Suicide and coping: specific coping behaviours associated with suicidal ideation and differences between predicted and actual coping among help-seeking individuals

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Abstract

Suicide is a substantial contributor to global mortality, with suicidal ideation (SI) a significant predictor of suicide. Research has demonstrated relationships between dispositional coping styles and SI. This study aimed to advance this research by moving from the disposition coping level to examining the specific coping strategies people use when experiencing SI. Further, it aimed to examine whether *prediction* of the coping strategies individuals would use if they experienced SI differs from the *actual* coping strategies employed by people that have experienced SI. Seventy-seven help-seeking adults ($M_{age} = 31.6$, $SD = 10.4$) with ($n = 49$) or without ($n = 28$) history of SI completed measures of SI-related coping (modified Brief COPE) and current emotional distress (DASS-21) via online survey. ANCOVA revealed a significant association between SI history status and endorsement of Problem-Focused coping strategies, while controlling for current emotional distress levels. Participants without SI history reported greater predicted Problem-Focused coping use than actual use reported by participants with SI history. Subsequent facet-level ANCOVAs demonstrated that participants without SI history predicted they would use Active Coping, Use of Informational Support, and Planning strategies to a greater extent than was reported by people who did experience SI. The findings suggest individuals without SI history may overestimate their ability to use such adaptive coping strategies, and may represent an overestimation of overall ability to cope with potential SI. Future research may build on these preliminary findings and examine the factors explaining these differences to help inform programs related to SI and coping.

Introduction

Suicidal ideation (SI) is a significant predictor of death by suicide, with only prior psychiatric hospitalisation and previous suicide attempts demonstrated to be stronger predictors (Franklin et al., 2017). Additionally, these predictors are inter-related, with SI constituting a prominent reason for psychiatric hospitalisation (Bowers, 2005; Jobes and Joiner, 2019; Larkin and Beautrais, 2010), and the presence of SI associated with an increased number of lifetime suicide attempts (Baca-Garcia et al., 2011; Szanto et al., 2001). There is therefore demonstrable value in increasing understanding of SI itself (Jobes and Joiner, 2019), and in investigating how individuals manage SI.

Coping, or the cognitive and behavioural efforts and strategies utilised by individuals to manage challenging demands (Lazarus and Folkman, 1984; Moos and Holahan, 2003), is key to an understanding of individuals' management of SI. The range of strategies individuals may employ to cope have been categorised in numerous ways (Moos and Holahan, 2003; Skinner et al., 2003). Broadly, coping strategies may be categorised as either adaptive (i.e., *helpful*) such as problem-solving and information-seeking, or maladaptive (i.e., *harmful*) such as substance use and self-pity (Woodhead et al., 2004; Surujlal & Nguyen, 2011). Adaptive coping strategies are approach-oriented, and either problem- or emotion-focused, and involve the individual utilising their own resources and those around them to actively engage with the current demand, in an effort to reduce, eliminate, or counteract their distress (Moos and Holahan, 2003). As such, greater use of adaptive coping strategies is associated with positive outcomes such as increased life satisfaction (Buser and Kearney, 2017). Conversely, maladaptive coping strategies are broadly avoidant in nature, and are associated with poorer outcomes (Cronkite et al., 1998; Nagase et al., 2009).

Current evidence on coping and suicide has focused on trait-level coping strategies – that is, the general disposition to use coping strategies in dealing with challenges and how this is associated with suicidal thoughts and behaviours. Within this literature, greater use of maladaptive coping strategies has been associated with increased SI (Marty et al., 2010; Woodhead et al., 2014) and suicidal behaviour (Ong and Thompson, 2019; Svensson et al., 2014). The association between greater use of avoidant coping strategies and increased SI remains significant after controlling for the influence of prior suicide attempts (Ambrus et al., 2020). Additionally, evidence shows decreased use of adaptive coping strategies to be associated with increased SI (Pienaar et al., 2007), while individuals with current suicidality employ less adaptive problem-focused coping strategies than non-suicidal controls (Sharif et al., 2014). Longitudinal evidence shows reduced likelihood of reporting SI at 1-year follow-up among adolescents employing greater adaptive problem-solving coping (Khurana and Romer, 2012).

The research above highlights how dispositional coping styles correlate with the occurrence of suicidal ideation and behaviour. In addition to this individual trait differences approach, research is needed to identify which specific coping strategies people actually employ in the context of experiencing suicidal thoughts. This would progress understanding from a trait-level analysis of coping to a context-specific level – that is, which strategies do people actually use when suicidal? Another question of interest is how people predict they might cope when experiencing SI. Specifically, whether individuals' predicted use of adaptive and maladaptive coping strategies approximates reported strategy use by individuals who have experienced SI. Increasing understanding of the relative use of coping strategies when experiencing SI, as well as the similarities and discrepancies in predicted and actual SI-

related coping would provide important insight into potential targets for intervention and skill-building, and may highlight potential avenues for preventing suicidal behaviour (Stanley et al., 2017).

Consistent with this, the current study aimed to:

- i) Investigate the extent of use of different coping strategies in response to suicidal ideation within a help-seeking sample, and;
- ii) Examine differences between actual and predicted suicidal ideation coping strategies reported by individuals with and without a history of suicidal ideation.

In light of the limited prior research and the novel nature of the study specific hypotheses were not formulated, and investigation was exploratory in nature.

Materials and Method

Participants and Procedure

A sample of 77 help-seeking adults (≥ 18 years) attending private psychology clinics in Victoria and New South Wales, Australia, completed an online survey containing the study measures following their first session with a registered clinical psychologist. There were no additional specific eligibility criteria. This study was reviewed and approved by the University Human Research Ethics Committee. Informed consent was obtained from all participants prior to study participation. No compensation was provided.

Materials

Sample Characteristics

Items were administered to ascertain participants' age, gender, ethnicity, relationship status, and education level, as well as whether they were currently studying and/or engaged in

paid employment. Participants were also asked to indicate whether they had ever experienced suicidal ideation (*Have you ever had thoughts about ending your life?*) via a dichotomous (*Yes/No*) item.

Coping Styles

The Brief Coping Orientations to Problems Experienced (Brief COPE; Carver, 1997) is a shortened, 28-item version of the COPE Inventory (Carver et al., 1989) used to assess coping skills utilised by respondents when faced with stressful events. The internal consistency and factor structure of the Brief COPE have been demonstrated to adequately replicate the longer COPE Inventory (Carver, 1997). Participants indicated the extent to which they employ each of the indicated coping behaviours (e.g., *I've been making jokes about it*) via a 4-point Likert scale (1 = *I don't do this at all*; 4 = *I do this a lot*). Fourteen specific coping behaviours (known as *facets*) are assessed, and grouped across three coping subscales: Problem-Focused (Four facets: Active coping, Use of informational support, Positive reframing, Planning), Emotion-Focused (Six facets: Emotional support, Venting, Humor, Acceptance, Religion, Self-blame), and Avoidant (Four facets: Self-distraction, Denial, Substance use, Behavioral disengagement).

In the current study, the Brief COPE was modified to probe coping styles *specifically related to suicidal ideation*. Participants were instructed to think specifically of SI when completing the scale, and individual items were prefaced by the phrase “*In relation to suicidal thoughts*” to ensure consistency across responses. For participants that indicated they had experienced thoughts of ending their life in the past, the scale items referred to how they actually coped with this. For participants who indicated they had not had thoughts of ending their life, the items referred how they *predicted* they would cope. Internal consistencies

(Cronbach's α) were acceptable in the current sample at .87 (Problem-Focused subscale), .64 (Emotion-Focused subscale), and .69 (Avoidant subscale).

Emotional Distress

Participants' current emotional distress was assessed via the 21-item version of the Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995). The DASS-21 assesses participants' levels of core symptoms of depression, anxiety, and stress. Participants respond to 21 brief items (e.g., *I felt I was close to panic*) via a 4-point Likert scale (0 = *Did not apply to me at all*; 3 = *Applied to me very much, or most of the time*) to indicate the applicability of the statement in the preceding week. Total scores range from 0-63, with higher scores indicating greater emotional distress. The DASS-21 has demonstrated excellent internal consistency in prior research (e.g., total scale Cronbach's α = .93; Henry & Crawford, 2005). Cronbach's α for the current sample was .95.

Data Analysis

Participants were categorised into two groups (SI history vs. no SI history) according to whether they indicated a presence of any lifetime history of SI. Six paired-sample *t*-tests were conducted to assess differences between coping subscale scores within groups. An independent samples *t*-test was conducted to assess for differences in DASS-21 scores between participant groups. Given that current emotional distress may influence how people retrospectively or prospectively perceive their coping ability (Faulk et al., 2013; Leandro and Castillo, 2010; Thompson et al., 2010), the DASS-21 total score was entered as a covariate in analyses to control for this influence. Three one-way analysis of covariance (ANCOVA) analyses were conducted to assess whether presence of lifetime SI history was associated with Brief-COPE subscale scores (Problem-Focused, Emotion-Focused, Avoidant) while

controlling for DASS-21 scores. If ANCOVA indicated SI history status to be significantly associated with subscale-level scores subsequent ANCOVA was conducted to assess for differences between SI history groups on the facets of the indicated subscale, while controlling for DASS-21 scores.

Results

Seventy-seven participants completed the study, 49 (63.6%) of whom reported a history of SI (No SI history: $n = 28$, 36.4%). Independent t -test revealed that participants with SI history reported significantly greater emotional distress than those without SI history ($t[75] = -2.95$, $d = 0.70$, $p = .004$). Descriptive characteristics are shown in Table 1.

[Insert Table 1 here]

Among participants with SI history, use of coping strategies was highest for Problem-Focused ($M = 2.50$, $SD = 0.60$), which was significantly higher than for Avoidant strategies ($M = 2.20$, $SD = 0.57$; $t[48] = 2.73$, $d = 0.51$, $p = .01$). Among participants without SI history, endorsement of Problem-Focused coping strategies was highest ($M = 3.03$, $SD = 0.68$). This was significantly higher than Emotion-Focused ($M = 2.47$, $SD = 0.40$; $t[27] = 6.14$, $d = 1.00$, $p < .001$) and Avoidant coping ($M = 2.13$, $SD = 0.57$; $t[27] = 5.30$, $d = 1.43$, $p < .001$). Endorsement of Emotion-Focused coping was also significantly higher than Avoidant coping ($t[27] = 3.07$, $d = 0.69$, $p = .005$) for this group. No other significant differences were found. All Brief COPE scores are displayed in Table 2.

[Insert Table 2 here]

ANCOVA models revealed a significant effect of SI history status on COPE Problem-Focused scores while controlling for emotional distress ($F[1,74] = 8.79, p = .004, \eta^2 = 0.11$). This indicated that participants without SI history predicted they would use problem-focused coping strategies if experiencing SI ($M = 3.03$) to a significantly greater extent than the actual reported use of these coping strategies among people who had experienced SI ($M = 2.50$). There were no significant group differences in the Emotion-Focused and Avoidant ANCOVA models.

Subsequent facet-level ANCOVAs revealed significant between-group differences on Problem-Focused facets of Active Coping ($F [1, 74] = 6.48, p = .013; \eta^2 = .08$), Use of Informational Support ($F [1, 74] = 11.88, p = .001; \eta^2 = .13$), and Planning ($F [1, 74] = 6.70, p = .012; \eta^2 = .08$), but not Positive Reframing. All significant differences indicated greater endorsement of problem-focused coping strategies among participants without SI history than actual use reported among those with SI history (see Table 2).

Discussion

The current study investigated the relative use of specific coping styles in relation to suicidal ideation. In addition, the differences between actual coping strategies utilised by individuals with a history of SI and predicted suicide-related coping as indicated by individuals with no history of SI were examined. Findings revealed problem-focused coping to be the most endorsed coping style in relation to SI among participants with SI history, and revealed endorsement to be significantly higher than for avoidant coping. Study findings also demonstrated predicted use of problem-focused coping among participants without a history

of SI to be significantly higher than actual problem-focused coping strategy use by participants with SI history. Predicted use was higher than actual use for three specific facets (active coping, use of informational support, and planning). No differences were found for emotion-focused or avoidant coping styles.

The finding that problem-focused coping was the most endorsed SI-related coping style among participants with SI history should be viewed in light of prior research demonstrating that use of this coping style is typically reduced among individuals with active suicidality compared to non-suicidal controls (Sharif et al., 2014). Specifically, the current finding demonstrates that although use of this coping style may be impaired among individuals experiencing SI, problem-focused strategies still constitute important means of coping with SI. Relatedly, the discrepancy between the actual and predicted problem-focused suicide-related coping reported suggests individuals who have not experienced suicidal thoughts may overestimate their likelihood of responding in this problem-focused manner, relative to actual use reported by individuals with a history of SI. Such active and approach-oriented coping strategies are generally considered to be adaptive (Shimazu and Schaufeli, 2007; Woodhead et al., 2014), which has been specifically demonstrated in relation to SI (Khurana and Romer, 2012; Sharif et al., 2014). Therefore, the discrepancy observed in the present study suggests that individuals without a history of SI may overestimate their ability to cope with potential SI more broadly. Alternatively, higher levels of problem-focused coping in individuals without SI may have been protective against the emergence of SI.

The lack of difference between predicted and actual reports of maladaptive avoidant coping is intriguing, particularly in light of prior research demonstrating associations between SI and greater use of such strategies (Ambrus et al., 2020; Marty et al., 2010; Woodhead et

al., 2014). Potentially, individuals were able to accurately estimate the extent to which they would employ this style of coping strategy in the event of suicidal ideation. Alternatively, it is possible that individuals with a history of SI under-reported prior use of such maladaptive strategies. This may be due to concerns about possible stigma surrounding some of the specific strategies discussed (e.g., substance use; Yang et al., 2017) and would be consistent with the low scores of avoidant coping observed in the current study. Additional investigation incorporating assessment of perceived stigma is required to examine this.

These findings highlight the value in improving coping skills among individuals without SI who exhibit risk factors for developing SI (e.g., depression or anxiety; Bae et al., 2013; Lee et al., 2010). The overestimation of coping ability in relation to potential SI demonstrated in the current study suggests that provision of adaptive coping skills to individuals who are indicated to be at an elevated risk of developing SI is warranted. Providing such skills to at-risk individuals prior to emergence of SI may facilitate effective management of and recovery from SI. However, targeted investigation of preventative coping skill training and its impact on the management of subsequent SI is needed.

Regarding study limitations, details of prior SI experienced by participants such as severity and recency of ideation were not assessed, and the influence of these factors is unknown. In addition, study participants were actively help-seeking, and thus use of specific coping strategies (e.g., active coping) may be over-represented due to the help-seeking nature of the sample. It would be beneficial for future studies to measure additional variables related to coping and SI (e.g., social support, general self-efficacy) to contextualise and build upon the current findings regarding the use of coping strategies in response to SI.

Conclusion

The current study found that individuals without SI history predicted greater use of problem-focused coping strategies in relation to potential SI than actual use reported by individuals with SI history. These findings suggest that individuals who have not experienced SI overestimate their ability to cope with potential SI, or that higher levels of problem-focused coping may be protective, and highlights the value in developing adaptive coping capacity among individuals at risk for developing SI. The current findings provide preliminary but important insights into how individuals cope with SI that can be followed up in more comprehensive future studies.

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Table 1. Descriptive Characteristics

	History of SI (<i>n</i> = 49) <u><i>n</i> (%)</u>	No History of SI (<i>n</i> = 28) <u><i>n</i> (%)</u>	Total Sample (<i>N</i> = 77) <u><i>n</i> (%)</u>
<u>Gender</u>			
<i>Male</i>	28	18	46
<i>Female</i>	(57.1)	(64.3)	(59.7)
<i>Intersex</i>	20	10	30 (39)
	(40.8)	(35.7)	1 (1.3)
	1 (2)	0 (0)	
<u>Education</u>			
<i>Secondary school</i>	8 (16.3)	2 (7.1)	10 (13)
<i>Diploma/Certificate</i>	10	2 (7.1)	12
<i>Undergraduate degree</i>	(20.4)	13	(15.6)
<i>Postgraduate degree</i>	18	(46.4)	31
	(36.7)	11	(40.3)
	13	(39.3)	24
	(26.5)		(31.2)
<u>Relationship Status</u>			
<i>Single</i>	25 (51)	7 (25)	32
<i>Romantic Partner (not</i>	6 (12.2)	8 (28.6)	(41.6)
<i>cohabiting)</i>	9 (18.4)	9 (32.1)	14
<i>Romantic Partner</i>	9 (18.4)	4 (14.3)	(18.2)
<i>(cohabiting)</i>			18
<i>Married</i>			(23.4)
			13
			(16.9)
<u>Ethnicity</u>			

<i>Caucasian</i>	44	28 (100)	72
<i>Asian</i>	(89.8)	0 (0)	(93.5)
<i>Pakistani</i>	4 (8.2)	0 (0)	4 (5.2)
	1 (2)		1 (1.3)
<u>Work</u>			
<i>Full-time</i>	26	18	44
<i>Part-time</i>	(53.1)	(64.3)	(57.1)
<i>Casual</i>	6 (12.2)	6 (21.4)	12
<i>None</i>	7 (14.3)	2 (7.1)	(15.2)
	10	2 (7.1)	9 (11.7)
	(20.4)		12
			(15.6)
<u>Study</u>			
<i>Yes</i>	14	8 (28.6)	22
<i>No</i>	(28.6)	19	(28.6)
	35	(67.9)	54
	(71.4)		(70.1)
<u>Age</u>			
<i>M (SD)</i>	31.6	31.0	31.3
<i>Range</i>	(11.6)	(8.3)	(10.4)
	18-69	20-59	18-69
<u>DASS-21 Score</u>			
<i>M (SD)</i>	29.9	20.3	26.4
<i>Range</i>	(14.2)	(13.3)	(14.5)
	6-63	0-51	0-63

Note: SI = Suicidal ideation. DASS-21 = Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995).

Table 2. Brief COPE Scores by Group

	History of SI (<i>n</i> = 49) <u><i>M</i> (<i>SD</i>)</u>	No History of SI (<i>n</i> = 28) <u><i>M</i> (<i>SD</i>)</u>	Total Sample (<i>n</i> = 77) <u><i>M</i> (<i>SD</i>)</u>
<u>Problem-Focused Coping</u>	2.50 (0.60)	3.03 (0.68)	2.69 (0.68)
<i>Active Coping</i>	2.64 (0.80)	3.23 (0.74)	2.86 (0.83)
<i>Use of Informational Support</i>	2.44 (0.85)	3.23 (0.91)	2.73 (0.94)
<i>Positive Reframing</i>	2.36 (0.78)	2.54 (0.82)	2.42 (0.79)
<i>Planning</i>	2.55 (0.81)	3.13 (0.69)	2.76 (0.81)
<u>Emotion-Focused Coping</u>	2.34 (0.44)	2.47 (0.40)	2.38 (0.43)
<i>Emotional Support</i>	2.66 (0.87)	3.23 (0.81)	2.87 (0.89)
<i>Venting</i>	2.32 (0.75)	2.50 (0.83)	2.38 (0.78)
<i>Humor</i>	1.96 (0.98)	1.88 (0.99)	1.93 (0.98)
<i>Acceptance</i>	2.56 (0.75)	2.52 (0.76)	2.55 (0.75)
<i>Religion</i>	1.59 (0.78)	1.98 (0.79)	1.73 (0.80)
<i>Self-Blame</i>	2.93 (1.02)	2.70 (0.77)	2.84 (0.94)
<u>Avoidant Coping</u>	2.20 (0.57)	2.13 (0.57)	2.17 (0.57)
<i>Self-Distraction</i>	2.88 (0.83)	3.04 (0.68)	2.94 (0.78)
<i>Denial</i>	1.96 (0.93)	2.09 (0.95)	2.01 (0.94)
<i>Substance Use</i>	2.07 (1.06)	1.82 (0.90)	1.98 (1.00)
<i>Behavioral Disengagement</i>	1.90 (0.88)	1.55 (0.82)	1.77 (0.87)

Note: Brief COPE = Brief Coping Orientations to Problems Experienced (Carver, 1997). SI = Suicidal ideation.