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When Aspiration Fails: A Study of Its Effect on Mental Disorder and Suicide Risk¹

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Abstract

Background—The Strain Theory of Suicide postulates that psychological strains usually precede suicide mental disorders including suicidal behavior. The four sources of strain are basically (1) differential value conflicts, (2) discrepancies between aspiration and reality, (3) relative deprivation, and (4) lack of coping skills. This paper focuses on the effect of perceived failed life aspiration on the individual's mental disorder and suicide risk.

Method—Data for this study were from a large psychological autopsy study conducted in rural China, where 392 suicides and 416 community living controls were consecutively recruited. Two informants (a family member and a close friend) were interviewed for each suicide and each control. Major depression was assessed with HAM-D and the diagnosis of mental disorder was made with SCID.

Results—It was found that individuals having experienced failed aspiration were significantly more likely than those having not experienced a failed aspiration to be diagnosed with at least one disorder measured by the SCID and major depression measured by HAM-D, and to be a suicide victim, which is true of both suicides and controls.

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The Contributors:

Yuanyuan Kong did the initial data management and analysis for this study. Qi Gao contributed to the literature review, and Ziyao Li did some reexamination of the data. Jie Zhang conceptualized the theory, designed the study, and wrote the paper.

Conflict of Interests:

There is not conflict of interests in the study and its publication.

Conclusion—This study supports the hypothesis that the discrepancies between an individual's aspiration and the reality is likely to lead to mental disorder including major depression and suicidal behavior. Lowering a patient's unrealistic aspiration can be part of the of psychological strains reduction strategies in cognitive therapies by clinicians' and mental health professionals.

Keywords

Aspiration; Suicide; Depression; Mental Disorder; China

1. Introduction

In etiological studies of suicide, theories of causes and strategies for the prevention range from social structure to individual characteristics. It has been argued that suicide prevention is more effective through such treatment as psychotherapy than by dealing with social structure and culture issues (Tidemalm, Elofsson, Stefansson, Waern, & Runeson, 2005). Therefore, the individual intervention for those at high risk of suicide has been mostly on psychiatric treatment (American Psychiatric Association, 2003). As the Strain Theory of Suicide has emerged with empirical evidence and psychological strain as a strong correlate that usually precedes suicidal behaviors (Zhang, 2005; Zhang, Dong, Delprino, & Zhou, 2009; Zhang, Wieczorek, Conwell, & Tu, 2011), it is imperative to test effects of psychological strains on suicidal behaviors, so as to develop some psychological treatment measures to reduce the risk of suicide.

The Strain Theory of Suicide postulates that psychological strains usually precede suicide and mental disorders including suicidal behavior. The four sources of strain are basically (1) differential value conflicts, (2) discrepancies between aspiration and reality, (3) relative deprivation, and (4) lack of coping skills (Zhang & Lester, 2008). Strain is not simply a stress. A strain is a consequence of two conflicting stresses that are working the same time on an individual and can lead to frustration, which may not be the result of a simple and mono-directional stress (Zhang et al., 2009).

There is a lack of studies so far that address the relationship between psychological strains and mental disorders. It is hypothesized that, as a co-morbidity of suicidal symptomatology, mental disorders, especially the major depression, can be preceded by psychological strains. O'Conner and colleagues (2012) studied 237 patients hospitalized following a suicide attempt who completed a range of clinical (depression, anxiety, hopelessness, suicidal ideation) and goal regulation measures (goal reengagement and disengagement) while in hospital, and found that suicidal behavior is usefully conceptualized in terms of goal self-regulation following the experience of unattainable goals. They suggested that treatment interventions should target the self-regulation of goals among suicide attempters and clinicians should recognize that different regulation processes need to be addressed at different points across the lifespan (O'Connor et al., 2012). This current study focuses on the effect of the failed aspiration (the increased discrepancy between aspiration and reality) on mental disorders among a group of suicides and their community living counterparts from a large psychological autopsy study in rural China.

2. Methods

2.1. Samples

The samples included men and women aged 15–34 years in rural China. We used established psychological autopsy methods and a case-control design to investigate the risk factors, mental disorders, and psychological strains of rural young suicides. Samples were from three provinces in China. Liaoning is basically an industrial province located in

Northeast China, Hunan an agricultural province in the Central South China, and Shandong a province with economic prosperity in both industry and agriculture and located on the east coast of China in the middle way of Liaoning and Hunan. The three provinces have been selected for study because of their geographical locations and comparative representation of the Chinese populations. Sixteen rural counties were randomly selected from the three provinces (6 from Liaoning, 5 from Hunan, and 5 from Shandong). In each of the 16 counties, suicides aged 15–34 were consecutively recruited from October 2005 through June 2008. Similar numbers of community living controls were recruited in the same counties about the same time periods. After successful interviews with the informants of the suicides, a total number of 392 suicide cases were entered for study. Among the 392 suicides 178 were female and 214 male.

In each of the 16 counties, a project coordinator from the county level Center for Disease Control and Prevention (CDC) monitored suicide occurrences. In each of the three provinces, a project director from the provincial CDC or the university the study was affiliated with requested reports on suicide cases about each month.

The community living control group was a random sample stratified by age range and county. In each province, we used the 2005 census database of the counties in our research. For each suicide, we utilized the database of the county where the deceased lived to randomly select a living control in the same age range (i.e. 15–34). As to gender, the random selection of controls aged 15–34 from each county database yielded approximately 50% of males and 50% of females, which also approximated the gender distribution of suicide cases in the study. The control sample did not exclude individuals who had been diagnosed with mental disorders or previous suicide attempts. Following are specific sampling methods for suicide cases and living controls.

2.2. Psychological Autopsy

Established by Robins and colleagues in 1959, The method of psychological autopsy (PA) is a data collection approach in suicide research as the means for obtaining comprehensive retrospective information about victims of completed suicide (Beskow, Runeson, & Asgard, 1990; Robin, Murphy, Wilkinson, Gassner, & Kayes, 1959). A variety of sources of information are used in PA studies, including evidence presented at inquest, medical records, and information from general practitioners, and hospital clinicians. The most important source, however, is interview of relatives and other key informants. A major concern of the method is the validity of the proxy responses that are supposed to accurately represent what the dead would have responded. However, the best indicator of the reliability and validity of the method is provided by the consistency of findings across PA studies (Brent, Perper, Kolko, & Zelenak, 1988). Kraemer and colleagues (2003) developed a model of informant selection that chooses the right informants based on conceptualizing the most relevant contexts and perspectives (Kraemer et al., 2003).

Regardless of the challenges, PA may be the only cost-effective way to study suicide victims. PA is particularly critical in studying Chinese completed suicide because of two other culture-specific reasons: (1) there is not yet in today's China a sophisticated medical examination system that could help find the causes of a non-criminal death, and (2) there is no established mental health or hospital system, especially in the rural areas, that could let us know the victims' health problems recorded prior to the completed suicide.

This research team first piloted the PA method to collect suicide data in rural China in 2001–2002. Both the culture feasibility of the protocol and the validity of the instruments were proved appropriate in Chinese societies (Zhang et al., 2003; Zhang et al., 2002). This

current study is based on the data collected in a large scale PA study conducted from October 2005 to June 2008.

2.3. Information sources

For each suicide and each control, we interviewed at least two informants, a family member and a close friend. Informants were first approached by the local health agency or the village administration by a personal visit. Upon their agreement on the written informed consent, the interview time was scheduled between two and six months after the suicide. Interviews with informants regarding living controls were scheduled as soon as the control targets and their informants were identified. Each informant was interviewed separately by one trained interviewer, in a private place of the hospital or the informant's home. We used tape-recording whenever accepted by the interviewee. The average time for each interview was 2.5 hours.

Inter-rater reliability was established and maintained by limiting the principle data gathering role to the 24 trained clinical interviewers and by comparison of duplicate ratings of the interviewers on a regular basis. The same interviewers participated in data collection for both case and control samples, promoting inter-rater reliability across that study boundary.

2.4. Measurements

For this study, one dependent variable of the analyses is dichotomous for the case-control status: suicide and living control. Other two dependent variables are major depression measured by HAM-D and mental disorder measured by the SCID. The risk factors under this study included age, gender, marital status, education, family annual income, negative life events, and the strain resulted from the discrepancy between perceived reality and aspiration.

Both age and education were measured by the number of years. Marital status was recoded into never married and ever married. The category of ever married included the currently married and living together, currently married but separated because of work, remarried, divorced, widowed and those non-married couples who lived together. We did not further identify subgroups for the ever married people because of the lack of observations in the divorced and the widowed. The family annual income was measured by Chinese Renminbi (RMB), and the exchange rate of RMB to the US dollars was about 7.5 RMB to 1 US dollars at the time of our study in China. The life event measures were based on the Paykel's Interview for Recent Life Events (Paykel, Prusoff, & Uhlenhuth, 1971) with some modifications and additions on top of the 44 items in Paykel's Interview for Recent Life Events. We added 19 items in consideration of the physical, psychological characteristics of 15–34 years old people in rural China. The negative life events data were coded as 1 = Yes and 0 = No. Table 1 illustrates the distributions of the demographic characteristics of the case and control samples.

The aspiration strain was assessed with two questions in the face to face interviews. We first asked what the biggest wish the target person might have, and then we asked whether the aspiration was realized by the target person either before the death (for suicides) or prior to the interview (for controls). Those individuals who had experienced failed aspiration were supposed to have a psychological strain.

All the responses from both suicides and controls on the aspiration regardless of fulfilled or failed were coded into five categories: physiological needs, safety needs, social belonging needs, esteem needs, and self-actualization. The five categorical aspirations are based on Maslow's theory of human needs, which range from the very basic need to sustain a simple living to reaching a spiritual enjoyment (Maslow, 1998). Table 1 presents the distribution of

the five levels of aspiration and the frequency and percentage of the failure on each of them between the suicide and control samples in the study.

Major depression was measured by Hamilton Depression Rating Scale (Hamilton, 1960) (HAM-D, 24 items). Each of the 24 items assesses the existence of a symptom of depression ranging from 0 to 2. Although the HAM-D was designed to measure severity of illness in patients already diagnosed with depression, previous experience indicated that it could be applied to normal people to screen out individuals who are not necessarily mentally ill. When the scale is applied to community controls and to the suicide attempters who may not have any depressive disorders, Item 4 (Insight 0–2) should be interpreted with caution, since a non-depressed individual will score higher than a depressed person on this item (for example, 2 = denies being ill at all).

The Chinese version of the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (SCID) (Spitzer, Williams, Gibbon, & First, 1988) was employed to generate diagnoses of global mental functioning for both suicides and living controls. The SCID has been used in proxy data collection and proven with excellent validity (Conwell et al., 1996). Since a target person's circumstances were generally assessed through two informants interviewed by researchers, discrepancies between informants might occur, due to different information available to each of them. Nonetheless, we should have one and only one assessment for each target person on an item. Consensus meetings were held every evening on the interview site by the interviewers to provide a chance for the interviewers to put the information together so as to reach a single assessment. This is particularly critical for mental health diagnoses assessed by the SCID. The psychiatrists on the team made a diagnosis decision for each suicide and control with the interview forms and discussions.

2.5. Integrating the information from different sources

There were two proxy interviews for each suicide case and each living control. Majority of the responses for the target person were same or similar. For the different responses on the target person, data were integrated with the following three principles. For the demographic information, we basically relied on the answers by the informant who should better know it. For example, a family member should be able to tell the target person's age and birth date more accurately than does a friend. Second, in estimating the cultural values of the target person, we used the average of the two informants' responses if they are different. Finally, to determine a diagnosis with the SCID, we always selected the positive response (e.g. existence of a symptom) on a measurement. These three guidelines were applied in integrating responses of both cases and controls.

3. Analyses and Findings

In the comparison between 392 suicides and 416 community living controls both aged 15–34 years and living in the same 16 counties of the three Chinese provinces, it is found that suicides are slightly older than the controls and tend to have less education years and lower family incomes than the controls (see Table 1).

The overall percentage of the individuals with failed aspirations (the aspirations or goals that were set up but were not achieved) was higher for the suicide group (94.6%) than for the control group (78.4%). Table 1 with the five specific levels of human needs indicates that suicides particularly failed to realize their social belonging aspiration.

Table 2 compares males and females in the case and control samples on their aspirations of each of the five needs. It is shown that females had higher aspiration of safety and esteem

needs, while males tended to aspire for social belonging and self-actualization. Overall however, males (88.7%) were more likely to fail to achieve an aspiration than females (83.2%).

The effects of failed aspirations are illustrated in Table 3. Here the total or the combination of the five aspirations was calculated for the aspiration scores and all the suicide cases and living controls were considered. As the table shows, those individuals who had an aspiration failed were more likely to have a mental disorder measured by the SCID, and more likely to suffer major depression measured by HAM-D.

Logistic multiple regressions were performed to assess the effects of aspirations that were not achieved by individuals on their mental disorder measured by SCID, major depression measured by HAM-D, and suicide risk measured by the case and control status. As shown in Table 4, those who have had an aspiration failed are almost three times more likely than those have not had a failed aspiration to suffer serious depression. Those who have had an aspiration failed are almost four times more likely than those have not had a failed aspiration to be a suicide victim. As to the SCID global functioning, those who have had an aspiration failed can be more likely than those have not had a failed aspiration to suffer a mental disorder, but with the negative life events controlled for in the regression model, the relationship is not significant at the .05 probability level.

4. Discussion and Conclusion

This study was aimed to identify the role of aspiration and failed aspiration in mental disorder and suicidal behavior among the young population in rural China. The discrepancy between aspiration and reality is one of the four sources of psychological strain that is supposed to precede mental disorder and suicidal behavior in the Strain Theory of Suicide (Zhang, 2005; Zhang et al., 2011). Analyses of the data collected in rural China with psychological autopsy (PA) supports the hypothesis that individuals having experienced failed aspiration were more likely than those having not experienced a failed aspiration to be diagnosed with at least one disorder measured by the SCID and major depression measured by HAM-D, and to be a suicide victim. Further, this finding is true of both suicides and those community living controls under study.

As predicted among the rural men and women aged 15–34 years, age is positively related to mental disorder and education level is inversely correlated with mental disorders. That family income is inversely related to mental disorders also supports the aspiration hypothesis: the better your family income is, the smaller the discrepancy between economic expectation and the reality. Marriage is not a significant protecting factor for mental disorder and suicidal behavior among rural Chinese youths, and marital status was dropped out of the regression model analysis. Marriage in rural China might have put more stress and increased expectation on the young people who are married than those not yet.

It was also found that males (88.7%) were more likely to fail to achieve an aspiration than were females (83.2%). It might be understood by the fact that, Chinese rural young men are expected to carry out more responsibilities and to be more successful in life than the rural young women (Tu, Hejtmanek, & Wachman, 1992). The more and higher expectations there are, the larger the distance to the reality can be.

In comparison with the living controls, the suicides particularly failed their social belonging aspiration. They might have been anxious to have a relationship with the family, friends, and others, as much as the living controls, or much more than the living controls, but the reality was not as good for them as for the living controls. More attention and care should have been paid to those individuals who are at suicide risk.

A negative life event increases the risk of mental disorder and suicide among the Chinese rural youths, but it is not stronger a factor than a failed aspiration. In the comprehensive model predicting the risk of mental disorder and suicide, failed aspiration, as one of the four sources of strain, is the strongest correlate of mental disorder and suicidal behavior.

However, this study has its limitations in the methodology. Information obtained from proxy interviews for the suicides may not be accurate, although the large sample size might have reduced the errors. It is also acknowledged that psychological autopsy method for suicide information is the only way to access the needed information as much as the researchers can (Hawton et al., 1998). A second limitation of the study is in its measure of failed aspiration. There were only two items in the interview instrument to determine if a person had an aspiration strain. Future studies on this topic should be with better and more sophisticated measures on the aspiration strain. The third limitation of the study is that social support was not included in the model. There have been numerous studies showing the relationship between strong social support and reduction of suicide risk (Robins & Fiske, 2009; Zhang, Xiao, & Zhou, 2010), and it might be an important moderating variable for the relationship between failed aspiration and mental disorders including suicidal behavior. For example, the therapist, irrespective of theoretical orientation, might be providing strong emotional support independently during the process (Thoits, 1986).

The Strain Theory of Suicide and mental disorder is supported by the data. Suicide prevention may begin with strain reduction and reducing the discrepancy between aspiration and reality. There might be two ways to do so: working even harder to achieve the goal, or lowering one's aspiration to an easily achievable level. The second option might be opposed and criticized by those who would strive for excellence for themselves and people around. However, when life is at stake, nothing else is more important.

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Role of the Founding Source:

The founding source, NIH/NIMH has no role in this study's findings and explanations.

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Table 1

Demographic Characteristics and Description of the Aspirations of the Case and Control Samples

Variables	Suicides (<i>n</i> =392)	Controls (<i>n</i> =416)	<i>t</i> / ²	<i>P</i>
Age, mean (S.D.)	26.84 (6.37)	25.69 (6.16)	2.59	0.010
Gender, <i>n</i> (%)				
Male	214 (54.6%)	202 (48.6%)	2.94	0.086
Female	178 (45.4%)	214 (51.4%)		
Marital status, <i>n</i> (%)				
Never married	161 (41.1%)	144 (34.6%)	3.58	0.058
Ever married	231 (58.9%)	272 (65.4%)		
Education, year, mean (S.D.)	7.38 (2.77)	9.15 (2.40)	−9.61	<0.001
Family annual income, <i>n</i> (%)				
Low (RMB<10,000)	158 (41.3%)	79 (21.1%)	51.01	<0.001
Middle (10,000 RMB 20,000)	174 (45.4%)	180 (48.1%)		
High (RMB>20,000)	51 (13.3%)	115 (30.7%)		
Negative Life Events, <i>n</i> (%)				
0	30 (7.7%)	152 (36.5%)	172.2	<0.001
1–3	166 (42.3%)	213 (51.2%)		
4	196 (50.0%)	51 (12.3%)		
Aspiration				
Realized	17 (5.4%)	73 (21.6%)	35.65	<0.001
Failed	296 (94.6%)	265 (78.4%)		
Level of Needs (Failed aspiration)			48.86	<0.001
Physiological needs	38 (13.1%)	56 (21.4%)	16.45	<0.001
Safety needs	108 (37.4%)	78 (29.8%)	0.19	0.666
Social belonging needs	61 (21.1%)	12 (4.6%)	32.66	<0.001
Esteem needs	34 (11.8%)	34 (13.0%)	3.55	0.060
Self-actualization	48 (16.6%)	82 (31.3%)	6.57	0.010

Table 2

Aspirations and Failed Aspirations by Gender

Aspiration	Male (n=354)	Female (n=297)	<i>2</i> /Z	<i>P</i>
Physiological needs	63 (17.8%)	51 (17.1%)	8.81	0.066
Safety needs	113 (31.9%)	112 (37.5%)		
Social needs	55 (15.5%)	31 (10.4%)		
Esteem needs	37 (10.5%)	45 (15.1%)		
Self-actualization	86 (24.3%)	60 (20.1%)		
TOTAL Aspiration				
Realized	40 (11.3%)	50 (16.8%)	4.15	0.042
Failed	314 (88.7%)	247 (83.2%)		

Table 3

The Relationship between Failed Aspirations and Mental Disorders

		Aspirations		² / <i>Z</i>	<i>P</i>
		Realized (<i>n</i>=90)	Failed (<i>n</i>=561)		
SCID, <i>n</i> (%)	Yes	13 (14.4%)	157 (28.0%)	7.37	0.007
	No	77 (85.6%)	404 (72.0%)		
HAM-D, median [<i>P</i> ₂₅ , <i>P</i> ₇₅]		0 (0, 0)	1 (0, 12.0)	−5.03	<0.001

Table 4

The Effects of Failed Aspirations on Depression, SCID Global Functioning, and Suicide Risk with Negative Life Events and Certain Demographic Variables Controlled for.

Predicting Variable	HAM-D (<i>n</i> =620)			SCID (<i>n</i> =622)			Suicide (<i>n</i> =622)		
	OR (95%CI)	<i>P</i>		OR (95%CI)	<i>P</i>		OR (95%CI)	<i>P</i>	
Age	1.05 (1.02–1.09)	0.001		1.06 (1.02–1.09)	0.001				
Education Years	0.90 (0.84–0.96)	0.002		0.92 (0.85–0.99)	0.021		0.79 (0.73–0.86)	<0.001	
Family annual income									
Low (RMB<10,000)	1		1	1		1			
Middle (10,000 RMB 20,000)	0.74 (0.50–1.11)	0.150		0.72 (0.47–1.11)	0.141		0.70 (0.45–1.08)	0.108	
High (RMB>20,000)	0.44 (0.25–0.78)	0.005		0.54 (0.30–0.96)	0.037		0.47 (0.27–0.82)	0.008	
Negative life events	1.34 (1.24–1.44)	<0.001		1.30 (1.20–1.41)	<0.001		1.56 (1.42–1.73)	<0.001	
Aspiration Failed	2.52 (1.25–5.10)	0.010		1.58 (0.82–3.08)	0.175		3.71 (1.98–6.94)	<0.001	
Nagelkerke R ²	0.256			0.209			0.395		