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RESEARCH ARTICLE

WILEY

Can I count on you? Social support, depression and suicide risk

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Abstract

Objectives: Interpersonal factors play an important role in the etiology and treatment of depression. Social support derives from compassionate words and helpful actions provided by family, friends or a significant other. The present study was designed to examine various sources of social support as they relate to the severity of depressive symptoms, hopelessness and suicide risk in adult psychiatric outpatients.

Method: Participants were recruited through mental health clinics at a veteran's affairs medical centre. A total of 96 depressed patients were assessed using a diagnostic interview and self-report measures of depression severity, hopelessness and social support. Among these depressed adults, 45.8% had attempted suicide at least once. Social support variables were compared between suicide attempters and non-attempters to better understand the relationship between social support and suicidal behaviour.

Results: Depression severity and hopelessness were both significantly associated with lower levels of social support in multiple areas. Individuals with a history of suicide attempt reported lower levels of available support as compared to those who have never attempted suicide.

Conclusion: Deficient social relationships increase the risk of suicide in depressed patients, exceeding the impact of depression alone on suicide risk. The lack of social support may play a vital role in feelings of hopelessness and isolation that contribute to a suicidal crisis. Psychosocial treatment should be considered to reduce the risk of suicide and severity of depression by strengthening social support and bolstering interpersonal relationships.

KEYWORDS
belongingness, death, depression, hopelessness, social support, suicide

1 | INTRODUCTION

Interpersonal factors play an important role in the aetiology, recovery, and treatment of depression. Patients often struggle emotionally due to interpersonal conflict, a loss of social connections, or a lack of perceived support. Social support is defined as the perception that other people are available to provide psychological or physical care (Cohen & Wills, 1985; Williams et al., 2004). Adults lacking social support show more severe depressive symptoms and higher levels of loneliness than those with more robust social support (Kleinberg

et al., 2013; Liu et al., 2016). Social support is an important resilience factor, which buffers against the negative psychological influences of stressful life events, thus increasing overall well-being and life satisfaction (Cao, 2021; Chen et al., 2017; Cohen & Wills, 1985; Wang et al., 2014). Further, individuals high in social support are better able to adaptively function and avoid negative mental health outcomes when exposed to traumatic life events (Schlechter et al., 2021). The source of social support is important to examine; both family and friend support separately show negative correlations with depressive symptoms (Dong & Zhao, 2022). However, results are equivocal when comparing the differential impact of family, friend and significant other support on variance in depression severity (Bell et al., 2018; Kleinberg et al., 2013).

Being socially integrated with others promotes a sense of stability, predictability, and self-worth (Cohen & Wills, 1985; Kleiman & Riskind, 2013). Social support acts as a protective factor for depression by mediating and weakening the relationship between loneliness and depressive symptoms (Liu et al., 2016). Research has attempted to home in on the specific characteristics of support that are most effective. Increased contact can help lessen depression severity, but contact does not always elicit feelings of connectedness or support (Kleinberg et al., 2013). Compared to frequency of contact, perceived quality of relationships may be a better predictor of loneliness, depression, and psychosocial stress (Wright et al., 2014). The positive affect exhibited after a social interaction creates a sense of companionship, which is a predictor of overall life satisfaction (Oh et al., 2014). The quality of social integration appears to be more powerful as a protective factor than quantity of social connection alone.

Higher levels of social support protect against both suicidal ideation and suicidal behaviour, especially for those most at risk (Kleiman et al., 2014; Kleiman & Liu, 2013). However, individuals must both perceive the availability of social support and utilize that support to increase self-esteem and reduce suicidal ideation (Kleiman & Riskind, 2013). Perceived support from family specifically is associated with past suicide attempts, with fewer attempts being reported by those with greater perceived family support (Bell et al., 2018). Lower social support has been related to suicidal ideation and a history of suicide attempts in adolescent psychiatric patients as well (Miller et al., 2015). In adolescents, lower support from teachers is associated with greater suicidal ideation, lower parental support is associated with having a past suicide attempt, and lower perceived school and friend support conferred the greatest odds of having a previous suicide attempt (Miller et al., 2015). These findings show how different sources of social support have distinct effects on depression, suicidal ideation, and suicide attempt history.

Social support has been found to protect patients with a history of trauma from suicidal thoughts (Panagioti et al., 2014). Veteran and civilian samples show that depression, posttraumatic stress disorder (PTSD), substance use problems, psychiatric disorders, physical problems, and functional difficulties are common risk factors for suicidality (Pietrzak et al., 2011). Those experiencing PTSD often use maladaptive coping strategies including escape avoidance, self-punishment, and evading of support-seeking behaviours that further put them at risk for suicide (Pietrzak et al., 2011). Specifically, those suffering from greater interpersonal difficulties who engage in avoidance strategies are more likely to experience suicidal ideation (Pietrzak et al., 2011). Individuals with PTSD who report greater perceived social support did not show an increase in suicidal behaviour, even after experiencing either an increase in PTSD symptoms or the highest level of PTSD symptoms (Panagioti et al., 2014). By increasing self-esteem and the utilization of social networks, social support acts as a buffer against suicidal thoughts (Kleiman & Riskind, 2013). Overall, findings suggest social support acts as an important protective factor against suicidality across populations and diagnoses.

Given the strong predictive power of hopelessness on suicidal ideation, the relationship between social support and hopelessness may be of importance when studying depression and suicidal behaviour (Franklin et al., 2017). Social support has a significant positive direct effect on hopelessness, and additionally, hopelessness has been shown to have a significant positive direct effect on the severity of depressive symptoms (Yang & Clum, 1994). Hopelessness has also been shown to have an indirect influence on suicidal ideation, suggesting that hopelessness and social support cumulatively affect suicidal thoughts (Johnson et al., 2019). The hopelessness theory of depression states that the effect of social support on depressive symptoms is mediated through hopelessness (Panzarella et al., 2006). This theory is reinforced by social support decreasing the likelihood of making negative inferences about life events, as well as reducing cognitive vulnerability to depressive thoughts, which would decrease hopelessness (Panzarella et al., 2006).

Past literature suggests that social support, depression and suicidal behaviour are interconnected, but these connections require clarification. Further examination is needed to understand how social support may protect those at risk from engaging in suicidal behaviours. The present study was designed to compare differences in social support between depressed veteran outpatients who have and have not struggled with suicidal behaviour. The study examines the relationship of social support with severity of depressive symptoms, pervasiveness of hopelessness, and presence of past suicide attempts in adult veterans. Specifically, this study aims to clarify the role of social support on depression severity, hopelessness and suicidal behaviour by dissecting the different variables that comprise social support. While the literature shows clear evidence to support the relationships between these constructs, it is important to understand if different types of relationships, perceived quality, or number of social relationships have discrete impact on depression, hopelessness, or suicidal behaviour. It was hypothesized that depressed veterans who had

Key Practitioner Message

- Social support is an important buffer against suicide attempts.
- Hopelessness and depression severity show a direct correlation with social support.
- Family support may have a unique association with suicide attempts.

previously attempted suicide would report overall deficient social support as compared to individuals with depression alone.

2 | METHODS

2.1 | Subjects

A total of 96 depressed psychiatric patients at a major veteran's affair (VA) medical centre in Ohio participated in the study. The sample were mostly older (mean = 53.89 years old), male (94.8%) and African American (62.5%). A minority of participants were involved in a romantic relationship (married or cohabitating) at the time of participation; 72.2% were single/never married, separated, widowed, or divorced. All participants met criteria for a depressive disorder, with the majority meeting criteria for recurrent major depressive disorder (78.1%) and others meeting criteria for single episode major depressive disorder (9.4%) and dysthymia (12.5%). Most participants had been struggling with depression for an average of 10 years. In the sample, 45.8% had previously attempted suicide at least once in their lifetime. Among those with a past suicide attempt, the majority had attempted once (54.5%) or twice (29.5%) in their lifetime. No significant between-group differences were found when comparing suicide attempters and non-attempters on both demographic and depression variables (see Table 1).

2.2 | Measures

The Structured Clinical Interview for DSM Disorders (SCID-IV; First & Gibbon, 2004) is a comprehensive structured diagnostic interview that was designed to evaluate all major forms of mental illness (First & Gibbon, 2004). The SCID has become the gold standard for diagnostic assessment in most research settings. When assessed for inter-rater reliability, the SCID-IV has shown overall moderate to excellent agreement for diagnoses across the DSM-IV (Lobbestael et al., 2011).

The Beck Depression Inventory (BDI-II; Beck et al., 1996a, 1996b) includes 21 items designed to evaluate the presence and severity of depressive symptoms (Beck et al., 1996a, 1996b). The BDI has been proven to be an excellent screening measure for depression; psychometric evidence supports the reliability and validity of the BDI-II as a sound measure of depression severity (Subica et al., 2014). The BDI has consistently shown good test–retest reliability when measuring the presence and severity of a major depressive episode along with high internal consistency (Steer et al., 1997, 2001).

The Beck Hopelessness Scale (BHS; Beck, 1988) includes 20 true–false statements designed to assess pessimistic expectations about the future (Beck et al., 1974). The BHS has been found to be a reliable and valid measure of pessimism and hopelessness with evidence that higher scores are indicative of suicidal ideation, depression and life satisfaction (Kliem et al., 2018). When assessing individuals who suffer from suicidal thoughts, the BHS ratings significantly differentiated individuals who eventually died by suicide versus natural causes, suggesting that hopelessness is distinctly related to death by suicide (Beck et al., 1985). The BHS has been found to positively correlate with measures of suicidal behaviour, suicide risk severity and number of suicide attempts (Rueda-Jaimes et al., 2018).

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) includes 12 items designed to assess a person's sense of social support from various sources (Zimet et al., 1988, 1990). The MSPSS includes subscales for support received from family, friends, and significant others. The MSPSS has demonstrated strong psychometric properties, including high levels of internal consistency, retest reliability, and support for the three-factor subscales

TABLE 1 Group comparisons of demographic and clinical differences.

	History of suicide attempt ($n = 44$)	No history of suicide attempt ($n = 52$)	Test statistic
Demographic variables			
Age; *M* (*SD*)	53.39 (8.70)	54.31 (9.34)	$t = 0.55$
Gender (male)	42 (95.5%)	49 (94.2%)	$t = 0.24$
Race (White)	13 (29.5%)	19 (36.5%)	$\chi^2 = 4.48$
Single (never married)	10 (22.7%)	11 (21.2%)	$\chi^2 = 4.88$
Employment status (unemployed)	21 (47.7%)	29 (55.8%)	$\chi^2 = 2.78$
Depression variables			
Depressive disorder	44 (100%)	52 (100%)	N/A
Length of depression in weeks; *M* (*SD*)	654.60 (873.13)	382.71 (633.23)	$t = 1.66$
Number of suicide attempts; *M* (*SD*)	2.05 (1.92)	0	N/A
BDI-II total; *M* (*SD*)	33.10 (12.55)	28.25 (11.15)	$t = 1.93$
BHS total; *M* (*SD*)	10.59 (2.31)	9.84 (1.96)	$t = 1.6$
SSQ – N average	1.00 (0.89)	1.29 (1.12)	$t = 1.28$
SSQ – S average	3.56 (1.59)	3.84 (1.66)	$t = 0.76$

Note: All figures are *n* and % unless otherwise specified.
Abbreviations: BDI-II = Beck Depression Inventory–II; BHI, Beck Hopelessness Scale; *M*, mean; *SD*, standard deviation.
$^{*}p < .05$, $^{**}p < .01$, and $^{***}p < .001$.

(Bruwer et al., 2008; Canty-Mitchell & Zimet, 2000; Zimet et al., 1988, 1990). MSPSS scores have displayed negative correlations with depression and anxiety scores, as well as positive correlations with ego-resiliency, which support discriminant and convergent validity (Park et al., 2022).

The Social Support Questionnaire–Short-Form (SSQ-SF; Sarason et al., 1987) includes six items designed to evaluate the number of supportive individuals in a person's social network (Sarason et al., 1983). Subscales for the number of perceived sources of social support, as well as how satisfied the participant is with these supporters, are included as two separate aspects of social support and should be considered separately in analysis (Sarason et al., 1983). The SSQ-SF has demonstrated strong psychometric properties through high reliability and is not highly influenced by social desirability (Sarason et al., 1983). Both the number of social support sources and satisfaction with those sources, as measured by the SSQ, have shown a negative correlation with suicidal ideation, suggesting those low on social support experience more suicidal thoughts (Singh, 2014).

2.3 | Procedure

Participants were recruited through an outpatient partial hospitalization program at a VA medical centre. All study procedures were fully approved by the institutional review board. Included participants were at least 18 years old and had a current primary diagnosis of a depressive disorder. After obtaining informed consent, the participant completed a SCID interview with a research assistant and independently completed the BDI-II, BHS, MSPSS and SSQ-SF. Participants were given a $10 gift card as compensation for their time.

3 | RESULTS

The social support subscales on the MSPSS were examined to compare suicide attempters to non-attempters, and significant between-group differences were found (see Table 2). Those with a previous suicide attempt reported significantly lower levels of total support from others, $t(88) = 2.25$, $p < .05$, and support from family members specifically, $t(92) = 3.23$, $p < .01$. Non-significant trends were seen when comparing the two groups on support from friends, $t(92) = 1.62$, $p = .10$, and significant others, $t(94) = 1.47$, $p = .15$, such that non-attempters reported higher mean support from both sources.

Individual items on the MSPSS were examined and revealed that participants with a history of a prior suicide attempt reported significantly lower levels of perceived support from family and friends, but not significant others when compared to depressed patients without a history of a suicide attempt (see Table 3). Participants with a history of a suicide attempt were more likely to report they do not feel their family really tries to help them, $t(94) = 2.79$, $p < .01$, they feel unable to discuss problems with family members, $t(94) = 3.41$, $p = .001$, and they lack family who would help them to make difficult decisions, $t(94) = 2.49$, $p = .01$. Attempters were also less likely to feel emotionally supported by their family, $t(95) = 3.67$, $p < .001$, and less likely to feel able to count on their friends, $t(94) = 2.41$, $p = .01$.

Individual items on the BDI were examined and revealed that participants with a history of a prior suicide attempt reported significantly higher levels of discouragement about their future, $t(76.39) = 13.99$, $p < .05$, as well as higher feelings of being punished, $t(95) = 2.66$, $p < .01$, as compared to those who did not report a history of a suicide attempt. They also endorsed lower self-esteem, $t(94) = 2.62$, $p = .01$, indicated by reports of losing confidence, being disappointed in themselves, or disliking themselves. All other items on the BDI were not significantly different between groups. Those with a prior history of a suicide attempt had higher total scores on the BDI, but this trend was only nearing significance, $t(87) = 1.93$, $p = .06$.

The SSQ subscales were analysed between groups by assessing the average number of supportive individuals identified and the average satisfaction scores (see Table 2). Neither the number of individuals, $t(79) = 1.28$, ns, nor the satisfaction scores, $t(79) = 0.76$, ns, were significantly different between attempters and non-attempters. Individual items on the SSQ were examined by splitting data into zero

TABLE 2 Group comparisons of social support subscales.

	History of suicide attempt ($n = 44$)	No history of suicide attempt ($n = 52$)	t value
MSPSS scales			
Total score	45.71 (18.92)	54.59 (18.46)	2.25*
Family support	13.88 (7.53)	18.60 (6.60)	3.23**
Friend support	14.26 (6.89)	16.57 (6.88)	1.62
Significant other support	17.07 (7.95)	19.37 (7.38)	1.47
SSQ scales			
Average number of people	1.00 (0.89)	1.29 (1.12)	1.28
Average satisfaction score	3.56 (1.59)	3.84 (1.66)	0.76

Note: All figures are *M* and (*SD*) unless otherwise specified.
Abbreviations: *M*, mean; MSPSS, Multidimensional Scale of Perceived Social Support; *SD*, standard deviation; SSQ, The Social Support Questionnaire–Short-Form.
*$p < .05$, **$p < .01$, and ***$p < .001$.

TABLE 3 *t*-test comparisons of individual items on the MSPSS.

	History of suicide attempt ($n = 44$)	No history of suicide attempt ($n = 52$)	*t* value
MSPSS items			
1. There is a special person who is around when I am in need	4.20 (2.12)	4.81 (1.94)	1.47
2. There is a special person with whom I can share joys and sorrows	4.27 (2.20)	4.72 (2.02)	1.03
3. My family really tries to help me	3.72 (2.12)	4.85 (1.75)	2.79**
4. I get the emotional help and support I need from my family	3.16 (2.08)	4.58 (1.75)	3.67***
5. I have a special person who is a real source of comfort to me	4.11 (2.21)	4.75 (2.06)	1.48
6. My friends really try to help me	3.55 (1.86)	4.23 (1.74)	1.86
7. I can count on my friends when things go wrong	3.25 (1.95)	4.17 (1.79)	2.41*
8. I can talk about my problems with my family	3.32 (2.00)	4.62 (1.73)	3.41***
9. I have friends with whom I can share my joys and sorrows	3.65 (1.88)	4.17 (1.91)	1.33
10. There is a special person who cares about my feelings	4.48 (2.19)	4.92 (1.95)	1.05
11. My family is willing to help me make decisions	3.67 (2.06)	4.64 (1.76)	2.49*
12. I can talk about my problems with my friends	3.64 (1.79)	3.88 (1.76)	0.68

Note: All figures are *M* and (*SD*) unless otherwise specified.
Abbreviations: *M*, mean; MSPSS, Multidimensional Scale of Perceived Social Support; *SD*, standard deviation.
*$p < .05$, **$p < .01$, and ***$p < .001$.

people identified and 1 or more people identified for each item. Chi-square analyses revealed an association between being able to identify someone who cares about the patient and suicide attempt status. Those who could not identify one person who cares about them were significantly more likely to have attempted suicide than those who identified at least one person, $X^2(1, N = 96) = 4.04$, $p = .04$. All other items on the SSQ were not significantly different between groups.

When examining all participants, depression severity was significantly and negatively associated with support from family members ($r = -.472$, $p < .001$), friends ($r = -.628$, $p < .001$), a significant other ($r = -.386$, $p < .001$), and total perceived support from others ($r = -.580$, $p < .001$), suggesting that a higher levels of social support is related to lower levels of depressive symptoms across these domains (see Table 4). Similarly, hopelessness was significantly and negatively correlated with family support ($r = -.224$, $p < .05$), friend support ($r = -307$, $p < .01$) and total support ($r = -.313$, $p < .01$) but not support from a significant other ($r = -.203$, ns).

TABLE 4 Correlations between depression severity, hopelessness, and social support subscales.

	Depression severity (BDI total)	Hopelessness severity (BHS total)
Social support subscales		
Support from family members	−.472***	−.224*
Support from friends	−.628***	−.307**
Support from a significant other	−.385***	−.203
Total perceived support	−.580***	−.313**

Abbreviations: BDI-II, Beck Depression Inventory–II; BHI, Beck Hopelessness Scale.
*$p < .05$, **$p < .01$, and ***$p < .001$.

4 | DISCUSSION

Higher levels of depression severity were associated with lower support from family, friends, a significant other, and total perceived support. These findings align with previous studies supporting lower social support is predictive of depressive disorders (Kleinberg et al., 2013). The more severe a patient reported their depression, the more they felt a lack of social support from all areas in life. Increases in any domain of support may help to reduce depressive symptoms, especially in those suffering from more severe depressive symptomology.

Interestingly, social support, but not depression severity, significantly correlated with past suicidal behaviours in the current study. Patients with a history of a suicide attempt reported significantly lower levels of family support and total support as compared to those who had never attempted suicide. These findings suggest that social support may be a more effective target for mitigating suicidal

behaviours as compared to depressive symptoms. Moreover, family relationships may be an especially important treatment target for someone experiencing chronic suicidality or with a history of an attempt. Results showed that suicidal patients specifically endorsed an overall lack of help from their family in many domains. Increases in family support may help reduce suicidal behaviours or prevent depressed individuals from engaging in suicidal acts. The strength of family support on suicidality may be because family relationships are often more reliable, more available, more enduring, or more abundant than friends or a significant other.

Similar to the findings on depression, higher levels of hopelessness were associated with less support from family, friends, and total support. Hopelessness is known to have a strong relationship with suicidality (Franklin et al., 2017). Given the current findings connecting hopelessness with social support, lower levels in social support domains may be considered a risk factor for suicidal behaviour in depressed individuals. Family and friend relationships may provide a different type of support that has a stronger impact on hopelessness than that of a significant other, however increases in any of these domains of social support may help reduce feelings of hopelessness. The current findings show prior attempt history has a significant positive association with discouragement about the future, which is significantly related to hopelessness (Abramson et al., 2006). Establishing hope is one of the most important methods of facilitating improvement in depression treatment. Hopelessness directly correlates with both deficient social support and suicidal behaviour, suggesting there may be a specific connection between these three constructs that requires further investigation. Social support may provide a source of hope for the future, which would mitigate the likelihood of acting on suicidal thoughts. In the current study, attempters were more likely than non-attempters to have significantly lower levels of self-esteem, which literature suggests has a significant relationship with depression, suicidal ideation, and loneliness (Creemers et al., 2012; Overholser et al., 1995). Self-esteem may have a connection with social support and hopelessness that directly impacts the likelihood of a depressed individual engaging in suicidal behaviours.

While substantial resources have been dedicated toward suicide prevention, actual prevention of suicide attempts and death have been relatively ineffective (Zalsman et al., 2016). Within a suicidal crisis, clinicians must protect the patient from injury, reduce feelings of hopelessness and despair, and elevate their subjective quality of life (Mehlum, 2021). The suicidal individuals' needs are typically assessed through an interview, and subsequent treatment planning and safety planning are then completed. While inpatient psychiatric care may be appropriate, most patients will be effectively treated in an outpatient setting (Mehlum, 2021). Unfortunately, many patients tend to drop out of follow-up or outpatient care, so implementing care and resources for the patient that are not reliant on treatment providers may be valuable. Utilizing a suicidal patient's friend and family relationships may be particularly useful in these scenarios. Involving those closest to the patient will mitigate feelings of hopelessness and abandonment, and increase feelings of support, all of which are important for decreasing the likelihood one engages in suicidal behaviour. Educating a patient's social support network on how best to be available and helpful to the client may increase their subjective well-being and facilitate stronger relationships within their network. These relationships are crucial for decreasing the odds of a suicidal act, especially when implementing safety plans that include a list of people to contact during a crisis scenario (Stanley & Brown, 2012).

Current results show that those who had attempted suicide were less likely to be able to identify a single person who cares about them compared to patients without a suicide attempt history. Past literature suggests even a single confidant or intimate relationship acts as a buffer to those who are vulnerable to developing depression (Brown & Harris, 1978). Furthermore, feeling a sense of social closeness is associated with decreased odds of suicide (Dempsey et al., 2021). Having just one important bond as a means of feeling socially connected can be a major source of support for someone who struggles with depression and suicidality and may be the source of hope that a depressed individual needs to not act on their suicidal thoughts. Although there is consistent research demonstrating depression as risk factor for suicide, the finding of the greater role of social support over depression for identifying risk could result in a major shift in how we screen and intervene around suicide. As we discover more about suicide aetiology, it is becoming increasingly clear that an overfocus on depression has resulted in missed opportunities for suicide prevention; the Centers for Disease Control (CDC) documented that most suicide decedents (54%) had never received a psychiatric diagnosis (Stone et al., 2018). The present study supports the clinical utility of specifically targeting social support in psychotherapy interventions with our clients instead of narrowly focusing on depressive symptoms.

An additional benefit of the present study was the utilization of military veterans as participants, as they are at greater risk for suicide than the general population. This inherently strengthens the clinical relevance of the study results. While the findings of the importance of family support in suicidal behaviour holds clinical implications for the general population, it is even more salient when considering the study population. Veterans often feel alienated from their families when reintegrating into society, even after serving during peace time (Morin, 2020). Often, they return markedly changed in behaviour, attitude, and mood. Families may have unrealistic expectations of the veterans' contribution after their return, and the veterans may not have strong relations with young children who were born or grew up while deployed. These expectations or difficulty in relationships may complicate family relationships. Further, difficulties obtaining work or overall financial strain may result in disappointment from family members, which clients may interpret as rejection or lack of support. Educating family members on expectations after discharge from the military could lead to greater family support, which may reduce suicide risk. The findings of the present study highlight the importance of family support in reducing suicide risk and indicate the need for evidence-based family therapies that enhance family support through improving understanding and communication.

The current findings may impact the future of suicide risk identification and prevention by providing evidence for a shift in training.

Current training emphasizes focus on screening for depression to identify suicide risk, but the findings suggest integrating a greater focus on screening for social support, particularly within the family. Most gatekeeper trainings focus on depression as a risk factor; however, these findings reveal that depression severity did not differentiate those who attempted suicide from those who did not attempt suicide. The present findings indicate a need to revise current gatekeeper and other training models to implement more efforts toward screening for and enhancing familial and other social support.

The current study has some notable limitations. Data collection was cross sectional in nature and therefore does not allow for causational relationships to be established. Further, the sample was recruited solely from a veteran affairs medical centre, which could limit generalizability across populations. Lastly, many of the variables measured relied on patient self-report data, which posits limits on interpretability as well.

Overall, findings suggest that social support is an important correlate when studying differences between depressed patients who may or may not engage in suicidal behaviour. In this sample, depression severity did not differentiate between attempters and non-attempters, suggesting that social support has a greater effect on suicidality than depression alone. Hopelessness, self-esteem, specific characteristics of social support, and overall support all display important relationships with suicidal behaviour that may be interrelated and may exceed the impact of depression severity. The current study specifically examined the relationship between distinct sources of support, depression severity, hopelessness, and suicidal behaviour. Overall, findings suggest relationships with family, as opposed to friends or a significant other, is paramount to distinguishing depressed individuals that engage in suicidal behaviour from those who do not. These findings confront the beneficial value of support from family members compared to other types of relationships.

While depression severity and hopelessness were both correlated with all three types of relationships, only suicidality was significantly associated with family relationships. The combined findings help to identify important targets for the treatment of depressed and suicidal individuals. Clinical interventions that involve bolstering family relationships and increasing familial emotional support may be particularly effective in reducing risk of engaging in suicidal behaviours, while interventions focused on boosting perceived connectedness across all types of relationships may be effective in reducing hopelessness and depression severity. These results highlight the interwoven impact of perceived social support with severity of depression, degree of hopelessness, and likelihood of suicide attempt. Further, these finding align with Klonsky's (Klonsky et al., 2021; Klonsky & May, 2015) three-step theory of suicide, which suggests pain, hopelessness, and lack of connectedness (as well as capability for suicide) are necessary conditions for suicide attempts to occur. These findings are important to understand the aetiology of suicidality and should be reinforced as specific targets for treatment when dealing with depressed patients at risk of suicidal behaviour. A recent meta-analysis by Hou et al. (2022) highlights the inconsistencies in the treatment of suicidality using social support methods. After examining randomized controlled trials utilizing social support as treatment, they found a non-significant result of lowered suicide attempts in the intervention group compared to treatment as usual, while death by suicide was reduced by 53% (Hou et al., 2022). The methods employed by these RCTs included one-to-one intervention using postcards, text messaging, face-to-face, telephone, or email contact by laypersons or professionals, while group interventions included group meetings or integrated group activities such as hiking or volunteering (Hou et al., 2022). These mixed findings may be due to interventions utilizing professionals or strangers rather than bolstering the existing relationships one has, specifically their family relationships. The current findings suggest more targeted social support interventions, such as family systems therapy, should be utilized to have a greater impact on suicidal behaviour in depressed populations.

CONFLICT OF INTEREST STATEMENT

There are no relevant financial or non-financial competing interests to report.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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