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Original Research

Relative Importance of Social Support and Social Connectedness as Protective Factors of Suicidal Ideation Among Selected Filipino Late Adolescents

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***Abstract*:** About 800,000 people die of suicide each year worldwide (World Health Organization, 2018). Many of these can be expected to be adolescents. Key protective factors have been found to buffer the risk of suicide (Suicide Prevention Resource Center, 2018). This study investigated the relative importance of two protective factors—social support and social connectedness—in a convenience sample of 811 Filipino youth. Participants completed the Inventory of Socially Supportive Behaviors, the Social Connectedness Scale, and the Adult Suicide Ideation Questionnaire. Results showed significant associations among social support, social connectedness, and suicide ideation. Social support and social connectedness correlated moderately, and both research variables correlated with suicide ideation, as well. When subjected to a stepwise regression, however, the incremental predictive value of social support was minor compared to social connectedness. This argues that clinical interventions should increase the salience of social connectedness, rather than focus exclusively on social support.

***Keywords*:** buffering hypothesis, protective factors, social support, social connectedness, suicide ideation, adolescents

Adolescence involves a heightened risk for both the onset and escalation of suicidal ideation, which in turn is a strong predictor of suicide behavior (Burke, et.al., 2016). College can be stressful because adolescents must cope with difficult academic and social challenges, such as leaving the family for school, meeting new friends for support, adjusting to a new environment, and evaluating themselves favorably or unfavorably against others (Cooke, Bewick, Barkham, Bradley, & Audin, 2006; Buote et al., 2007; Wilcox et al., 2010; Cleary, Walter, & Jackson, 2011; as cited in Sta. Maria et al., 2015). Suicidal ideation may also result from the academic demands, pressures, and difficulties of formal education (Daniel & Goldston, 2009; Ang & Huan, 2006). Given the concurrence of rapid change and environmental stress, some youth may think of suicide as the only solution (Sanchez-Teruel & Robles-Bello, 2014). In the Philippines, Quintos (2017) found that individuals age 20-24 had the highest reported suicidal ideation. As he explained, at this point in life the individual transitions from being a student to a working adult, which demands responsibility and independence.

According to Scanlan and Purcell (2009), suicidal ideation is very common in young people. Between 22% and 38% of the youth are estimated to experience suicidal thoughts at some point. Suicidal

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ideation usually develops in late teens and continues to increase up to the age of 24 (American Foundation for Suicide Prevention, 2010; Pan-American Health Organization, 2003; as cited in Sanchez-Turuel & Robles-Bello, 2014). According to Sanchez-Turuel and Robles-Bello (2014), the highest risk typically occurs between 15 and 24 years of age.

Efforts to reduce suicide have attempted to understand 1) the sequence of behaviors and cognition that results in suicide, and 2) the balance of risk and protective factors that might initiate and sustain this sequence. According to Barrios, Everett, Simon, Nancy, and Brener (2000), suicidal ideation is a good start for studies in suicidality because suicidal ideation constitutes the beginning of a continuum of stages. Suicide behaviors and attempts begin with suicidal ideation (Beck, Kovacs, & Weissman, 1979). Suicidal ideation is then followed by planning, preparing, threatening, attempting, and ends with suicide. Nock et al. (2008), defined suicide ideation as "thoughts of engaging in behavior intended to end one's life" (p. 134). They found that suicidal ideation is indeed a common precursor of suicide plans and attempts. Scanlan and Purcell (2009) referred to suicide ideation as "thoughts that life is not worth living" (p. 1). These would range from vague and fleeting thoughts to definite, well thought out plans for killing oneself, including deep delusional engrossment regarding self-destruction (Nock & Banaji, 2007; Oquendo, Halberstam, & Mann, 2003; Goldney, Winefield, Tiggermann, Winefield, & Smith, 1989; as cited in Rizk et al., 2018). Quintos (2017) provided some validation for the progression from ideation to actual suicide, stating that all youth who have attempted to die by suicide have suicide ideation before the actual attempt.

Suicide is further said to have two "ends," risk factors on one end and protective factors on the other (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011). Risk factors are those factors that increase the probability that a person becomes psychopathological or has behaviors that may be problematic (Tebes, Kaufman, Adnopoz, & Racusion, 2001, as cited in Matlin, Molock, & Tebes, 2011). Risk factors increase the probability of suicidal ideation proceeding down the continuum to planning, preparing, threatening, attempting, and actual suicide. According to Sanchez-Turuel and Robles-Bello (2014), current suicide research is focused mostly on risk factors. The most well studied risk factors include: anticipated or actual losses, life stresses, prior suicide attempts, exposure to others' suicide, mental disorders (e.g. depression, bipolar disorder, schizophrenia, borderline, antisocial personality disorders, conduct disorder, psychotic disorders or symptoms, substance abuse disorders), serious or chronic physical health problems, having access to lethal means, physical or sexual abuse, incarceration, being a victim of bullying, a refugee, a migrant, an indigenous person, or a non-heterosexual person, having family history of mental health problems (e.g. suicide, substance abuse, hopelessness, impulsive and aggressive tendencies, and childhood abuse), cultural or religious beliefs that suicide is noble, social isolation, barriers to mental health treatment, and unwillingness to seek help due to stigma concerns (American Association of Suicidology, 2015; American Foundation for Suicide Prevention, 2015; Centers for Disease Control, 2015; National Institut of Mental Health, 2015; World Health Organization, 2018; Yen, Liu, Yang, & Hu, 2015).

In contrast to risk factors, protective factors safeguard an individual from possible risk factors by helping them cope with problems more effectively (Sanchez-Teruel & Robles-Bello, 2014). Different protective factors and risk factors tend to be cumulative, that is, to have their own independent effects on suicide behavior. If great enough, the influence of protective factors may neutralize the influence of risk factors. According to Butcher, Hooley, and Mineka (2015), protective factors often lead to resiliency, which is the capability of a person to overcome and adjust to adverse situations. Matlin, Molock, and Tebes (2011) explained that protective factors are characteristics present in the life of an individual that prevent the development of psychopathology or other problem behaviors, thus moderating the influence of risk. According to the buffering hypothesis (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011), resilience may be viewed in three ways: (1) as a separate dimension to risk, acting to moderate the impact of a risk factor upon suicidality; (2) as a polar opposite of risk; and (3) as a psychological construct defined as "an ability or perceived ability of the individual to overcome difficulties, or a set of positive beliefs or personal resources which can buffer the individual from adversity" (Johnson, Gooding, Wood, & Tarrier, 2010; Johnson et al., 2010; Osman et al., 2004; Rutter, Freedenthal, & Osman, 2008; as cited in Johnson, Wood, Gooding, Taylor, & Tarrier, 2011 p. 565). Finally, the distinction between risk and protective factors suggests two forms of intervention, either decreasing risk factors, increasing protective factors, or both (Suicide Prevention Resource Center & Rodgers, 2011).

Two commonly mentioned protective factors are social support and social connectedness. As protective factors, they are hypothesized to reduce the risk of suicide (Kleiman & Liu, 2013; Joiner, 2005). Turner and Turner (1999) defined social support as an "interpersonal social resources that involve either the presence or the implication of stable human

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relationships." Social support consists of acts that usually make a person aware that other people care, love, and value him and that he is a part of social system (Cobb, 1976). According to Kleiman and Liu (2013), social support is something that can help someone when they are trying to manage stressful events or challenges that are related to psychopathology through the presence of other people. Social support can either be positive, as seen in socio-emotional exchanges between an individual and their network of family members and peers, or negative, which is seen in inadequate family support, so critical to the transitions encompassed by adolescence (Cumsille & Epstein, 1994). According to Mackin, Perlman, Davila, Kotov, and Klein (2017), parental and peer support are both related to having less suicidality, with parental support having a stronger effect. This study also found that social support is effective in buffering suicidality. In another study, by Rigby and Slee (1999) showed that a student may have high suicide ideation when they are involved in problems about bullying and have a low social support. This study also suggests that having social support from schools can help in reducing suicide ideation. In the cultural context, Uba (1994), stated that for Asians, forms of support are shown by providing concrete action for another person. In addition to this, a collective sense of identity and respect for the elderly, which are mainly about involvement and control, are seen to influence the formation of social support. In the Filipino setting, social support comes in many forms and may appear in ways as merely spending time together, this was referred to as companionship support, wherein help may be indirectly related to the problem at hand (Fernandez, 2011). Filipino youth, according to Fernandez (2011), value the wisdom that they acquire from their parents, teachers, and mentors. These types of support are different from the westernized countries that focus more on autonomy or independence, whereas in the Filipino setting, group harmony is valued more.

Social connectedness has been defined as understanding that there are people that one can rely on or talk to (Lee, Dean, & Jung, 2008), that is, interpersonal closeness and all that closeness might entail. Thus, Whitlock, Wyman, and Barreira (2012) regard connectedness as a psychological state in which the individual feels that he is valued, cared, trusted and respected by surrounding people, such as family, peers and community. Social connectedness can influence both psychological and physiological health by acting as a buffer against environmental stressors and supporting immune functions, which in turn may prevent depression and suicide (Goss, Harrod, Gliner, Stallones, & DiGuiseppi, 2012). The Suicide Prevention Resource Center (2018) indicated that social support and connectedness are key protective factors against suicide which is believed to help buffer the risk factors present in the life of an individual. Those with poor social support and social connectedness tend not to disclose their suicide ideation (Husky, Zablith, Fernandez, & Kovess-Masfety, 2016). In a study by Ouano and Pinugu (2013), on Filipino youth, social connectedness can be gained when students are praised and appreciated by authority figures and when they feel like they belong with their social groups. This study also stated that thinking of academically striving for their future and their family can help them feel socially connected. In addition, a study by Datu and Valdez (2012), social connectedness appeared to be one of the factors that strengthened an adolescent's sense of happiness and being worry free. As the Philippines is part of a collectivist society, social connectedness strengthens the joyous state of the people, wherein such behaviors are highly rewarded.

Although both social support and social connectedness have been found to be protective factors (Whitlock, Wyman, & Barreira, 2012), they may not be equally important. For example, Detrie and Lease (2007) found that social connectedness was a better predictor than social support for psychological well-being. There is reason to believe that the importance of social connectedness as a protective factor may begin to exceed the importance of social support once the individual reaches adolescence, if only because adolescence brings the individual into contact with more social networks than ever before (Detrie & Lease, 2007). On the other hand, increases in social connectedness necessarily facilitate social support, simply because youth can be expected to have a larger circle of people in their lives from which to obtain support from. As such, it is not clear whether social support or social connection is more important to suicide prevention.

In the current study, we examined four hypotheses in a sample of Filipino youth. First, we sought to replicate the relationship between social support and social connectedness. Second, we sought to replicate the relationship between these two protective variables and suicide ideation. Third, we sought to investigate the relative importance of social support and social connectedness as predictors of suicide ideation, since this finding is highly relevant to intervention efforts.

Fourth and finally, we sought to examine the above three hypotheses in the context of what may be termed "youth" or "late adolescence." Adolescence is commonly understood as beginning when puberty starts and ends when the adolescent becomes socially independent (Steinberg, 2014). An expanded

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and more inclusive definition of adolescence from ages ranging 10-19 to ages ranging 10-24 years old is essential for the development of appropriate changes in society. This change in the age range would also correspond more closely to the adolescent growth and what most people understand about this life stage (Sawyer, Azzopardi, Wickremarathne, & Patton, 2018). Jaworska and MacQueen, (2015) pointed out that an expanded definition and timeframe of adolescence which would include up to 25 years old. They stated that the adult roles associated with social and personal responsibility extend into the early 20's because of the delayed traditional adult responsibilities in modern societies. Likewise, Teipel (2013) noted that 18-24 is part of the late adolescent stage, which encapsulates a time during there are very frequent changes in the life of an individual. Problems during adolescence can be especially stressful, because they are perceived as afflicting one nascent sense of self and, hence, one's potential in life. This stage also includes the time for adolescents to gradually take on roles expected of them and the necessary skills they need during their adulthood (Teipel, 2013). As noted, competing with the common terminology of late adolescence is the term "youth." "Overlapping with adolescence, the term youth became popular about the time of the UN's first International Youth Year, in 1985. Although youth is typically defined as the period between 15 and 24 years of age, the Barcelona Statement from the associated world congress defined youth as a social category, and the congress proceedings were remarkable because of the absence of age definitions." (Sawyer, Azzopardi, Wickremaranthne, & Patton, 2018). The Youth in Nation-Building Act (RA 8044) of the Philippines also defines the youth as "those persons whose ages range from fifteen (15) to thirty (30) years old." In this article, we will continue to use the familiar term "adolescence".

Method

Research Design

A cross-sectional, predictive research approach was used in the current study. This design is obtained by crossing the research objective and time dimension (Johnson, 2000). The objective is to forecast a phenomenon using data collected from research participants at a single time point. For the current study, this means establishing whether the variable of interest (suicide ideation) can be predicted from the other variables (social support, social connectedness) using the same sample (Johnson, 2000; Belli, 2008). Thus, social support and social connectedness were used to predict suicide ideation among selected Filipino adolescents.

Participants

Eligible participants of the study are Filipinos with ages ranging specifically from 18 to 24 years old; those belonging to the late adolescence stage. A total of 944 were initially recruited. However, 133 students were removed because they declined to complete the instruments or provided incomplete answers. Using the G power statistics, the power of sample needed to produce 95% confidence interval and error of 5% were 652. The total participants were 811 Filipino youth (469 males; 342 females), with ages ranging from 18 to 24 (M =19.70; SD = 1.49) from various colleges and universities within Metro Manila. Five schools were included in the study, all of which were private schools. Participants were selected using convenience non-probability sampling. No compensation was given. Participation was voluntary and each subject signed an informed consent before completing the measures. Table 1 presents other demographic characteristics of the present study's participants.

Measures

Inventory of Socially Supportive Behaviors (ISSB). The Inventory of Socially Supportive Behaviors was developed by Manuel Barrera, Jr., Irwin N. Sandler, and Thomas B. Ramsay in 1981. The ISSB is a 40-item self-report measure that assesses how often individuals received various forms of assistance during the preceding month at the time of testing (Barrera, Sandler, & Ramsay, 1981). Each item is scored on a five-point Likert scale, with choices (A) being not at all, (B) once or twice, (C) about once a week, (D) several times a week, and (E) being about every day. The ISSB is used to measure social support through questions like, "listened to you talk about your private feelings", "talked with you about some interests of yours", and "comforted you by showing you some physical affection" (Barrera, Sandler, & Ramsay, 1981). Responses are scored 1 to 5 and summed to obtain a total frequency score. An average frequency score can be calculated to whenever there is substantial missing data. Higher scale scores indicate higher social support. Low scale scores indicate lower social support. The test-retest reliability of the ISSB has been measured at .88 (Barrera, Sandler, & Ramsay, 1981). The construct validity of the ISSB was shown in its correlation with social network size (r = .322 to .401) and the Moo's Family Environment Cohesion subscale (r = .359; Barrera, Sandler, & Ramsay, 1981). In the current study, the ISSB scale obtained a Cronbach's alpha reliability of .94.

Social Connectedness Scale - Revised (SCS-R). The Social Connectedness Scale was developed by Richard M. Lee and Steve Bernard Robbins in 1995

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and was revised in 2005 (Lee, Draper, & Lee, 2001) to produce the SCS-R. The SCS-R is a self-report scale which assesses the degree to which youth feel connected to others in their social environment. It consists of 20-items answered on a six-point Likert scale, ranging from one (1) strongly disagree to six (6) strongly agree. Sample items include, "I feel close to people" and "I feel understood by the people I know." Negatively worded items (e.g. "I don't feel I participate with anyone or any group.") are reverse scored. The total score is the sum of the items. Higher score indicates more connectedness with other people while low scores indicate less connectedness with other people. Convergent validity has been shown through high correlation with measures of independent self-construal and collective self-esteem (Lee, Draper, & Lee, 2001). Discriminant validity has been shown through low correlations with measures of interdependent self-construal, collective identity, somatization, obsessive-compulsiveness, phobic anxiety, and too much interpersonal responsibility and controlling behaviors (Lee, Draper, & Lee, 2001). The SCS-R has a coefficient alpha of .92 for a college student sample (Williams & Galliher, 2006). The reliability coefficient of SCS-R in this study was .87.

Table 1. Other Demographic Characteristics of the Participants (N = 811).

Characteristics	n	%
Relationship Status		
Single	648	79.90
In a relationship	161	19.85
Married	4	0.49
Sexual Orientation		
Heterosexual	691	85.20
Lesbian	4	0.49
Gay	17	2.1
Bisexual	56	6.91
Others (Neutral & Asexual)	2	0.24
Religion		
Catholic	665	82
Born Again	96	11.84
Iglesia ni Cristo	15	1.85
Muslim	8	0.99
Others:		
Agnostic	4	0.49
Atheist	1	0.12
Baptist	3	0.37
Jehova's Witness	2	0.25
United Methodist	3	0.37
Protestant	2	0.25
Seventh day Adventis	2	0.25
Union Espiritista Cristiana de Filipinas, Incorporada	1	0.12
Evangelical Christian	1	0.12
None	9	1.11

Adult Suicide Ideation Questionnaire (ASIQ). The adult Suicide Ideation Questionnaire was developed by William M. Reynolds in 1991. The ASIQ is used to screen for suicide ideation among college students and adults, ages 18 years to 88 years old, through questions such as ''I thought that killing myself would solve my problems" and "I wished I had the nerve to kill myself." The ASIQ contains 25 items scored on a 7-point Likert scale ranging from six (6) Almost every day to zero (0) I never had this thought. The ASIQ total score is the summation of its items. Thus, total scores range from 0 to 150, with a high score indicating greater suicide ideation (Reynolds, 1991). ASIQ includes thinking that one deserves to die, suicide as a way of making others notice one's worth, thinking that no one would care if one lived or died, and suicide as solution to one's problems (Reynolds, 1991). The ASIQ has high reliability, with internal consistency coefficient of .97, with reported test-retest coefficient ranging from .85 to .95. Correlations ranging from .38 to .60 with scales measuring depression, hopelessness, anxiety, and self-esteem have provided evidence of construct validity. A correlation of .63 with the Suicide Ideation Questionnaire (Reynolds, 1991) provides evidence of convergent validity. The ASIQ had a Cronbach's alpha coefficient of .97 in the current study.

Procedure

The research proposal for this study was submitted to and approved by the Ethics Board of the University of Santo Tomas prior to data gathering. Schools from

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Metro Manila were selected through simple random sampling. Formal letters requesting participants were then sent to the selected colleges and universities in the Metro Manila area. Once we were allowed to conduct our study, we were given a set of classes which agreed to have their students be part of the study. The students completed the instruments inside their classrooms, where they received an informed consent and were asked to complete a personal data sheet and test battery containing the three research measures. Participants were debriefed after finishing the questionnaires. The current study had a distress protocol prepared wherein participants who expressed negative feelings were either referred to their respective school's guidance counselor or were recommended to consult a psychologist in the UST Psychotrauma Clinic.

Results

Table 2 shows social support and social connectedness had a high and significant positive correlation. High negative correlations were found between suicidal ideation and social support and suicidal ideation and social connectedness.

A multiple linear regression was conducted to establish the unique contributions of social support and social connectedness to suicide ideation and when social support and social connectedness are combined (Table 3). Social support accounted for 0.77% (-.0882) of the unique variance in suicide ideation. A negative regression coefficient (B = -.108, t = -.2.52, p < 0.05) indicated that increased social support decreases suicide ideation.

Social connectedness on the other hand accounted for $-.420^2$ or 17.6% of the amount of unique variance of suicide ideation. Social connectedness was also found to have a negative regression coefficient (B = -1.06, t = -.13.18, p < 0.05), thus indicating that increased social connectedness also decreases suicide ideation. Moreover, social support and social connectedness when combined accounted for more variance in suicidal ideation than either variable alone at 18.1%.

Table 2. Means (M), Standard Deviations (SD), and Inter-correlations of the study variables: Inventory of Socially Supportive Behaviors (ISSB), Social Connectedness Scale - Revised (SCS-R), Adult Suicide Ideation Questionnaire (ASIQ).

	M	SD	ISSB	SCSR	ASIQ
ISSB	125.25	25.62	1		
SCSR	81.69	12.42	.412* *	1	
ASIQ	25.64	31.42	-.247* *	-.420* *	1

Note: N = 811, **. Correlation is significant at the 0.01 level (2-tailed)

Table 3. Regression for Social Support and Social Connectedness to Suicide Ideation.

	Adjusted R Square	Partial Correlation	B	T
ISSB	.181	-.088	-.108	-2.52
SCSR	.181	-.420	-1.06	-13.18

Discussion

The present study investigated the relationships among social support, social connectedness, and suicide ideation. We asked 1) whether social support and social connectedness are related, 2) whether they are related to suicide ideation, 3) which variable made the greatest unique contribution to the prediction of suicidal ideation, controlling for the other, and 4) whether the associations stated in the first two hypotheses, which really represent replications of findings already established in the literature, would generalize to the late adolescence stage among Filipinos. As noted above, this age range is overlapped by "youth," now considered by some to be a distinct social category. As such, continuity of research findings between adolescence and youth becomes an empirical question.

The results supported our first hypothesis that social support and social connectedness are significantly related. Social support and social connectedness had a significant positive relationship (r = .412), a correlation far below the level widely accepted as supporting the convergent validity of two measures of the same construct, that is, .70 or higher (Loevinger, 1957). This demonstrates that the two scales measure somewhat different things, and that their respective constructs mean somewhat different things. Social support may be assumed to require more intimate communication that social connection, simply because social support, as operationalized in the current study, appears to be

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focused more on concrete acts of support than on the psychological state of feeling connected. Moreover, because social support consists of acts, it is received in response to some stressor(s), which requires that the supportive person be informed about and understand the nature of the stressor(s). From there, the supportive person may offer encouragement or suggest solutions designed to resist the stressor. A look at the scale items for social support shows that they are primarily concerned with specific supportive acts.

In contrast, social connection is more of a psychological state, being concerned with feeling valued, loved, and cared for, about interpersonal closeness. Since psychological states necessarily involve the propensity to act in a manner congruent with the state, social connection can be expected to lead to social support. Being connected through care and understanding for another person usually means wanting to support them. Nevertheless, individuals at risk may or may not communicate the nature or content of their stressors. Social connection, therefore, involves the possibility of social support, while also involving a constellation of other secondary benefits, such as social affiliation, evidence of integration into social groups, and even emotional intimacy that goes beyond any stressors the individual might be feeling. Social connection, for example, might involve talking about good times shared together, which cannot be construed as social support. As such, social connectedness implies social support, but does not equal social support.

Not surprisingly, both social support and social connectedness had a significant inverse relationship with suicide ideation, which supported our second hypothesis. Increases in either social support or social connectedness was associated with decreasing suicide ideation. There is ample precedent in the literature for this finding. Miller, Esposito-Smythers, and Leichtweis (2015) found that being isolated and having limited social support is linked to suicide ideation and suicide attempts. Whatley and Clopton (1992) found that college students having high social support decreased the probability of suicide ideation. Endo et. al. (2013) found that those with suicide ideation received low amount of social support from their family. Social support has been connected with suicide ideation and attempts (Miller, Esposito-Smythers, & Leichtweis, 2015). Gonçalves, Sequeira, Duarte, and Freitas (2014) found that weak social support was related to suicide ideation and risk among university students. Finally, Kimbrough, Molock and Walton (1996), found that among African American college students, social support from family and friends appear to buffer depression and suicidal ideation.

Social connectedness was likewise inversely related with suicide ideation. Again, there is ample precedent in the literature for this finding. Jo and Kim (2016), which found that as the sense of belongingness and connectedness go up, suicide ideation goes down. He, Fulginiti, & Finno-Velasquez, 2015) found that youth with low suicidal ideation were more connected to their primary caregiver. Low social connectedness has been linked with suicide ideation, non-fatal behavior, and suicide in later life (Fassberg et al., 2012). Arango et al. (2018) investigated three subtypes of social connectedness (family, school and community) among bully victimized youth aged 12-15 years old and found that all three subtypes were negatively correlated with suicidal ideation.

Our third hypothesis suggested that the protective effects of social support and social connection might not be equal. In a stepwise regression, social connectedness accounted for 17.6% of the variance in suicidal ideation. Social support was excluded from the equation, its unique predictive contribution being no longer significant. Indeed, when both social support and social connection were entered into a multiple regression, 18.1% of the variance in suicidal ideation was accounted for, a small increment over the 17.6% of social connection alone.

The finding that social connectedness is much more strongly associated with suicide ideation than is social support has important implications for future suicidology research and suicide prevention. Because the relationship between social connectedness and suicide ideation is much greater than the relationship between social support and suicide ideation, interventions that increase the perception of social connectedness are likely to be more successful in protecting again suicide ideation. Whitlock, Wyman, and Barreira (2012) lists the benefits of social connectedness in youth in that (1) connectedness could lead to a positive appraisal of stressful situations and lessen suicide ideation and behavior, (2) with increasing social connectedness, a great number of people can detect the presence or cues of suicide ideation, and (3) higher connectedness exposes the individual to social influences that can promote constructive coping strategies. Social connection was found to be an important protective factor against suicide-related events among youth in a study on the suicidal ideation and distress among immigrant adolescents (Cho & Haslam, 2009). Borowsky, Ireland, and Resnick (2001) concluded that feeling connected to others was important to the well-being of youth. Robert, Desgranges, Séguin, and Beauchamp (2018) suggested that for vulnerable and high-risk youth, the risk of suicidal behavior, which includes suicide ideation, was minimized by social connectedness.

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The relatively stronger association of social connectedness and suicidal ideation versus social support and suicide ideation has important clinical implications. When faced with clients experiencing suicidal ideation, counselors and therapists may wish to make salient to their clients the most important social relationships in their lives. Feelings of intimacy and connection appear to be foundational to resiliency in the face of stress. Social connectedness makes salient the relationships give life meaning, and do so in a way that moves the client's thoughts away from "client versus stressor" by bringing into focus a broader network of social relationships that have unique meaning for the client. These meanings may be positive and soothing, and not at all reminiscent of the current stressor(s). In other words, social connectedness has the potential to open up the scope of the client's attention to social patterns of engagement that lie beyond their current problems. In contrast, social support may actually narrow attention to the current problem, which suggests that social support could be counterproductive in the absence of a sense of connection.

Finally, we would briefly note that the fourth hypothesis suggested that because of the overlapping nature of adolescence and youth, it was unclear whether the first two hypotheses of our study would generalized to a population of Filipino college students, who may be considered to exist at the boundary of adolescence and youth considered as social categories. Both hypotheses represent replications of findings already established in the literature, and both hypotheses were supported, which supports their validity, both cross-culturally and across social categories defined by age.

Limitations and Future Directions

The current research recognizes certain limitations. This research is a predictive cross-sectional design which is intended only to investigate if social support and social connectedness forecast suicide ideation using self-report data collected from the same population of selected Filipino late adolescents. Similarly, it may be argued that the "cultural validity" of the measures could be increased. Replication with measures derived and normed exclusively with a Filipino population would strengthen the current findings, when such measures become available.

Future research should examine other protective factors, such as self-esteem, family support, and self-acceptance (Sanchez-Teruel & Robles-Bello, 2014). Various stages of the suicide process, such as planning and attempting, could examined instead of a sole focus on suicide ideation (Katsaras et al., 2018). Perhaps certain protective factors are effective at one stage of the suicide process, but not at others. Clinicians and counselors often see clients following a suicide attempt. It is necessary to validate that interventions effective at the ideation stage are also effective after a suicide attempt. Other researchers could likewise explore investigating our research variables (suicide ideation, social support, social connectedness) in terms of differences in demographic variables (e.g. gender, year-level). Finally, future research could broaden the scope of participants in terms of cities and provinces, age, and inclusion of public colleges and universities in the Philippines to strengthen the generalizability of the results.

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