472	.436	.00	2	54.699	.00

DV: Spiritual involvement

Predictor variable	Adjusted R square	Beta	Sig.	dF	F	Sig.
Psychological wellbeing	.255	.511	.00	1	42.131	.00

Table Of Regression

DISCUSSION

The research proposed to study the correlation between Spiritual involvement, Psychological wellbeing, Perceived physical competence to Suicidal Ideation. The results of correlation have been put forth above. Let us now examine the hypothesis and interpretation.

Hypothesis one stating "There will be negative correlation between spiritual involvement and suicidal ideation in times of covid-19" was **rejected (r=.359, p<0.01)**. The hypothesis stated meant that as spiritual involvement of a person increases his suicidal ideation decreases or a person with suicidal ideation will show low spiritual involvement but as this hypothesis has been rejected, let us see what are the reasons for it. This study used Becks suicidal ideation scale to obtain data. Suicidal ideation is a very sensitive topic and it might be possible that participants were not honest while answering many of the questions as tests like such need participants to be open and vulnerable. A study by Cantor(1976) reported that frequency of self -re-ported suicidal thoughts was higher in a sample of college students who had made past suicide attempts than among students with no history of self-destructive behavior. Wetzel's (1975, 1976a, 1976b) studies seem to indicate a continuity between

suicide idea-tors and suicide attempters on a number of attitudes. The present study and the work of Wetzel support the assumption that underlays construction of the scale, namely, that self-destructive tendencies are manifest unidentifiable and quantifiable thoughts, wishes and attitudes about suicide. Hence a concepts like ideation in itself very hard to analyze and to measure. Also, spirituality means different things to different people hence the scale used to access falls short in the indian context where spiritual involvement and religion goes hand in hand.

Hypothesis two stating "There will be negative correlation between perceived physical healthiness and suicidal ideation in times of covid-19" **was rejected (r=.099)**. According to the hypothesis, the more the perceived physical health of an individual the less likely is the suicidal ideation. The findings were significant at .141 level which is more than 0.05 level hence the hypothesis stands rejected. There can be many reasons for the insignificant coefficient. The test used for perceived physical health might not have been able to access the physical wellbeing as it was supposed to. Moreover, also biased responses of lack of awareness of one's own physical well-being could also be a reason. There are various reasons why the correlation coefficient is insignificant. First, the perceived health competence scale fails to measure the overall health and also contains cultural bias. Second, as already stated, suicidal ideation scale of beck used in this study is direct and to the point but people are not open to answering such personal questions due to fear of being seen or judged or also due to confirmation bias.

Hypothesis **three** stating "There will be negative correlation between psychological well-being and suicidal ideation in times of covid-19" was **rejected (r=.149).** According to the hypothesis, a person's good psychological health results in lesser suicidal ideation. The finding was found significant at .051 level, which is greater than 0.05 level hence we reject the hypothesis. There can be many reasons for insignificant coefficient, most likely being the social angle where disclosing one's psychological vulnerability is treated as a sign of weakness. Along with that as already discussed people are not open to topics like suicidal ideation. Beck's suicidal ideation test is very direct and questions direct motives of suicide which may cause discomfort to participants to disclose. When a significance test results in a high probability value, it means that the data provide little or no evidence that the null hypothesis is false. However, the high probability value is not evidence that the null hypothesis is true. In a recent study in a UK epidemiological sample of women, Abbott et al. (2006) undertook a detailed psychometric assessment of the 42-item PWB using factor analysis procedures appropriate for the ordinal response format of the Ryff items. Their findings broadly confirmed the six-factor structure; but method factors were necessary to achieve acceptable model fit and to ensure that construct variance was not obscured by common response tendencies to similarly worded items (Abbott et al. 2006). Further, in this sample the modelling supported the notion of a second-order general well-being factor defined by loadings from four of the six-first-order dimensions (environmental mastery, personal growth, purpose in life, self-acceptance). The high correlation between these four factors has also been confirmed in subsequent studies (e.g. Burns and Machin 2009).

All psychometric studies to date have been concerned with the construct validity of the PWB scales. Little is known about the precision of measurement of the PWB scales i.e. the accuracy of the scores that are derived from applications of this measure of well-being in different samples. To our knowledge, the reliability (or precision of measurement) of estimated PWB scores has not previously been investigated. Since there are many scales in

existence which measure negative aspects of well-being by assessing symptoms of mental disorder, it is particularly important for a scale which purports to be about positive well-being to show high precision of measurement at high values of the scale. Ideally, for population wide measurement of individual variation in these new constructs, items need to be designed with response wording that enables well-being to be measured accurately across the range from low, through mid-range to high levels, so that the effective measurement range is as wide as possible.

In summary, our findings suggest that for more reliable measurement of 'high well-being' the PWB requires the identification and addition of questions which tap into the more positive end of the well-being continuum. We propose that the second-order factor offers a potentially more reliable measure for capturing variations in well-being across the continuum than derived from the component subscales. Further work on the validity of the second-order measure is now warranted, particularly across other population samples which include men, and also different age groups. Finally, more in-depth theoretical work on the underlying dimensional structure of psychological well-being is required, particularly in light of the similarities identified between the second-order PWB factor model and Deci & Ryan's three dimensional well-being model.

In light of the growing interest in the measurement of well-being amongst researchers, practitioners and policy makers (Dolan and White 2007; Huppert et al. 2009; Layard 2005; Marks and Shah 2005) there is a pressing need for scales which can measure well-being effectively across the full spectrum. Our analysis has shown that the subscales of the Ryff's six dimensional PWB, adequately measure average levels of well-being, but have low precision of measurement at high levels. Whilst we support the use of the second-order factor as a general measure of well-being, we recommend that future well-being scales should be designed to include items that discriminate more reliably at high levels along the well-being continuum.

Amudhan et al. argue that public health approaches for suicidality and suicide should not be compartmentalised, and they call for an applaudable approach which combines universal, selective and indicated interventions through multi-sectoral public health approaches."From personal experience I know that I've had moments of feeling suicidal, but they have been momentary and I would never act on these thoughts. Should I be the target of an intervention?" said Amudhan.

This paper could have been considerably strengthened by including a sub-analysis looking at the different components of the score i.e. suicidal ideation, plans, intent and attempts. As a composite score it assumes that suicidal ideation, plans, intent and attempts lie on a continuum. The current evidence suggests that suicidal ideation (the assumed start of this continuum) poorly predicts suicide in both psychiatric (positive predictive value: 3.9%) and non-psychiatric (0.3%) samples (McHugh C. et al 2019). The subgroup analysis would have gone some way towards providing more convincing evidence that suicidality should be a target for suicide prevention. If it truly was a good target for intervention, we would see similar associations between each item of the score as one would do overall.

Hypothesis four stating "There will be positive correlation between psychological well-being and perceived physical health in times of covid-19" **(r=.544, p<0.01) was accepted**. This states that a person's psychological and perceived physical health are correlated

positively wherein a physically healthy person feels psychologically good and likewise a person a good mental health views one's own physical health in good light to. Not to forget the various researches that establish not just the view but the scientific association of good mind and good body.

"A healthy mind in a healthy body" was the Romans' prescription for the good life way back in the 1st Century, and new medical research suggests they were right. In a world first, Australian experts have studied how lifestyle can lead to the onset of depression, and how a healthier lifestyle might help those suffering from depression. It's the first time the issue has been studied from both sides.

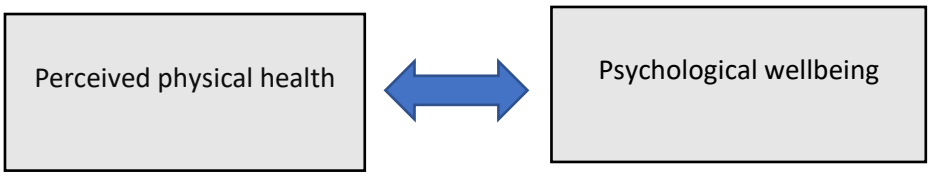
Following 1200 people over five years, the major project assessed the lifestyles of people aged 26-36 and followed up when they were aged 31-41. They assessed lifestyles through a score comprising body mass index, smoking, alcohol consumption, leisure time, physical activity and diet. Dr Seana Gall of the University of Tasmania's Menzies Institute for Medical Research led the research. She says people with healthier lifestyles at the beginning of the study were significantly less likely (22%) to develop a first episode of depression over the five years.

Those with a history of depression tended to lose points for those lifestyle factors over the five years (46%). This was more important than the issues that are often associated with depression – socio-economic position, parental and marital status, social support, major life events, cardiovascular disease history and self-rated physical health.

Dr Gall says the results suggest a healthier lifestyle may protect against the first onset of depression and the findings are relevant for those managing the physical and mental health of younger adults.

"Our findings have implications for reducing the higher risk of cardiovascular disease that is seen in those with depression and also potentially reducing the risk of developing depression in young people" Dr Gall says.

Also as we have seen in the review of literature too that many studies have already proven the relationship between good physical health and good psychological health.



A Diagram Showing the Relationship Between Perceived Physical Health And Psychological Wellbeing.

Hypothesis **five** stating "There will be positive correlation between spiritual involvement and psychological wellbeing in times of covid-19" **(r=.511, p<0.01) was accepted**. Therefore it means that there exists a positive correlation between spiritual involvement and psychological wellbeing. The more a person is spiritually involved the better his

psychological state and vice versa. Many studies have already proven meditation, a part of spirituality and its positive effects on mindfulness and good psychological health.

Studies demonstrated the positive impact of spirituality on physical health and mental health as well as on other positive health outcomes such as subjective well-being, health-related quality of life, coping skills, recovering from mental illness, or less addictive or suicidal behaviors (Mueller et al., 2001; Miller and Thoresen, 2003; Kharitonov, 2012; Unterrainer et al., 2014). However, we must bear in mind that spirituality is a complex construct and as such it is defined in multiple ways and measured with different tools (Lun and Bond, 2013). The relationship between spirituality and psychological well-being was stronger in the human mind and spirit group of students. As longitudinal studies among adolescents by Kor et al. (2019) show spirituality is stable over time and contribute to better subjective well-being. It may also be considered to be a fundamental character strength and a crucial factor of positive development. Thus, spirituality may as well strengthen psychological well-being. Moreover, Giannone and Kaplin (2020) confirm that existential thinking and the production of meaning may be related to mental health. In general, spiritual intervention programs also contribute to mental health and well-being (Sanyal et al., 2020). Moreover, spirituality showed a similar relationship with health-related behaviors and was indirectly associated with psychological well-being through health-related behaviors. In other words, it seems that spirituality is not only directly associated with psychological well-being, but also might be moderated by health-related behavior. This is consistent with existing research (Jesse and Reed, 2004; Park et al., 2009; Unterrainer et al., 2014) and is an indication that spirituality is, in fact, a determinant of psychological well-being prior to health-related behavior.

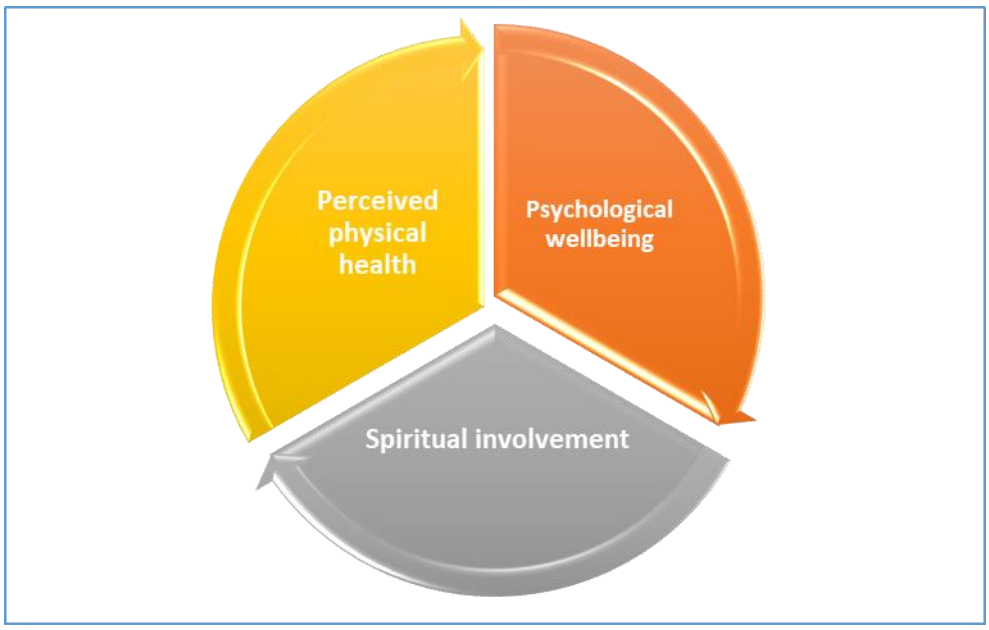
Spirituality contributes to promote the mental health by providing a framework for describing life's experiences and because of that creating a sense of integrity and existential interconnection. Individuals with spiritual experience and religious beliefs can cope with their stress and psychological problems and the confrontation methods are stronger in them, spirituality creates a power which affects on the physical postures, feelings, thoughts and communications and will be affected by them. Actually, spiritual well-being has a protective effect and acts against stress and leads to gain physical and psychological healthy life and supportive behaviors such less use of cigarette and alcohol, more physical activity, having goal and meaning in life, hopefulness, optimism and improves individual's psychological status (Harvey, 2004).

Hypothesis **six** stating "There will be a positive correlation between spiritual involvement and perceived physical health in times of covid-19**" (r=.159, p<0.04) was accepted**. This shows that with greater spiritual beliefs and involvement the perceived physical health also rises. And lower spiritual involvement might also signal lack of perceived good health.

According to Rabin (1999), spiritual or religious practices, such as prayer, can have positive influence on health. One possible mechanism by which participation in religious or spiritual activities fosters a beneficial health effect is the relaxation of the sympathetic nervous system (SNS) and enhancement of immune function (Rabin, 1999). Spirituality may be related to immune system functioning and its effect on health by enhancing one's ability to cope with stress, resulting in better health practices, increased social interaction, and a greater satisfaction with and quality of life (Rabin, 1999). Another explanation for the linkage between spirituality and mental health could include a placebo response, in which mere belief in the effectiveness of a practice often produces an unanticipated beneficial

response. The perceived health benefit gained through spiritual belief systems may be experienced by those engaging in spiritual or religious activities (Rabin, 1999).

Spiritual activities may alleviate depression by enhancing feelings of happiness and increasing greater satisfaction with life, resulting in fewer negative psychosocial stressors (Rabin, 1999). Belief in God may provide emotional assurances that produce favorable autonomic responses, including a decrease in stress-induced catecholamines (neurotransmitters) and mental relaxation (Rabin, 1999).



Circular Relationship Between All Three Variables

First, people with chronic physical conditions are at risk of developing poor mental health. Poor physical health can cause worries, anxiety, depression, stress, lack of concentration and lack of spiritual involvement.

Second, people with serious mental health conditions are at high risk of experiencing chronic physical conditions. Poor mental health can weaken the immune system making the person vulnerable to diseases and viral infections.

Third, lack of spiritual involvement is a risk factor for mental health problems (isolation, hopelessness, lack of purpose and patience) and increased vulnerability to physical illness (poor hygiene, lack of self-discipline). Spiritual decadence can disturb healthy mind-body balance through negative thoughts and deviation from the righteous deeds.

Spiritual involvement as predictor of Suicidal ideation –
12.1% of suicidal ideation is predicted by Spiritual involvement. Other dimensions do not predict Suicidal ideation significantly. Beta value show a positive relationship between spiritual involvement meaning as one increases so does the other and is spiritual involvement decreases so does suicidal ideation.

Perceived physical health and spiritual involvement as predictor of Psychological wellbeing –

29% of psychological wellbeing is predicted by perceived physical health. Also beta values show a positive relationship between both of these variables.

47.2% of psychological wellbeing is predicted by spiritual involvement. Also beta values show positive relation between psychological wellbeing and spiritual involvement.

Psychological wellbeing as predictor of Spiritual involvement –

25.5% of spiritual involvement is predicted by psychological wellbeing. Also beta values show positive relation between psychological wellbeing and spiritual involvement.

Summary

The complete statistical depictions along with graphical representations are done in this chapter. The stats and numbers are analyzed in order to achieve and validate the hypothesis that was set in the beginning of the study. Tabular definitions of the data are done which is attained from the SPSS software. Acceptance and rejections of hypothesis is also done in this unit. The acceptance and rejections are justified with the help of proper literature supporting the similar analysis.

CONCLUSION

- From the above study we can conclude that suicidal ideation is directly and indirectly affected by various variables. Moreover, Spiritual involvement, perceived physical health and psychological wellbeing in itself are co-related and impact how they affect suicidal ideation.
- Spiritual involvement has shown a positive correlation to physical health perceived and psychological wellbeing.
- Psychological wellbeing has shown a positive correlation to suicidal ideation as against the proposed hypothesis as the finding failed to be significant. But a positive correlation has been established between psychological wellbeing and perceived physical health and spiritual involvement.
- Perceived physical health has shown a positive correlation but as the findings were not significant more research news to be carried out.
- Overall, Suicidal ideation is a grave concern for us today and every study takes us close to controlling it better.

LIMITATIONS OF PRESENT STUDY

- The study only considers people of 20-30 age group. Hence people from other age groups were not a part of this study. Also factors like gender or marital status were not controlled which might affect the results in various ways.
- The study is limited to the people of Maharashtra. As also due to the covid situations the study was also limited to people who were accessible through mail thus it was overall an online study. Hence people who are not much acquaint with the online resources could not participate.
- The study is limited to people with basic reading and writing abilities. Also no personal contact could be established. Tests like Suicidal ideation scale are very difficult and sensitive as people are not willing to be honest hence it was a challenge. Physical health competence scale used to access person's physical wellbeing is very subjective to analyze.

IMPLICATIONS

- This study undertaken to understand the relationship between suicidal ideation, perceived physical health, psychological wellbeing and spiritual involvement adds to our knowledge how certain wellbeing is no longer confined concept but as interconnected topic.
- A physically fit person feels psychologically well and hence he can or does adapt to practices like meditation or yoga which in turn keep his health better. It is not a unidirectional concept.
- Talking about suicidal ideation, study does make us aware that it exists and even if it is difficult to reach certain findings, this study will surely help in analyzing it better.

SUGGESTIONS FOR FUTURE RESEARCH

- To assess physical health wellbeing a better parameter of the same could be used to understand its effect on suicidal ideation, merely knowing how a person feels about one's physical health is not enough. To actually know if good health affects suicidal ideation is the goal.
- Research was conducted on a sample of 120, hence a larger sample would result in much better results.
- Merely knowing suicidal causes isn't enough, research should also focus on how to implement preventive measures for the same.

REFERENCES

A. B. Zonderman, "Effects of age, hypertension history, and neuroticism on health perceptions," Experimental Gerontology, vol. 21, no. 4-5, pp. 449–458, 1986.

A. LaRue, L. Bank, L. Jarvik, and M. Hetland, "Health in old age: how do physicians' ratings and self-ratings compare?" Journals of Gerontology, vol. 34, no. 5, pp. 687–691, 1979.

A. Ozaki, M. Uchiyama, H. Tagaya, T. Ohida, and R. Ogihara, "The Japanese centenarian study: autonomy was associated with health practices as well as physical status," Journal of the American Geriatrics Society, vol. 55, no. 1, pp. 95–101, 2007.

Adams DM, Overholser JC, Lehnert KL. Perceived family functioning and adolescent suicidal behavior. Journal of the American Academy of Child and Adolescent Psychiatry. 1994;33(4):498–507. [PubMed]

American Association of Suicidality. Youth suicide fact sheet. 2006. Retrieved July 6, 2007, from http://www.suicidology.org/associations/1045/files/Youth2004.pdf.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. 4. Washington, DC: American Psychiatric Press; 1994.

Barrios LC, Everett SA, Simon TR, Brener ND. Suicide ideation among US college students: Associations with other injury risk behaviors. Journal of American College Health. 2000;48(5):229–233. [PubMed]

Beck AT, Rush AJ, Shaw BF, Emery G. Cognitive therapy of depression. New York: Guilford. Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review. 1979;8(1):77–100.

Boden JM, Fergusson DM, Horwood LJ. Anxiety disorders and suicidal behaviours in adolescence and young adulthood: Findings from a longitudinal study. Psychological Medicine. 2007;37(3):431–440.

C. D. Mulrow, M. B. Gerety, J. E. Cornell, V. A. Lawrence, and D. N. Kanten, "The relationship between disease and function and perceived health in very frail elders," Journal of the American Geriatrics Society, vol. 42, no. 4, pp. 374–380, 1994.

Clum GA, Febbraro GAR. Stress, social support, and problem-solving appraisal/skills: Prediction of suicide severity within a college sample. Journal of Psychopathology and Behavioral Assessment. 1994;16(1):69–83.

Collingwood, J. (2018). The Relationship Between Mental & Physical Health. Psych Central. Retrieved on May 24, 2020, from https://psychcentral.com/lib/therelationship-between-mental-and-physical-health/

D. A. Revicki and J. P. Mitchell, "Strain, social support, and mental health in rural elderly individuals," Journals of Gerontology, vol. 45, no. 6, pp. S267–S274, 1990.

D. Jopp and C. Rott, "Adaptation in very old age: exploring the role of resources, beliefs, and attitudes for centenarians' happiness," Psychology and Aging, vol. 21, no. 2, pp. 266–280, 2006.

D'Attilio JP, Campbell BM, Lubold P, Jacobson T, Richard JA. Social support and suicide potential: Preliminary findings for adolescent populations. Psychological Reports. 1992;70(1):76–78.

Daniel SS, Walsh AK, Goldston DB, Arnold EM, Reboussin BA, Wood FB. Suicidality, school dropout, and reading problems among adolescents. Journal of Learning Disabilities. 2006;39(6):507–514.

Dugas, E; Low, NP; Rodriguez, D; Burrows, S; Contreras, G; Chaiton, M; et al. (2012).

Durkheim E. In: Spauelding JA, Simpson G, editors. Suicide: a study in sociology. 1951 ed. London: Routledge & Kegan Paul; 1897.

E. L. Idler, "Age differences in self-assessments of health: age changes, cohort differences, or survivorship?" Journals of Gerontology, vol. 48, no. 6, pp. S289–S300, 1993.

Fergusson DM, Horwood LJ, Ridder EM, Beautrais AL. Suicidal behaviour in adolescence and subsequent mental health outcomes in young adulthood. Psychological Medicine. 2005;35(7):983–993.

Fergusson DM, Lynskey MT. Suicide attempts and suicidal ideation in a birth cohort of 16-year-old New Zealanders. Journal of the American Academy of Child and Adolescent Psychiatry. 1995;34(10):1308–1317.

G. G. Fillenbaum, Multidimensional Functional Assessment of Older Adults: The Duke Older Americans Resources and Services Procedures, Lawrence Erlbaum Associates, Hillsdale, Mich, USA, 1988.

G. I. J. M. Kempen, J. Ormel, E. I. Brilman, and J. Relyveld, "Adaptive responses among Dutch elderly: the impact of eight chronic medical conditions on health-related quality of life," American Journal of Public Health, vol. 87, no. 1, pp. 38–44, 1997.

G. Kaplan and O. Baron-Epel, "What lies behind the subjective evaluation of health status?" Social Science and Medicine, vol. 56, no. 8, pp. 1669–1676, 2003.

G. V. Ostir, K. S. Markides, M. K. Peek, and J. S. Goodwin, "The association between emotional well-being and the incidence of stroke in older adults," Psychosomatic Medicine, vol. 63, no. 2, pp. 210–215, 2001.

Garrison CZ, McKeown RE, Valois RF, Vincent ML. Aggression, substance use, and suicidal behaviors in high school students. American Journal of Public Health. 1993;83(2):179–184.

Gili-Planas M, Roca-Bennasar M, Ferrer-Perez V, Bernardo-Arroyo M. Suicidal ideation, psychiatric disorder, and medical illness in a community epidemiological study. Suicide and Life-Threatening Behavior. 2001;31(2):207–213.

Gould MS, Fisher P, Parides M, Flory M, Shaffer D. Psychosocial risk factors of child and adolescent completed suicide. Archives of General Psychiatry. 1996;53(12):1155–1162.

H. Iwasa, K. Kawaai, Y. Gondo, H. Inagaki, and T. Suzuki, "Subjective well-being as a predictor of all-cause mortality among middle-aged and elderly people living in an urban Japanese community: a seven-year prospective cohort study," Geriatrics & Gerontology International, vol. 6, pp. 216–222, 2006.

Harris TL, Molock SD. Cultural orientation, family cohesion and family support in suicide ideation and depression among African American college students. Suicide and Life-Threatening Behavior. 2000;30(4):341–353.

Harter S, Marold DB, Whitesell NR. Model of psychosocial risk factors leading to suicidal ideation in young adolescents. Development and Psychopathology. 1992;4(1):167–188.

J. Evert, E. Lawler, H. Bogan, and T. Perls, "Morbidity profiles of centenarians: survivors, delayers, and escapers," Journals of Gerontology A, vol. 58, no. 3, pp. 232–237, 2003.

Joiner T. Why people die by suicide. Cambridge: Harvard University Press; 2005.

K. Andersen-Ranberg, M. Schroll, and B. Jeune, "Healthy centenarians do not exist, but autonomous centenarians do: a population-based study of morbidity among danish centenarians," Journal of the American Geriatrics Society, vol. 49, no. 7, pp. 900–908, 2001.

Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Archives of General Psychiatry. 1999;56(7):617–626.

Kyle J. Spirituality: its role as a mediating protective factors in youth at risk for suicide. J Spirituality Mental Health. 2013;15(10):47–67.

L. W. Poon, S. M. Jazwinski, R. C. Green et al., "Methodological considerations in studying centenarians: lessons learned from the Georgia Centenarian Studies," in Annual Review of Gerontology and Geriatrics: Biopsychosocial Approaches to Longevity, L. W. Poon and T. T. Perls, Eds., vol. 27, pp. 231–264, Springer, New York, NY, USA, 2007.

Mireault M, de Man AF. Suicidal ideation among the elderly: Personal variables, stress and social support. Social Behavior and Personality. 1996;24(4):385–392.

Moreira-Almeida A, Neto FL, Koening HG. Religiousness and mental health: a review. Rev Bras Psiquiatr. 2006;28:3.

N. Bradburn, The Structure of Psychological Well-Being, Aldine, Chicago, Ill, USA, 1969.

N. Hoeymans, E. J. M. Feskens, D. Kromhoup, and G. A. M. Van Den Bos, "Ageing and the relationship between functional status and self-rated health in elderly men," Social Science and Medicine, vol. 45, no. 10, pp. 1527–1536, 1997.

P. Schönemann-Gieck, C. Rott, M. Martin, V. D'Heureuse, M. Kliegel, and G. Becker, "Similarities and differences between self-rated and proxy-rated health in extreme old age, vol. 36, no. 6, pp. 429–436, 2003.

Paloutzian RF, Ellison CW. Loneliness, spiritual well-being and quality of life. In: Peplau LA, Perlman D, editors. Loneliness: a sourcebook of current theory, research and therapy. New York: Wiley; 1982. p. 224–37.

Petronis KR, Samuels JF, Moscicki EK, Anthony JC. An epidemiologic investigation of potential risk factors for suicide attempts. Social Psychiatry and Psychiatric Epidemiology. 1990;25(4):193–199.

Pierce GR, Sarason IG, Sarason BR. General and relationship-based perceptions of social support: Are two constructs better than one? Journal of Personality and Social Psychology. 1991;61(6):1028–1039.

Reifman A, Windle M. Adolescent suicidal behaviors as a function of depression, hopelessness, alcohol use, and social support: A longitudinal investigation. American Journal of Community Psychology. 1995;23(3):329–354.

Reinherz HZ, Giaconia RM, Silverman AB, Friedman A, Pakiz B, Frost AK, Cohen E. Early psychosocial risks for adolescent suicidal ideation and attempts. Journal of the American Academy of Child and Adolescent Psychiatry. 1995;34(5):599–611. [PubMed] [Google Scholar]

Reinherz HZ, Tanner JL, Berger SR, Beardslee WR, Fitzmaurice GM. Adolescent suicidal ideation as predictive of psychopathology, suicidal behavior, and compromised functioning at age 30. American Journal of Psychiatry. 2006;163(7):1226–1232. [PubMed] [Google Scholar]

Religiosity in Subjective Well-Being of Individuals With Different Religious Status. *Front. Psychol*. 10:1525. doi: 10.3389/fpsyg.2019.01525

Rivinus TM. The deadly embrace: The suicidal impulse and substance use and abuse in the college student. Journal of College Student Psychotherapy. 1990;4(3):45–77.

S. E. Fienberg, E. F. Loftus, and J. M. Tanur, "Cognitive aspects of health survey methodology: an overview," Milbank Memorial Fund Quarterly, Health and Society, vol. 63, no. 3, pp. 547–564, 1985.

S. H. Kim, G. Wolde-Tsadik, and D. B. Reuben, "Predictors of perceived health in hospitalized older persons: a cross-sectional and longitudinal study," Journal of the American Geriatrics Society, vol. 45, no. 4, pp. 420–426, 1997.

S. S. Bassett, J. Magaziner, and J. R. Hebel, "Reliability of proxy response on mental health indices for aged, community-dwelling women," Psychology and Aging, vol. 5, no. 1, pp. 127–132, 1990.

Shaheen H, Jahan M, Shaheen F, Shaheen S. Impact of spirituality on suicidal ideation among university students. In: Husain A, Kaneez S, Jahan M, editors.Studies in spiritual psychology. New Delhi: Research India Press; 2014. p. 202–21.

Sokero TP, Melartin TK, Rytsala HJ, Leskela US, Lestela-Mielonen PS, Isometsa ET. Prospective study of risk factors for attempted suicide among patients with DSM-IV major depressive disorder. The British Journal of Psychiatry: The Journal of Mental Science. 2005;186:314–318. [PubMed] [Google Scholar]

Steinhausen HC, Metzke CWW. The impact of suicidal ideation in preadolescence, adolescence, and young adulthood on psychosocial functioning and psychopathology in young adulthood. Acta Psychiatrica Scandinavica. 2004;110(6):438–445. [PubMed] [Google Scholar]

Stewart SM, Lam TH, Betson C, Chung SF. Suicide ideation and its relationship to depressed mood in a community sample of adolescents in Hong Kong. Suicide and Life-Threatening Behavior. 1999;29(3):227–240. [PubMed] [Google Scholar]

Stoelb M, Chiriboga J. A process model for assessing adolescent risk for suicide. Journal of Adolescence. 1998;21(4):359–370. [PubMed] [Google Scholar]

The World Health Report: Reducing risks, promoting health life. World Health Organization. 2002. https://www.who.int/whr/2002/en/. Accessed 20 Oct 2018.

Westefeld JS, Homaifar B, Spotts J, Furr S, Range L, Werth JL., Jr Perceptions concerning college student suicide: Data from four universities. Suicide and Life Threatening Behavior. 2005;35(6):640–645. [PubMed] [Google Scholar]

Wu P, Hoven CW, Liu X, Cohen P, Fuller CJ, Shaffer D. Substance use, suicidal ideation and attempts in children and adolescents. Suicide and Life-Threatening Behavior. 2004;34(4):408–420. [PMC free article] [PubMed] [Google Scholar]

Yama MF, Tovey SL, Fogas BS, Morris J. The relationship among childhood sexual abuse, parental alcoholism, family environment and suicidal behavior in female college students. Journal of Child Sexual Abuse. 1995;4(4):79–93.

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Conflict of Interest

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