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SUICIDAL BEHAVIOURS IN ADJUSTMENT Disorder and DEPRESSIVE EPISODE: a case-control study

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**Abstract**

*Background:* Little is known about suicidal ideation and behaviours in adjustment disorder (AD). In this paper we sought to examine the variables independently associated with suicidal ideation and behaviour in patients diagnosed with AD or depressive (DE) episode among psychiatric outpatients and in liaison psychiatry.

*Methods:* 370 patients who were referred to the liaison psychiatry services (including those seen in the Emergency Department) at 3 Dublin hospitals, and were clinically diagnosed with either DE or AD, based on the ICD 10 diagnostic criteria, were recruited to the study. We examined their demographic and clinical characteristics, and the associations between these and suicidal ideation and behaviour on multivariate analysis.

*Findings:* Younger age, single marital status, and greater severity of depressive symptoms, were significantly associated with suicidality across both diagnoses. On multivariate analysis, greater severity of depressive symptoms was associated with suicidality in those with AD ( $P=0.012$ ) and DE ( $p=0.009$ ). Those with AD exhibited suicidality at lower symptom scores than did those with DE but in both groups it still occurred at the highest level of severity. There were differences in the objective circumstances measure of suicide intent.

*Interpretation:* Suicidality in AD and DE has broadly similar risk factors but differ in aspects of suicide intent. Different mechanisms may underpin suicidality in those with AD compared to DE.

*Funding:* This study did not receive any funding.

## Introduction

Suicidal ideation is common in major depressive disorder (MDD) and depressive episode (DE), with a prevalence of between 10 and 48%.<sup>1</sup> Suicidal ideation is more common in those admitted to psychiatric units with a diagnosis of adjustment disorder (AD) than in other diagnoses, including DE.<sup>2</sup> In community samples comparing AD and DE the prevalence of suicidal ideation is similar.<sup>3</sup>

Suicidal behaviour in AD (self-harm irrespective of motivation or intent) is common, varying between 25% and 60%, depending on age.<sup>4,5</sup> Compared to those with DE, suicidal behaviour in AD is associated with lower levels of education, single marital status, lower socio-economic status, more familial instability, emotional deprivation in childhood and less planning of the attempt<sup>6</sup>. The risk factors associated with suicidal behaviour in DE include younger age, major depression, dysthymia, PTSD and alcohol dependence.<sup>7</sup> Suicidal behaviours occur earlier in the course of AD than in DE,<sup>6</sup> as does suicide.<sup>8,9</sup>

All aspects of suicidality, including suicidal ideation, behaviour or death by suicide have been under researched in AD, instead focussing on DE and other mood disorders.<sup>7</sup> This neglect is surprising considering suicidality is commonly associated with AD in the emergency department (ED)<sup>10</sup> and among those admitted for in-patient psychiatric treatment.<sup>2</sup>

The results presented here are part of a larger study examining AD and DE in liaison psychiatry. We examined the variables independently associated with suicidal ideation and behaviour in those diagnosed with AD or DE.

The aim of this study was to identify similarities and risk factors associated with suicidality in AD and DE respectively. We hypothesised that these would be similar in both diagnoses.

## Methods

We recruited patients from the liaison psychiatry services (including those seen in the ED) at three Dublin hospitals who were diagnosed by the liaison psychiatrists with either DE or AD, based on ICD-10 diagnostic criteria.<sup>11</sup>

We excluded those whose primary diagnosis was a substance use disorder, with cognitive impairment, who were incapable of giving informed consent, who were under 18, who had psychotic symptoms and who were not competent in the English language.

Patients were interviewed at two points by a researcher blind to the clinical diagnosis, at recruitment and at 6 months using validated instruments. This paper will focus on the cross-sectional data obtained from the first interview. The instruments used included:

1. SCAN – Schedules for Clinical Assessment in Neuropsychiatry,<sup>12</sup> a clinician-administered structured interview schedule providing diagnoses based on ICD-10; it includes AD in a section entitled ‘Inferences and Attributions’, only used if caseness for another diagnosis is not reached.
2. BDI-II – Beck Depression Inventory, second edition<sup>13</sup> is a 21-item self-report schedule of depressive symptoms (range 0- 63), with higher scores indicating more severe symptomatology. For analysis, we used the total score on BDI-II minus question 9 (measuring suicidality) to avoid collinearity.
3. IDS-C30 – Inventory of Depressive Symptoms – Clinician Rated<sup>14</sup> is a 30-item clinician administered schedule of depressive symptoms (range 0-90), where higher scores indicate greater symptom severity. We excluded question 18, measuring suicidality, to avoid collinearity
4. The List of Threatening Experiences<sup>15</sup> a measure of life events in the preceding 6 months, comprising 12 questions for 12 different traumatic life events (range 0-12).
5. SAPAS Standardised Assessment of Personality- Abbreviated Scale<sup>16</sup> is an 8-item self-rated personality disorder screen (range 0 – 8), where a score of >3 indicates a probable personality disorder.

6. Oslo Social Support Scale<sup>17</sup> is a self-rated instrument which assesses perceived social support, comprising three subscales. The total score ranges from 3-14, with a higher score indicating greater perceived support.
7. SFS – Social Functioning Schedule<sup>18</sup> was used to assess social dysfunction by rating functioning over a number of domains on an analogue scale. A higher score indicates greater levels of social dysfunction.
8. SIS – Suicide Intent Scale<sup>19</sup> is a 15-item self-report questionnaire with subjective and objective measures of severity of intent in patients presenting with suicidal behaviour. Each question is rated 0-2, with a higher score indicating a greater degree of suicidal intent.
9. SSI - Scale of Suicidal Ideation<sup>20</sup> is a 19-item self-report schedule assessing suicidal ideation in individuals who did not present following suicidal behaviour. Each question is rated 0-2, with a higher score indicating a greater degree of suicidal ideation.
10. DUREL – Duke University Religion Scale<sup>21</sup> is a 5-item scale measuring aspects of religiousness. For this study subscale 1, examining participation in organised religion, was used.

### **Measures of suicidality**

To assess suicidality we used three different measures:

- a. All participants completed the IDS-C30:<sup>14</sup> Question 18 (Q18) allows evaluation of suicidality spanning passive death wishes, suicidal ideation and self-harm.
- b. Participants who presented following an act of suicidal behaviour completed the SIS.<sup>20</sup>
- c. Participants who presented with features other than suicidal behaviour completed the SSI.<sup>19</sup>

### **Definitions**

Suicidality was defined as any symptom relating to suicide, including suicidal ideation or suicidal behaviour.

Passive death wishes were coded as an absence of suicidal ideation.

Suicidal behaviour refers to self-harm irrespective of method used or its lethality, motivation or level of suicide intent.

### **Diagnostic gold standard & measures of AD**

Structured interviews for AD are poorly developed. In those that include AD, the diagnosis is only made if the threshold for another disorder is not met. This approach, ignoring context, has been criticised by many researchers in the area of stress-related disorders.<sup>22,23</sup> Accordingly, we chose clinical diagnosis as the diagnostic gold standard for this study, although we also used a structured interview (SCAN) for the purpose of other analyses.<sup>12</sup>

### **Power Calculation & Statistics**

Power calculations were based on methodology of Smith and Morrow.<sup>24</sup> For 95% confidence of detecting a difference in depressive symptomatology of similar magnitude to that detected in Casey et al:<sup>25</sup> at a significance level of  $p < 0.05$ , we required 180 individuals with AD and 180 with DE.

Statistics analysis was conducted using SPSS (v20) and STATA. Univariate analysis included Independent Samples T-test, the Mann-Whitney U Test and Chi-Square Test examining the differences in suicidality for various demographic and clinical variables. Binary multivariate analysis using ordinal and linear regression examined the independent contribution of these variables to suicidality in AD and DE.

In our secondary analysis we conducted an exploration of possible mediators of the relationship between life events and suicidality in AD, using the method of Baron and Kenny.<sup>27</sup>

### **Ethics**

Prior to commencement, this study was approved by the Research Ethics Committees of the MMUH (May 2008), the Rotunda Hospital (December 2009), and SJH (November 2011). This study was



conducted in accordance with the Declaration of Helsinki (World Medical Association, 2008). All participants provided written informed consent.

## Results

370 individuals were identified: 185 with a clinical diagnosis of AD and 185 with a diagnosis of DE. Of these, 173 with AD and 175 with DE agreed to participate. Among those with AD, 19.7% had features of suicidality (either suicidal ideation or behaviour) while in DE the figure was 24.6%. This difference was not significant. On SCAN diagnosis, there was a significant excess of suicidality in patients with DE compared with AD: 24.1% and 10.2% ( $p=0.030$ ) respectively.

We examined suicidality in both diagnostic groups using Q18 of the IDS-C30. In AD, 9.8% ( $n= 17$ ) of participants presented with suicidal behaviour, 9.8% ( $n= 17$ ) with suicidal ideation, 31.2% ( $n= 54$ ) with passive death wish and 49.1% ( $n= 85$ ) without any suicidal ideation /death wish. In DE, the figures respectively were 12% ( $n= 21$ ), 12.6% ( $n= 22$ ), 40.6% ( $n= 71$ ) and 34.9% ( $n=61$ ). These differences between the two groups were not significant ( $p=0.063$ ).

### *Demographic and clinical profile*

The demographic profile of suicidal and non-suicidal patients (Q18 of IDS-C30) for both diagnostic groups is shown in table 1.

*Table 1 near here*

Suicidal participants with AD were younger, with higher depression scores (even when items relating to suicidality were removed), less likely to participate in organised religion, more likely to have possible personality disorder and with more life events than those who were not suicidal. There was a trend towards lower levels of social support, and no association with social functioning.

Suicidal participants with DE were younger, had higher depression scores and less participation in organised religion than the non-suicidal participants. They were less likely to be married, had lower

social supports and experienced more impairment in social functioning. Unlike AD, there was no relationship to personality disorder and no excess of life events. Gender differences were absent in both diagnostic groups. Thus there were similarities and differences between both diagnostic groups who reported suicidality.

Further examination of the suicidal groups in the AD and DE indicated that those with AD had significantly lower total scores on BDI-II (30.4 vs 37.5;  $t=-2.449$ ,  $p=0.024$ ) compared to DE, and on IDSC-30 (36.2 vs 43.9;  $t=-3.655$ ,  $p=0.013$ ). This demonstrates that individuals with AD become suicidal at a lower symptom threshold. They also experienced more life events, but social support and social functioning did not differ.

#### *Multivariate analysis*

We performed three further analyses to explore the variables independently associated with suicidality. In the first analysis, we examined the effect of these variables on suicidality separately in AD and DE using ordinal regression, with suicidality (measured by Q18 of IDS-C30) the dependent variable.

#### *Table 2 near here*

Severity of depressive symptoms, indicated by higher BDI-II score, was independently associated with suicidality after other variables were controlled for in AD ( $p=0.004$ ) and DE ( $p=0.011$ ).

Younger age was associated with suicidality in patients with DE ( $p=0.035$ ).

For the second analysis we examined the variables associated with suicidal ideation using linear regression, where the total score of the SSI was the dependent variable (Table 3). The  $R^2$  values indicated a greater contribution to suicidality by these variables in DE 27.9% than AD 22.5%.

#### *Table 3 near here*

Greater severity of depressive symptoms was associated with higher scores on the SSI (indicating greater severity of suicidal ideation) in both groups ( $p=0.006$  in AD;  $p<0.001$  in DE). Lower social

support was associated with higher scores in DE ( $p=0.005$ ). Younger age was significantly associated with suicidality in AD ( $p=0.032$ ).

In view of the findings on univariable analysis that suicidal participants with AD experienced significantly more life events with higher rates of personality disorder, we conducted a secondary analysis examining the possible mediating role of personality disorder on the relationship between life events and suicidality in AD, but this was not significant (results available on request).

In the third analysis, those who presented with suicidal behaviour were examined separately. Numbers were small: 9.8% ( $n=17$ ) and 12% ( $n=21$ ) for AD and DE respectively. It was not possible to carry out separate multivariate analyses, due to lack of power. When both diagnostic groups were combined no variables were significantly associated with severity of suicidal behaviour on SIS.

Of note, there was no difference in the total score on SIS between the diagnostic groups (mean= 12.3 AD, 15.2 DE;  $p=0.110$ ), but higher scores on the subscale examining objective circumstances (mean 5.0 AD, 6.9 DE;  $p=0.038$ ) and differences of borderline significance in the subjective subscale (mean 6.8 AD, 8.9 DE;  $p=0.051$ ) in DE were identified.

## Discussion

There has been little research into suicidal ideation and behaviour in AD, and existing studies have major flaws, being, variously, retrospective, based on case notes and without multivariate analysis. This study is unique in its field, using validated research instruments, *a priori* power calculations and multivariable analysis.

The results indicate that AD is a potentially serious condition which can present with life-threatening features, with similar proportions in AD and DE reporting suicidal ideation or behaviour. While our study population was a liaison psychiatry sample, studies from outpatient samples<sup>25</sup> and random community based samples<sup>3</sup> describe similar results in prevalence of suicidal ideation. The occurrence of suicidality at a lower symptom score in AD suggests that this group are more

vulnerable. Both groups were above the cut-off for severe depression on BDI and IDS-C30, even when the item measuring suicidal ideation was excluded. This we replicated previous findings which identified suicidal behaviour occurring at similarly high levels of depressive symptoms in AD compared to other mood disorders.<sup>26</sup>

The finding of poor agreement between SCAN and clinical diagnosis of AD and DE was not surprising and a Cohen's kappa score of 0.232 ( $p < 0.001$ ) has already been reported by us in this sample.<sup>27</sup> Poor agreement between clinical and structured interview diagnosis was also identified in a study of those presenting to the ED with suicidal behaviour, and as in this study when a structured diagnostic instrument was used DE predominated.<sup>28</sup> This is likely to be due to structured interviews regarding AD as a sub-threshold condition, trumped by DE once the symptom criteria are met. A criticism voiced by many is that the diagnostic instruments used in epidemiological research only measure symptoms and ignore context.<sup>22,23</sup> A related problem, complicating the diagnosis of AD, is the non-specific nature of symptoms, resulting in overlap with mood and anxiety disorders. Thus it has been recommended that clinical diagnosis should be the Gold Standard until specifically-designed instruments are available.<sup>22,23</sup> One such instrument has recently been developed and its psychometric properties remain to be tested.<sup>29</sup>

In this study, the profile of suicidal participants with AD and with DE differs although in both, severity of depressive symptoms and non-participation in organised religion were significantly associated with suicidality.

When risk factors for suicidality were explored in multivariate testing, these differences disappeared except for severity of depressive symptoms which remained an independent risk factor in both groups, along with younger age in DE. When those with suicidal ideation were examined (excluding those with suicidal behaviour) using linear regression, the most consistent independent risk factor for suicidal ideation was severity of depressive symptoms in both diagnoses, with younger age in AD and poor social supports in DE risk factors for increasing severity. These variables have been identified previously.<sup>26</sup> Thus, there was partial support for our hypothesis.

The absence of life events or personality disorder as an independent contributor to severity of suicidality or of suicidal ideation was unexpected as both have been frequently described in the self-harm literature.<sup>30</sup> However it is possible that dimensions of personality, rather than personality disorder per se, influences suicidality and its expression in self-harm. One study suggested that different mechanisms might be responsible for suicidal behaviour in AD and DE,<sup>6</sup> nominating poor coping skills in AD and personality disorder in DE. This needs to be tested in further studies using dimensional measures of personality.

The over-riding finding that the severity of depressive symptoms is the most convincing contributor to the degree of suicidality or the severity suicidal ideation in both diagnostic groups has implications for the assessment of self-harm risk. The finding that suicidality is present when the threshold for a severe syndrome is reached is important, indicating that AD is, like DE, a severe condition requiring cautious clinical management and the use of appropriate interventions, social, psychological or pharmacological.

Finally we did not identify any independent risk factors in those who presented with self-harm in either DE or AD or if such risk factors differed in those with suicidal ideation versus behaviour. This is likely due to lack of power or unidentified risk variables not included in our analysis, although we did examine those commonly associated with self-harm. Further studies using adequate sample sizes, focussing specifically on those with AD who transition from suicidal thoughts to self-harm are required.

Our finding that those with DE who self-harmed had significantly higher scores in the objective circumstances score on the SIS (measuring planning, attempts at concealment, final acts, isolation and so on) accords with studies which identified the episodes of self-harm in those with AD as more impulsive and less likely to have been planned when compared to DE.<sup>6</sup> Further studies would clarify if this finding can be generalised to AD in other settings or is confined to those AD patients presenting to the ED.

A strength of this study is the large sample size, calculated *a priori*, to ensure adequate power. Previous studies examining the relationship between AD and suicidality had lower numbers. Additionally, this study controlled for a wide range of known variables associated with suicidal ideation and self-harm. A third strength, although others might consider this a weakness, is the use of clinical diagnosis as the 'gold standard' rather than structured interviews. We considered this in the design of the study, concluding that the inherent flaws in the diagnostic instruments would result in a conflation of AD with DE, and would not be useful in distinguishing between the two diagnoses. Thus we made a decision to follow the advice of others in this field, in the absence of any adequate diagnostic interviews for AD at the time.

The weaknesses include the failure to find any differences between those who self-harmed in AD and DE, which could be overcome by specifically targeting a self-harm group in future studies. This prevented us from identifying risk factors related to the transition from suicidal ideation to behaviour. Finally, due to its setting in liaison psychiatry our findings may not generalise to specific populations such as primary care or community psychiatry.

This study adds to the limited research base on suicidality in AD, and suggests that different mechanisms may underpin suicidality in AD and DE. Although suicidal thoughts and behaviours occur at lower depressive symptom scores in AD, they occur in the severe range in both groups. Further studies exploring the mechanisms underpinning suicidality in AD and DE are required, with specific personality features worthy of examination. Studies examining factors associated with the transition from suicidal ideation to suicidal behaviour, especially in AD, are required to enhance our understanding of this important clinical area.

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**Declaration of Interests**

The authors have no interests to declare

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**Table 1: Demographic and clinical characteristics of patients divided by suicidality from Q18 of the IDS-C-30\* dichotomised into no suicidal/ passive death wish, and suicidal ideation/behaviour**

	Adjustment Disorder Mean (SD)/n (%)			Depressive Episode Mean (SD)/n (%)		
	Not suicidal n= 139	Suicidal n= 34		Not suicidal n = 132	Suicidal n= 43	
<b>Mean Age, years (SD)</b>	<b>45.3 (15.8)</b>	<b>36.5 (10.1)</b>	<b>0.002<sup>a</sup></b>	<b>46.1 (15.4)</b>	<b>39.1 (13.0)</b>	<b>0.008<sup>a</sup></b>
<b>Gender</b>						
Male, n (%)	48 (34.5)	11 (32.4)	0.211 <sup>b</sup>	46 (34.9)	17 (39.5)	0.121 <sup>b</sup>
Female, n (%)	91 (65.5)	23 (67.6)		86 (65.1)	26 (60.5)	
<b>Marital Status</b>						
Single, n (%)	44 (32.1)	16 (47.1)	0.075 <sup>b</sup>	39 (30.2)	21 (50.0)	0.004 <sup>b</sup>
Married/Cohabit, n (%)	58 (42.3)	15 (44.1)		72 (55.8)	11 (26.2)	
Other, n (%)	35 (25.6)	3 (8.8)		18 (14.0)	10 (23.8)	
<b>Depressive symptoms: Mean BDI score minus question 9, range 0-60(SD)<sup>†</sup></b>	<b>22.6 (10.3)</b>	<b>30.4 (11.5)</b>	<b>0.000<sup>a</sup></b>	<b>28.2 (10.4)</b>	<b>37.5 (11.6)</b>	<b>0.000<sup>a</sup></b>
<b>Depressive symptoms: Mean IDSC-30 score Minus Q 18, range 0-87(SD)</b>	<b>28.5 (10.9)</b>	<b>36.2 (14.0)</b>	<b>0.000<sup>a</sup></b>	<b>35.8 (11.3)</b>	<b>43.9 (10.1)</b>	<b>0.000<sup>a</sup></b>
<b>Participation in organised religion: Mean DUREL subscale 1 score range 1-5 (SD)</b>	<b>2.4 (1.6)</b>	<b>1.6 (1.6)</b>	<b>0.009<sup>a</sup></b>	<b>2.0 (1.6)</b>	<b>1.3 (1.6)</b>	<b>0.013<sup>a</sup></b>
<b>Personality: Mean SAPAS score, range 0-8 (SD)</b>	<b>2.9 (1.8)</b>	<b>3.7 (1.5)</b>	<b>0.015<sup>a</sup></b>	3.4 (1.8)	3.7 (1.9)	0.301 <sup>a</sup>
<b>Social Support: Mean Oslo Social Support Scale score, range 3-14 (SD)</b>	<b>10.5 (2.6)</b>	<b>9.5 (2.9)</b>	<b>0.054<sup>a</sup></b>	<b>10.1 (2.4)</b>	<b>8.8 (2.7)</b>	<b>0.004<sup>a</sup></b>
<b>Social Functioning: Mean Social Functioning Scale score, range 0-10(SD)</b>	2.6 (1.8)	3.2 (1.9)	0.099 <sup>a</sup>	<b>3.0 (1.8)</b>	<b>3.7 (1.8)</b>	<b>0.026<sup>a</sup></b>
<b>Life Events: Mean score on List of Threatening Events, Range 0-12</b>	<b>2.1 (1.6)</b>	<b>2.9 (2.0)</b>	<b>0.015<sup>a</sup></b>	1.2 (1.3)	1.4 (2.0)	0.370 <sup>a</sup>

*a = Independent (2-sample) t-test; b= Chi-square Test;*

*\*Q18 of the IDS-C-30 allows the assessing clinician to categorise as having no suicidal ideation (0), having a passive death wish (1), having suicidal ideation (2), or as having presented with suicidal behaviour (3).*

*† Depressive symptoms were measured using the Beck Depression Inventory (BDI), and we used the total score minus the score from question 9, which is the question which examines suicidality.*

**Table 2: Ordinal logistic regression in patients with AD and DE diagnoses (N=348), with suicidality as the dependent variable, from Q18 of the IDS-C-30\***

	Adjustment Disorder n=173			Depressive Episode n= 175		
	p	B	CI	p	B	CI
<b>Age</b>	0.061	0.963	0.926 - 1.002	<b>0.035</b>	<b>0.956</b>	<b>0.917 - 0.997</b>
<b>Gender</b>	0.539	0.759	0.316 - 1.827	0.657	1.232	0.491 - 3.095
<b>Marital status</b>						
Single	-	1.000	-	-	1.000	-
Married / Cohabiting	0.286	0.585	0.218 - 1.566	0.493	1.418	0.522 - 3.847
Other	0.233	2.281	0.588 - 8.845	0.387	0.514	0.114 - 2.320
<b>Depressive symptoms (BDI-II – Q9)<sup>†</sup></b>	<b>0.004</b>	<b>1.069</b>	<b>1.022 - 1.119</b>	<b>0.011</b>	<b>1.068</b>	<b>1.015 - 1.124</b>
<b>Social functioning</b>	0.806	0.968	0.750 - 1.250	0.131	0.800	0.599 - 1.069
<b>Social support</b>	0.127	0.871	0.730 - 1.040	0.328	0.909	0.752 - 1.100
<b>Life Events</b>	0.480	0.901	0.673 - 1.204	0.631	1.066	0.820 - 1.387
<b>Participation in organised religion</b>	0.248	0.839	0.622 - 1.131	0.572	0.912	0.663 - 1.255
<b>Personality</b>	0.721	1.047	0.814 - 1.345	0.381	1.124	0.866 - 1.459

*\*Q18 of the IDS-C-30 allows the assessing clinician to categorise as having no suicidal ideation (0), having a passive death wish (1), having suicidal ideation (2), or as having presented with suicidal behaviour (3).*

*<sup>†</sup>Depressive symptoms were measured using the Beck Depression Inventory (BDI-II), and we used the total score minus the score from question 9, which is the question which examines suicidality.*

**Table 3: Linear regression with Total Score of Scale of Suicidal Ideation (N=291) as the continuous dependent variable for AD and DE**

	Adjustment Disorder n=145 R <sup>2</sup> = 22.5%			Depressive Episode n= 131 R <sup>2</sup> = 27.9%		
	B	P	CI	B	P	CI
<b>Age</b>	<b>-0.066</b>	<b>0.032</b>	<b>-0.127 - -0.006</b>	-0.036	0.281	-0.103 - 0.030
<b>Gender</b>	-1.539	0.074	-3.229 - 0.151	0.843	0.385	-1.071 - 2.757
<b>Marital status</b>						
Single	0.000	-	-	0.000	-	-
Married / Cohabiting	-1.426	0.134	-3.295 - 0.444	-0.687	0.497	-2.685 - 1.310
Other	-0.404	0.720	-2.632 - 1.823	1.105	0.461	-1.855 - 4.066
<b>Depressive symptoms (BDI-II – Q9)<sup>†</sup></b>	<b>0.129</b>	<b>0.006</b>	<b>0.037 - 0.221</b>	<b>0.181</b>	<b>0.000</b>	<b>0.095 - 0.267</b>
<b>Social functioning</b>	-0.123	0.657	-0.669 - 0.423	-0.351	0.213	-0.906 - 0.204
<b>Social support</b>	-0.246	0.170	-0.597 - 0.106	<b>-0.599</b>	<b>0.004</b>	<b>-1.000 - -0.199</b>
<b>Life events</b>	0.394	0.149	-0.143 - 0.931	0.549	0.077	-0.061 - 1.159
<b>Participation in organised religion</b>	0.235	0.420	-0.339 - 0.809	0.134	0.639	-0.429 - 0.697
<b>Personality</b>	0.456	0.070	-0.037 - 0.948	0.350	0.184	-0.169 - 0.868
<p><i>*Q18 of the IDS-C-30 allows the assessing clinician to categorise as having no suicidal ideation (0), having a passive death wish (1), having suicidal ideation (2), or as having presented with suicidal behaviour (3).</i></p> <p><i><sup>†</sup>Depressive symptoms were measured using the Beck Depression Inventory (BDI-II), and we used the total score minus the score from question 9, which is the question which examines suicidality.</i></p>						