Relationship between life skills, repetitive negative thinking, family function, and life satisfaction in attempted suicide

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ABSTRACT

Background: Impaired life skills, family dysfunction, negative thinking and low life satisfaction may predispose to suicidal behavior. There is paucity of study that examined these variables in suicide attempt.
Aims: This study was conducted to know the levels and the relationships of these variables in attempted suicide.
Settings and Design: Hospital-based cross-sectional.
Materials and Methods: In this hospital-based cross-sectional study, 328 participants with a history of attempted suicide were assessed using socio-demographic and clinical pro forma, life skills profile (LSP), perseverative thinking questionnaire (PTQ), satisfaction with life scale (SLS), and family assessment device (FAD) after obtaining informed consent.
Statistical Analysis: Descriptive statistics, Mann–Whitney U and Kruskal–Wallis-H test and regression analysis.
Results: Results revealed a mean scores on PTQ, LSP, SLS, and FAD to be 29.93 (standard deviation [SD] =13.5), 21.32 (SD = 13.5), 15.71 (SD = 6.8), and 26.46 (SD = 4.57), respectively. In linear regression analysis ($R^2 = 0.815$, $df = 3$, $F = 475.715$, $P = 0.001$), LSP score had a statistically significant positive association with PTQ score (beta = 0.861, $t = 32.76$, $P = 0.001$) and FAD score (beta = 0.068, $t = 2.79$, $P = 0.004$); while negative association with SLS score (beta = −0.078, $t = −2.92$, $P = 0.004$).
Conclusions: The study findings suggest of impaired life skills, life dissatisfaction, impaired family function, and elevated repetitive negative thinking pattern in attempted suicide. Better life skills have a positive association with higher life satisfaction, family function, and low repetitive thinking and thus seem to have a protective effect against suicidal behavior in the population.

Key words: Attempted suicide, family dysfunction, life satisfaction, life skills, repetitive negative thinking

INTRODUCTION

Repetitive negative thinking (RNT) is defined as excessive and repetitive thinking about negative experiences and is difficult to control.[¹] RNT is considered a transdiagnostic process and heightened level of RNT have been observed in serious emotional problems.[²] RNT has an important role in development, maintenance, and recurrence of many psychiatric disorders[¹] and has been found to be associated with suicide.[²] It may lead to a sense of entrapment and hopelessness that may contribute to the

How to cite this article: Ram D, Koneru A, Gowdappa B. Relationship between life skills, repetitive negative thinking, family function, and life satisfaction in attempted suicide. Indian J Psychiatry 2020;62:283-9.
onset and maintenance of suicidal ideation, and lead to the shift from ideation to suicide acts.\(^8\)

Family, the basic unit of any society, is essential for normal social growth and development. Family functioning includes interactions and relationships within the family, particularly enhancing cohesion, adaptability, organization, and quality of communication. Healthy family functioning occurs within a family environment with clear communication, well-defined roles, cohesion, and good affect regulation. Family dysfunction has been associated with many mental disorders including suicidal behavior.\(^3\) Family history of suicide/attempted suicide is often associated with conflict and ruptured family relations. Lack of clear boundaries, codependence on family, family malfunction, and noncorrect parenting style are predictors of suicidal behavior.\(^4\) The significance of family factors has important ramifications in the management of parasuicide\(^5\) and family therapy has been recommended as a treatment approach in attempted suicide.\(^6\)

A life skill is defined as personally responsible sequences of self-helping choices in specific psychological skill areas conducive to mental wellness.\(^7\) The World Health Organization conceptualized life skills as abilities for adaptive and positive behavior that enables the individual to deal effectively with the demands and challenges of everyday life.\(^8\) It can be grouped into three broad categories of skills: cognitive skills for analyzing and using information; personal skills for developing personal agency, managing self and inter-personal skills for communicating, and interacting effectively with others.\(^9\) Indirect evidence suggests impaired life skills among those involved in suicidal behavior.\(^9\)

Life satisfaction is overall quality of life according to one’s own chosen criteria.\(^10\) It is an assessment of life as a whole on the basis of the fit between personal goals and achievements. It is the hallmark of the realm of subjective well-being as it centers on the individual’s own judgments, not on some criterion which is judged to be important by the investigator.\(^11\) Dissatisfaction is often associated with mental illness, health risk factors such as poor health behavior and poor social support. Life satisfaction is considered to be a strong predictor of mortality and psychiatric morbidity\(^12\) and has been found to have a long-term effect on the risk of suicide.\(^12\)

The relationships of life skill, RNT, family function, and life satisfaction in suicide attempt is unknown. Although indirect evidence suggests poorer life skills, family dysfunction, and life dissatisfaction in attempted suicide, there is still a knowledge gap as to how they are interrelated. This information will have therapeutic and preventive implications in attempted suicide. With the above background, this study was conducted to know the levels and relationships of life skill, family function, life satisfaction, and RNT in attempted suicide. We hypothesized that interrelation of life skill, family function, and life satisfaction will be positive, while RNT will have negative relationships with these variables.

**MATERIALS AND METHODS**

**Study design, participants, and procedure**

This cross-sectional study was conducted between December 2017 and July 2018, at the out-patient department of psychiatry in a tertiary care center in South India after gaining approval from the institutional ethics committee. The center caters mental health care service to rural as well as urban populations and provides suicide prevention services. Service users are referred from different departments, though many often directly avail the service. Of the 350 individuals screened, 328 met the selection criteria and were recruited in the study after obtaining an informed consent. Most of the excluded participants were unable to participate due to inability to provide adequate information sought in this study. Individuals aged 18–65 years irrespective of gender were included in this study, if they had attempted suicide within 1 month. A suicide attempt was defined as “self-inflicted, potentially injurious behavior with nonfatal outcome for which there is evidence of intent to die” for this study.\(^13\) After detailed history and mental status examination, participants were excluded if they were unable to provide required information, had a history of intellectual disability, terminal illness, dementia, and presence of psychotic symptoms.

**Measurements**

All eligible participants underwent psychiatric and medical evaluation by a psychiatrist and a physician respectively. Information regarding family functions was obtained from family members. All participants underwent further evaluation with the following tools in order:

1. **Socio-demographic and clinical pro forma:** The pro forma consisted of Age, Gender, Occupation, Education, Marital Status, Socio-economic status, Residence, Religion, Method of suicide attempt, Psychiatric diagnosis, Medical diagnosis, Family history of suicide

2. **Perseverative thinking questionnaire (PTQ):** PTQ was developed by Ehring et al. in 2011 to measure RNT.\(^14\) This 15-item self-report measure has a response option of never (score = 0) to almost always (score = 4) with a possible score range of 0–60. A higher score indicates more RNT. The scale can be sub-divided into core negative thought, unproductiveness, and mental resources. The PTQ has demonstrated excellent internal consistency (\(\alpha = 0.95\)) and test–retest reliability.\(^15\) This tool has been used in Indian Population.\(^15\) For this study, the questionnaire was translated into Kannada language.
3. Family assessment device (FAD): The tool was developed by Ryan et al., in 2005. FAD scale used in this study is based on the McMaster model of family functioning. The FAD measures structural, organizational, and transactional characteristics of families. This self-report scale consists of 12 items. Respondents are asked to rate how well each statement describes their own family. Answers are coded on a 4-point Likert scale, and response ranges from 1 (strongly agree) to 4 (strongly disagree) with possible score range of 12–48. Low score indicates better family functioning and higher scores indicate worse level of family functioning. The study revealed reliability value of the FAD to be 0.97. The FAD has been widely used in both research and clinical practice particularly in screening to identify families experiencing problems, identifying specific domains in which families are experiencing problems, and assessing change following treatment. The tool has been used in Indian Population and was translated into Kannada for this study.

4. Life skills profile (LSP) 16: The 16 item version was constructed by the original authors for an Australian casemix research project – Mental Health Classification and Service Costs Project. Initially, the LSP scale was developed by Parker et al. in 1989 to measure life skills that can be used by a care taker. The scale can be divided into subscales such as self-care, anti-social, withdrawal, and compliance. Each item has a response option of 0-1-2-3. High scores indicate low levels of life skills. The scale has good score on reliability and validity, and has been used in Indian population. In this study, the scale was translated into Kannada.

5. The satisfaction with life scale (SLS): The scale was developed by Diener et al. in 1985 to measure life satisfaction. The self-applied likert scale has 5 items with the response options of 1 (strongly disagree) to 7 (strongly agree) with possible score range of 5–35. Score <20 indicates low satisfaction while higher score indicates more satisfaction. Coefficient alpha for the scale ranged from 0.79 to 0.89. The scale has been used in Indian Population and this scale was translated in Indian language before use.

After ascertaining that there were no comprehension issues, the scales were used in this study for assessment.

### Statistical analysis

Statistical analysis was done using SPSS version 22 (IBM Corp., Armonk, NY, USA). Descriptive statistical analysis was used for socio-demographic and clinical characteristics. Mann–Whitney U and Kruskal–Wallis–H test was used to know the group differences on the score of PTQ, FAD, LSP, and SLS with sociodemographic and clinical variables. Regression analysis was done to find out the association of LSP with FAD, PTQ and SLS score.

### RESULTS

In this cross-sectional study, 350 individuals were screened, and 328 met the selection criteria. Most of the excluded participants were unable to participate due to inability to provide adequate information sought in this study.

#### Sociodemographic and clinical characteristics

Majority of the participants were Hindus, female, working, married, of lower socioeconomic status, from a rural background, had attempted on life using organophosphorous poison, were without family history of suicide or medical diagnosis or any psychiatric disorders [Table 1A].

The mean of age was 35 (standard deviation [SD] = 1.21) years. Mean score on PTQ, LSP, SLS and FAD were 29.93 (SD = 13.5, maximum possible score = 60), 21.32 (SD = 13.5, maximum possible score = 48), 15.71 (SD = 6.8, maximum possible score = 35) and 26.46 (SD = 4.57, maximum possible score = 48) correspondingly [Table 1B].

#### Demographic and clinical relationships of family assessment device, satisfaction with life scale and perseverative thinking questionnaire score

In the Mann–Whitney U test, scores on SLS had a statistically significant group difference on the variables of gender (MU = 1.1, P = 0.023) and psychiatric diagnosis (MU = 1.0, P = 0.010); while scores on PTQ had a statistically significant group difference in medical (MU = 8519.0, P = 0.002) and psychiatric diagnoses (MU = 8984.5, P = 0.001). Similarly, scores on LSP had a statistically significant group difference on the variables of medical (MU = 8.2, P = 0.001) and psychiatric diagnoses (MU = 8.6, P = 0.001) [Table 2A]. The method of the attempt had a statistically significant group difference on the scores of PTQ (df = 2, P = 0.004), as did Religion on scores of SLS (df = 2, P = 0.012) and SES on the scores of FAD (df = 2, P = 0.037) in Kruskal–wallis H test [Table 2B].

#### Relationships of diagnosis with family assessment device, satisfaction with life scale, and perseverative thinking questionnaire score

In the Mann–Whitney U test, scores on PTQ had a statistically
significant group difference on the diagnosis variables F
30 (MU = 3716.0, P = 0.001), F 40 (MU = 402.5, P = 0.001)
and F 60 (MU = 687.0, P = 0.004). Similarly, score on LSP
had a statistically significant group difference on diagnosis
variables F 30 (MU = 3.6, P = 0.001), F 40 (MU = 422.5,
P = 0.001) and F 60 (MU = 761.0, P = 0.011); while score
on SLS had a statistically significant group difference on the
diagnosis variables F 30 (MU = 3892.0, P = 0.001) and F
60 (MU = 874.5, P = 0.041) [Table 3].

### Table 1A: Sociodemographic and clinical characteristics

| Variables                  | n (%)          |
|---------------------------|----------------|
| Gender                    |                |
| Male                      | 154 (47.0)     |
| Female                    | 174 (53.0)     |
| Occupation                |                |
| Unemployed                | 121 (36.9)     |
| Unskilled                 | 118 (36.0)     |
| Skilled                   | 89 (27.1)      |
| Marital status            |                |
| Married                   | 242 (73.8)     |
| Single                    | 86 (26.2)      |
| Socioeconomic-status      |                |
| Low                       | 79 (24.1)      |
| Middle                    | 237 (72.3)     |
| High                      | 12 (3.7)       |
| Education                 |                |
| Uneducated                | 33 (10.1)      |
| Up to primary             | 56 (17.1)      |
| Up to high school         | 148 (45.1)     |
| Graduate and PG           | 91 (27.7)      |
| Domicile                  |                |
| Rural                     | 207 (63.1)     |
| Urban                     | 121 (36.9)     |
| Religion                  |                |
| Hindu                     | 317 (96.6)     |
| Muslim                    | 7 (2.1)        |
| Christian                 | 4 (1.2)        |
| Method                    |                |
| Poisoning                 | 228 (69.5)     |
| Overdose                  | 83 (25.3)      |
| Hanging                   | 17 (5.2)       |
| Psychiatric diagnosis     |                |
| Absent                    | 205 (62.5)     |
| Present                   | 123 (37.5)     |
| Medical diagnosis         |                |
| Absent                    | 235 (71.6)     |
| Present                   | 93 (28.4)      |
| Family history of suicide |                |
| Absent                    | 278 (84.8)     |
| Present                   | 50 (15.2)      |

### Table 1B: Demographic and clinical characteristics

| Variables                  | Minimum | Maximum | Mean  | SD  |
|---------------------------|---------|---------|-------|-----|
| Age                       | 18.00   | 77.00   | 35.27 | 1.21|
| PTQ score                 | 2.00    | 58.00   | 29.93 | 13.51|
| LSP score                 | 4.00    | 44.00   | 21.32 | 8.71 |
| SLS score                 | 5.00    | 32.00   | 15.71 | 6.81 |
| FAD score                 | 14.00   | 37.00   | 26.46 | 4.57 |

PTQ – Perseverative thinking questionnaire, LSP – Life skill profile, SLS – Satisfaction with life scale, FAD – Family assessment device, SD – Standard deviation

### Table 2A: Demographic and clinical relationships of family assessment device, satisfaction with life scale and perseverative thinking questionnaire score

| Variables                  | n   | Mean rank | MU    | Z    | P   |
|----------------------------|-----|-----------|-------|------|-----|
| SLS score* Gender          |     |           |       |      |     |
| Male                       | 154 | 177.16    | 1.1   | -2.277 | 0.023 |
| Female                     | 174 | 153.30    |       |       |     |
| SLS score* psychiatry diagnosis |     |           |       |      |     |
| Absent                     | 205 | 174.99    | 1.0   | -2.590 | 0.010 |
| Present                    | 123 | 147.01    |       |       |     |
| PTQ score* psychiatry diagnosis |     |           |       |      |     |
| Absent                     | 205 | 146.83    | 4.5   | -4.359 | 0.001 |
| Present                    | 123 | 193.96    |       |       |     |
| PTQ score* medical diagnosis |     |           |       |      |     |
| Absent                     | 235 | 154.25    | 9.0   | -3.112 | 0.002 |
| Present                    | 93  | 190.40    |       |       |     |
| LSP score* psychiatry diagnosis |     |           |       |      |     |
| Absent                     | 205 | 145.42    | 8.6   | -4.708 | 0.001 |
| Present                    | 123 | 196.30    |       |       |     |
| LSP score* medical diagnosis |     |           |       |      |     |
| Absent                     | 235 | 153.13    | 8.2   | -3.455 | 0.001 |
| Present                    | 93  | 193.24    |       |       |     |

FAD – Family assessment device, SES – Socioeconomic status, SLS – Satisfaction with life scale, PTQ – Perseverative thinking questionnaire

### Table 2B: Demographic and clinical relationships of family assessment device, satisfaction with life scale, and perseverative thinking questionnaire score

| Variables                  | n   | Mean rank | df   | P   |
|----------------------------|-----|-----------|------|-----|
| FAD score* SES             |     |           |      |     |
| Low                        | 78  | 178.60    | 2    | 0.037 |
| Middle                     | 237 | 162.17    |      |     |
| High                       | 12  | 105.33    |      |     |
| SLS score* religion        |     |           |      |     |
| Hindu                      | 317 | 163.59    | 2    | 0.012 |
| Muslim                     | 7   | 251.71    |      |     |
| Christian                  | 4   | 83.75     |      |     |
| SLS score* education       |     |           |      |     |
| Uneducated                 | 33  | 116.09    | 3    | 0.016 |
| up to primary              | 56  | 160.34    |      |     |
| Up to high school          | 148 | 172.49    |      |     |
| Graduate and above         | 91  | 171.62    |      |     |
| PTQ score* method of attempt |     |           |      |     |
| Poisoning                  | 228 | 158.95    | 2    | 0.004 |
| Overdose                   | 83  | 189.57    |      |     |
| Hanging                    | 17  | 116.59    |      |     |
| LSP score* method          |     |           |      |     |
| Poisoning                  | 228 | 155.88    | 2    | 0.010 |
| Overdose                   | 83  | 191.54    |      |     |
| Hanging                    | 17  | 148.12    |      |     |

*Is used to indicate statistical test between variable. FAD – Family assessment device; SES – Socioeconomic status; SLS – Satisfaction with life scale; PTQ – Perseverative thinking questionnaire

Relationships of life skills profile score with score of family assessment device, perseverative thinking questionnaire, and satisfaction with life scale

In linear regression analysis ($R^2 = 0.815, df = 3, F = 475.715, P = 0.001$) (LSP score been dependent variable, predictor variables were FAD, PTQ and SLS score), LSP score had a statistically significant positive relationship with PTQ score (beta = 0.861, $t = 32.76, P = 0.001$) and FAD
DISCUSSION

Good life skills, life satisfaction, and family functioning appear to be protective factors for life while RNT appears to have associated with adverse mental health consequences.[25] Since these factors are may be important determinants of suicidal behavior, this study was conducted to know their interpersonal relationships.

The demographics of this study were similar to previous reports from the same center[24] and appear to be due to the characteristics of population the center provides clinical service. Clinical features were characterized by poisoning being common method of attempt; less number of patient with family history of suicide, medical diagnosis, and psychiatric diagnosis. Common psychiatric disorders observed in this study were F 30 (mood disorder), F 40 (anxiety disorder), F 10 (substance use disorder), and F 60 (personality disorder). There was an elevated score on PTQ subscales. This finding resembled with other recent reports from South India conducted among nursing students.[15] RNT patterns have been found to be strongly associated with suicide. Following negative emotional experiences, RNT may lead to a sense of entrapment and hopelessness that may contribute to the onset of suicidal ideation and then facilitate the transition from thinking about suicide to making a suicide attempt by increasing an individual’s capability for suicide through repetitive exposure to violent thoughts and imagery associated with suicide.[20] Immediate availability of means to attempt on life may determine the methods of choice, while severity of suicidality may determine the lethal method that is adopted as observed in this study. It has been argued that RNT is a form of ineffective problem solving that functions to down regulate negative affect. It can be regarded as an avoidant coping strategy, because it impedes processing of emotional and somatic responses.[27] However, we observed that low life skills score was positively associated with higher PTQ score. It can be assumed that elevated RNT level is a form of impaired cognitive skill that may associated with suicidality.

Life skills are essential for normal living. By its inherent nature, suicidality is associated with impairment in life skills as observed in this study and is consistent with other reports from India in patients with schizophrenia.[23] Illness predisposes a person afflicted with illness to stress and hence poorer life skills and satisfaction.[28] Illnesses are known to interfere with ability of self-care and functioning and can lead to the illness becoming disabling. On the other hand, such a disabling illness may be associated with stigma particularly if it is a mental illness. Stigma contributes to suicidal ideation and possibly actual attempt. Indirect evidence reveals poor life skills are associated with suicidality.[29] We also observed a low score on SLS compared to the other reports from Indian population.[29] Life dissatisfaction has a long-term effect on the risk of suicide, and this seems to be partly mediated through poor health behavior.[12] We observed better life satisfaction in males than females and this is consistent with the previous reports. There appears to be gender difference with regards to life satisfaction in India. Indian culture and traditions appear to play a role as males are more privileged than females in all sphere of life, which may boost life satisfaction.[30] Women are burdened with increasing life demands and assuming multiple roles that may lead to mounting life dissatisfaction. Life satisfaction may improve with high social support, and social participation.[30] Life satisfaction reduces with occurrence of mental illness that further contributes to suicidal behavior and we had found a similar line of observation.[31] We also observed a positive relationship between better life skills and more life satisfaction, similar to other reports from nonsuicidal population.[32] It appears that life satisfaction

| Table 3: Relationships of diagnosis with family assessment device, satisfaction with life scale and perseverative thinking questionnaire score |
|-----------------------------------------------|
| Diagnosis     | n  | Mean rank | MU | Z    | P    |
|----------------|----|------------|----|------|------|
| PTQ score      |    |            |    |      |      |
| No Diagnosis   | 203| 120.31     | 3716.0 | −4.283 | 0.001 |
| F30            | 58 | 168.43     |      |      |      |
| F40            | 11 | 172.41     |      |      |      |
| F60            | 13 | 157.15     |      |      |      |
| SLS score      |    |            |    |      |      |
| No Diagnosis   | 203| 140.83     | 3892.0 | −3.940 | 0.001 |
| F30            | 58 | 96.60      |      |      |      |
| F60            | 13 | 74.27      |      |      |      |
| LSP score      |    |            |    |      |      |
| No Diagnosis   | 203| 120.05     | 874.5  | −2.040 | 0.041 |
| F30            | 58 | 169.33     |      |      |      |
| LSP score      |    |            |    |      |      |
| No Diagnosis   | 203| 104.08     | 422.5  | −3.473 | 0.001 |
| F40            | 11 | 170.39     |      |      |      |
| LSP score      |    |            |    |      |      |
| No Diagnosis   | 203| 105.75     | 761.0  | −2.559 | 0.011 |
| F60            | 13 | 151.46     |      |      |      |

SLS – Satisfaction with life scale; PTQ – Perseverative thinking questionnaire; LSP – Life skill profile

| Table 4: Relationships of life skill profile score with score of family assessment device, perseverative thinking questionnaire and satisfaction with life scale |
|-----------------------------------------------|
| Model    | Unstandardized coefficients | Standardized coefficients | t  | P    |
|----------------------|-----------------------------|---------------------------|----|------|
| Model 1              |                            |                           |    |      |
| Constant             | 2.850                       | 1.628                     | 1.751 | 0.081 |
| PTQ score            | 0.555                       | 0.017                     | 0.861 | 0.376 | 0.001 |
| SLS score            | −0.100                      | 0.034                     | −0.078 | −2.920 | 0.004 |
| FAD score            | 0.130                       | 0.047                     | 0.068 | 2.790 | 0.006 |

Dependent Variable: LSP score, predictors variable: FAD score, PTQ score, SLS score, R2=0.815, df=3, F=475.715, P=0.000. PTQ – Perseverative Thinking Questionnaire; SLS – Satisfaction with life scale; FAD – Family assessment device; LSP – Life skill profile
and mental illness have a reciprocal relationship with each other. Mental illness can impair life satisfaction and life satisfaction itself can boost mental health particularly if it is accompanied with more social support.[33] Mental illness may also have a reciprocal relationship with RNT as observed in this study, with the latter being a transdiagnostic entity in psychiatric disorders.[34]

Family dysfunction is more common in persons with attempted suicide. Some domains of life skills such as social skills and compliance appear to mediate healthy family functioning, and dysfunction in these domains may be reflected as dysfunction. Our findings are similar to the report from the western countries that show higher level of family dysfunction among parasuicide.[33] Family dysfunction is also reported as a salient predictor of suicide risk in the community corrections sample population.[36] Family dysfunction prevails more among lower socioeconomic status as observed in this study and also has been a risk factor for suicidal attempt.[35] Family dysfunction may partly be due to poor life skills among family members that often lead to conflicts as observed in this study. Indirect evidence suggests a lower level of life skills with dysfunctional family members and intervention in this domain may improve the skills.[37]

We observed significant elevated level of PTQ among those with mood disorder, anxiety disorder and personality disorder and is consistent with previous reports. Being a transdiagnostic entity, RNT appears to be involved in onset, maintenance, exacerbation and recurrence of anxiety, personality, and depressive disorders.[38] It is argued that RNT is characterized by the same process across disorders, which is applied to a disorder-specific content. Another observation is lower level of life satisfaction with mood and anxiety disorder. There is hardly any research examining the life satisfaction in Axis I psychiatric disorder. Indirect evidence suggests lower level of life satisfaction in presence of mood and personality traits.[39] Similarly, there is no research examining the life skills in Axis I disorder, while we observed impaired life skills with diagnosis of mood, anxiety, and personality disorder. It appears that there may be a reciprocal relationship of these disorders with life skills that improves with life skill training.[18,19]

Consistent with our hypothesis we found significant relationship between low life skills and RNT. Similarly, we also found life skill to be positively related with a lower life satisfaction and impaired family dysfunction. The study has revealed that RNT can mediate self-compassion component of life skills. Self-compassion helps to responds with kindness rather than harsh self-judgment, recognizing that imperfection is a part of the shared human experience. In general population, life skills (consciouslyness, effective communication, and creative thinking) appears to have a positive correlation and life satisfaction and this may be extrapolated in attempted suicide. People with acceptable ability and skills such as stress and excitement overcoming, ability to communicate effectively in their areas of interest have a degree of satisfaction. Indirect evidence indicates that life skill level influence the family functioning, and life skill training improves quality of life. This is particularly important for some life skill such as intimacy, relationship, decision-making, problem solving, critical thinking, and control of excitements and fighting stress.[30]

Limitations
The findings of the study should be interpreted with caution as it may not be generalized to general population. Other limitations of the study include no use of structured tool to rule out psychiatric disorder, a cross-sectional study design and lack of a control group. Despite these limitations, we believe that our study also has some clear advantages in the form of adequate sample size, use of standardized tool for Indian population.

CONCLUSIONS
With the findings in this study, it can be concluded that suicide attempt is associated with poorer life skills, elevated RNT, low satisfaction with life, and impaired family function. Levels of life skills are positively associated with better life satisfaction, family function and low repetitive thinking. Study findings imply that an individual with attempted suicide should be assessed for life skills, RNT, family function, and life satisfaction and should be adequately and appropriately addressed.

Acknowledgments
The authors would like to thank Yahosha, Shamaya, Hagai, Asther, Yasuas, Marias (Divine Retreat Centre, Chalakudy, Kerala, India), Ashish, Akash, and Mini for their moral support.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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