SUMMARY

Suicide is a global health problem and the field of suicide has attracted considerable attention in recent years. The cost of suicide is not only the loss of life, but the mental, physical and emotional stress imposed on family members and friends. The empirical attempts have been made continuously for understanding the nature of suicide, its antecedents, causes and prevention. Suicidal ideation and suicidal behaviour among students in the age of adolescents and youths is still, a worldwide problem. Life for many adolescents is not easy, as adolescence period is considered as period of storm and stress due to their psychological and physical development. High level of parental expectations, academic demands, adjustment to new situations, environment, peer pressure, break-up with boy / girl are some of the most common events in the life of the individual which lead to serious consequences resulting in suicidal behavior. Kumar and Singh (2006), reported that stressful life events leads to depression and anxiety which sometimes causes of suicide and suicidal attempts among youths. The increased attitude to suicide has resulted in a massive expansion in research. Suicidal behaviour ensures results of an interaction of socio-cultural, developmental, psychiatric, psychological and family environmental factors (Bridge, Goldstein and Brent, 2006).

In some instances for different reasons, suicide as the cause for death might be hidden and in some areas it is completely unreported (Bertolote and Fleishman, 2002). Risk factors may be thought of as leading to or being associated with suicide; that is, individual
"possessing" the risk factor are at greater potential for suicidal behavior. On the other hand, protective factors reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biological, psychosocial, environmental or socio-cultural in nature. Understanding the interactive relationship between protective in suicidal behavior and how this interaction can be modified are challenges to suicide prevention are discussed below:-

1. Psychological capital:- Psychological capital represents an individual’s psychological positive state in the process of growth and development. At the end of last century, Seligman advocated the positive psychology movement, emphasizing the research should be focused on individual's positive emotions, characteristics and psychology, rather than just concerned person's negative symptoms. This positivity may help in the prevention of suicidal behaviour and thoughts. Zubrick et.al (2000) suggested that families also have access to psychological capital that can be used on behalf of children and young people. Psychological capital includes parents’ psychological health, level of family cohesion, perceived level of family support and level of stress and conflict within the family may influence on suicidal behaviour and thoughts. Luthans et.al (2004) defines four psychological capital constructs who facilitate/reduce the suicidal potential.

   Self-efficacy refers to how well individuals believe that they can manage and meet the demands and tasks of daily living (Silburn, Zubrick, Garton, Gurrin, Burton, Dalby, Carlton, Shepherd and
Lawrence, 1996). Many scientists believe that sport will increase self-confidence and control over the negative issues. It plays an important role in human performance determinants such as goals, aspirations, and the perceived opportunities of a given project (Bandura, 2000; Maddux, 2002). On the other hand, people with low self-efficacy tend toward suicide, delinquency, eating disorders, and depression in the face of moral-behavioral and emotional disorders such as lack of motivation, stress (Hassanzadeh, 2003).

Optimists tend to take credit for positive occurrences in their lives while providing external, temporary, situation specific explanations to negative occurrences. Psychological capital optimism differs from traditional optimism, although, in that it has the caveats of being both sensible and flexible. In this manner, it remains a resource that is not likely to suffer harmful effects of having “too much of a good thing.” Optimism in terms of happiness, research on optimism as demonstrated a positive relation with mental well-being (Scheier and Carver, 1992) as well as life satisfaction (Seligman, 2002). Optimism is a very important protective factor for suicidal behaviour which plays positive role in development of good psychological health and wellbeing. On the basis of large number of research conducted on optimism, psychologists suggested that optimism exert a protective effect against suicidal ideation (Hirsch, Conner, and Duberstein, 2007; Hirsch et al., 2007; Roberts, Roberts, and Chen, 1998). Optimism also function as a protective factor in the presence of adversity and decrease suicidal ideation (Blankstein, Lumley, and Crawford, 2007). Cato (2012) revealed that there is a significant negative relationship
between optimism and suicide. Similarly, Sánchez-Teruel, García-León, and Muela-Martínez (2013) found that students more likely to have suicidal ideation are less optimistic, have poorer social skills and less social support.

Hope is commonly used in everyday language, but within the context of positive psychology, has a specific meaning with substantial theoretical support. Importantly, considerable research over the past several years indicates it has a very positive impact on athletic accomplishment, academic achievement, emotional health, the ability to cope with illness and other hardships. Beck et al. (1985) claimed that hopelessness as an important psychological construct for understanding suicide in last twenty five years. Hopelessness can affect to depression and in turn predicting suicide act. Wetzel et al., (1980) revealed that there is significant relationship between hopelessness and suicide intent. Besides that hopelessness was predictive of actual suicide (Beck et al., 1988). Minkoff et al., (1973) found that the intensity of suicidal intent was highly correlated with hopelessness than with depression. However, hopelessness does not consistently predicting suicide ideation, if depression was controlled (Esposito et al. 2003). It has been suggested that hopelessness may place adolescents for only a certain times at risk for suicidal behavior (Dori and Overholser, 1999).

Resiliency defined as the capacity to rebound or bounce back from adversity, failure, conflict, or even positive events, progress, and responsibility (Luthans, 2002). Resilience involved behaviors, actions, and thoughts that can be learned and developed in anyone.
Resilience is extremely influenced by a person's environment. The study of resilience found that the capability of individuals and support like families, groups, and communities to cope effectively in the face of significant adversity and suicide risk i.e. useful way of find out protective factors (Masten, 2001). Coutu, (2002) reported that Resilient individuals possess a ‘staunch acceptance of reality, a deep belief, often buttressed by strongly held values, that life is meaningful and a strange ability to improvise’. Low resilience may be a risk factor for suicidal behavior (Roy, Sarchiapone and Carli, 2007).

2. **Emotional Capital**: Emotional Capital is another strong predictor of mental health and psychological wellbeing. In varied life conditions growth of emotional capital draw a major impact in exploring the ways of handling different life hassles which leads to suicide. Salovey and Mayer (1990) defined Emotional capital as ‘people who understand and manage their emotions in a meaningful way are able to guide one’s actions and thinking. Emotional capital is the set of competencies that inhere to the person useful for personal, social, professional and organizational development (Gendron, 2004). They play a role in people’s entire life, in people’s behavior, in reactions in their day-to-day life: at school, at work, everywhere (social life, private life / marriage life). Since emotional competencies are crucial and useful to perform better socially, economically and personally, it considers as a capital (Gendron, 2002).

3. **Social capital**: Social capital is a concept widely promoted nowadays in fields of public health and community development. Thus social capital is very much a feature of society, or groups of
people, rather than individuals, and it can be regarded as similar to Durkheim’s viewpoint of social integration (Cullen and Whiteford 2001; Spellerberg 2001). However, it also has elements of conflict theory as it stressed that uneven access to social capital by sub-groups of the population can lead to inequalities in physical and mental health.

Common themes from these miscellaneous theorists are that positive social connections may be protective against suicide, whereas discordant or overly enmeshed connections may elevate risk for suicide. Social factors alone are insufficient to explain the factors of suicidal thought and behavior. Rather, social factors interact with characteristics or different aspects of individual’s behaviour to influence the risk for suicide. As mentioned above research constantly suggests a variety of factors associated with suicide ideation, including: social support; undesirable life events and circumstances; depression, and physical health (Gliatto and Rai, 1999; Mazza and Reynolds, 1998; Reifman and Windle, 1995; M.D. Rudd, 1990; Schutt, Meschede, and Rierdan, 1994; Vilhjalmsson, Sveinbjarnardottir and Kristjansdottir, 1998). Although stressors generally decline an individual’s social resources and thus increase distress, the impact of these distresses on suicide ideation have been shown to be buffered or moderated by these resources (Schutt, Meschede, and Rierdan, 1994). In real meaning, people with high levels of distress along with high levels of social resources, have low suicide ideation. In general, however, the social resources explored have been limited to the individual’s perceived social support (Ensel and Lin, 1991). It is an expulsion of interest in the broader concept of
social capital but it contains little research about the impact of social assets in general on suicide ideation as well as its mediating and/or buffering role.

The main aim of the study is to examine the relationship among the measures and to see the effect of protective factors on suicidal potential. The problem of the study can be stated as:

**A STUDY OF SUICIDAL POTENTIAL IN RELATION TO PSYCHOLOGICAL, EMOTIONAL AND SOCIAL CAPITAL**

Sample for the present study was drawn from various public and government schools of Sirsa district of Haryana. A total of 411 participants (204 males and 207 females) were selected randomly from 10+1, 10+2 and under-graduate classes of the educational institutions about equal number of participants were selected from Science, commerce and arts streams. The ages of the participants ranged between 16 to 22 years with a mean age of 19.5 years. They participants were belonging to middle class families and their academic atmosphere may be treated as homogeneous. The selected sample covers all walk of society.

**Tools Used:** The following measuring tools were used in the study

2. **Time Questionnaire (TQ):** The Questionnaire (TQ) is developed by Robert Yufit and Bonnie Benzies (1979) to explore and quantitatively assesses suicidal potential among adolescent. The Questionnaire consisted of 39-item distributed in 3 sections-the Present, Future, and the Past-which contain both
multiple choice and open-ended items. The sum of three section scores yields the total TQ scores.

3. **Social capital questionnaire**: The questionnaire was developed by Onyx and Bullen (2000). It consisted of 36-item which measure eight distinct dimensions. These can be categorized in two broad categories i.e. capacity building block and social arenas with four sub-scales termed as capacity building blocks i.e. feeling of Trust and Safety, Social Agency, Tolerance of diversity, and value of life. The other four sub-scales are related to the Social arenas i.e. community connections, neighborhood connections, family and friends and work connections.

4. **Multidimensional Measure of Emotional Intelligence (MMEI)**: The Multidimensional Measure of Emotional Intelligence (MMEI) was constructed by C. R. Darolia (2003). It comprised of 80 multi-choice items distributed in five dimensions- Self Awareness, Managing Emotions, Motivating Oneself, Empathy and Handling Relationship.

5. **The General Self-Efficacy Scale (GSE)**: This scale is developed by Jerusalem and Schwarzer (1979). The scale is uni-dimensional and it consists 10 items in a response on a 4-point scale. Sum up the responses to all 10 items to yield the final composite score with a range from 10 to 40.

6. **Beck Hopelessness Scale (BHS)**: The scale was developed by Beck, Weissman, Lester and Trexler (1974) to assess the extent of negative attitude about the future as perceived by adolescents and adults. The BHS consists of 20 true-false
statements 9 are keyed **FALSE** (item no. 1, 3, 5, 6, 8, 10, 13, 15, 19) and 11 are keyed **True** (item no. 2, 4, 7, 9, 11, 12, 14, 16, 17, 18, 20) to indicate endorsement of pessimism about the future. Each of the 20 statements is scored 1 or 0.

7. **Life Orientation Test-Revised (LOT-R):** The test was developed by Scheier, Carver, and Bridges (1994). The scale consists of 10 statements designed to assess levels of generalized optimism, or the generalized expectations of favorable outcomes. In LOT-R, there are 10 items out of these four were filler items and six were scale items (3 items of the scale measure were related to optimism and 3 items measures of pessimism).

8. **Resilience Scale:** The first version of scale was developed by Wagnild and Young (1993). The short version consist 14 items and each item is rated on a 7- point Likert scale. The response pattern was strongly disagree (1) to strongly agree (7). The scale was intended to assess the capacity to withstand life stressor, to thrive and make meaning from challenges. The total scores for the scale ranges from 14 to 98. Scoring of the tests was done in accordance with the scoring pattern mentioned in respective manuals.

The obtained data were treated statistically for Descriptive Statistics, t- test, Pearson’s product moment correlation and Linear Multiple Regression Analysis through **SPSS**. Discriminant analysis is also used to find out the potent predictors of group membership between low suicidal potential and high suicidal potential groups.
OBJECTIVES: -

1. To compare the male and female participants on the measures of psychological capital.
2. To compare the male and female participants on the measures of emotional capital.
3. To compare the male and female participants on the measures of social capital.
4. To study the gender differences on the measures of suicidal potential.
5. To examine the relationship of psychological capital with suicidal potential.
6. To study the relationship of emotional capital with suicidal potential.
7. To examine the relationship of social capital with suicidal potential.
8. To ascertain the contribution of psychological capital, emotional capital and social capital in suicidal potential.

HYPOTHESES

1. There is likelihood of no gender difference on the measures of psychological capital.
2. There is likelihood of no gender difference on the measures of emotional capital.
3. There is likelihood of no gender difference on the measures of
social capital.
4. There is likelihood of gender difference on the measures of suicidal potential.
5. Psychological capital is likely to be associated negatively with suicidal potential.
6. Emotional capital is likely to be associated negatively with suicidal potential.
7. Social Capital is likely to be associated negatively with suicidal potential.
8. Psychological capital, emotional capital and social capital will contribute substantially in suicidal potential.

FINDINGS OF THE STUDY

1. Participants belonging to female group are having high mean score ($\bar{x} = 123.73$) on psychological capital as compared to participants belonging to male group($\bar{x} = 119.84$). The ‘t’ value being 2.49 which is significant at .05 probability level. Hence, hypothesis no. 1 is not supported.

2. Both male and female participants do not differ significantly on the measures of emotional capital ($t = 1.33$, $p = .184$). This support the hypothesis no. 2.

3. The mean of male group ($\bar{x} = 83.70$) is higher than their female counterparts ($\bar{x} = 82.15$) on social capital. The ‘t’- value being 1.96, which id significant at .05 probability level. Thus, hypothesis no 3 is rejected.

4. Female group participants are having high mean scores ($\bar{x} = 232$)
17.01) on suicidal potential as compared to male group participants (x = 13.79). The 't' value being 4.19, which is significant at .001 probability level. The hypothesis no. 4 is accepted.

5. Overall psychological capital and its measures i.e. self-efficacy, optimism and resilience correlates negatively with suicidal potential whereas hopelessness correlates positively with suicidal potential. The correlation between psychological capital and suicidal potential is found r = -.27(p < .01). Suicidal potential is found to be correlated negatively with self-efficacy (r = -.27, p< .01), optimism (r = -.18, p < .01) and resilience (r = -.24, p< .01) and positively with hopelessness (r = .46, p< .001). The hypothesis no. 5 is accepted.

6. All the dimensions of emotional capital, except empathy, have negatively significant correlation with suicidal potential. Suicidal potential correlates negatively significant with self-awareness (r = -.14, p< .01), managing emotion(r = -.10, p< .05), motivating oneself (r = -.27, p< .01) and handling relationship(r = -.18, p< .01) and overall emotional capital (r = -.21, p< .01). Thus, the hypothesis no. 6, regarding the negative relationship between emotional capital and suicidal potential is accepted.

7. The correlations between the measures of social capital and suicidal potential ranges between -.15 to .01. Out of nine correlations four are significant at and above 0.05 level of significance. Suicidal potential correlates negatively with social context (r = -.11, p< .05), neighborhood connection(r = -.15, p<
.01), and tolerance and diversity (r = -.11, p < .05). The overall social capital correlates negatively significant with suicidal potential (r = -.11, p < .05). The hypothesis no. 7 is accepted.

8. The linear combination of hopelessness, self-efficacy, motivating oneself, trust and safety, neighborhood connection, and managing emotions jointly explain the variance of 31% (R^2 = .306) in suicidal potential. It supports the hypothesis no. 8.

9. The discriminant function analysis reveals that a linear combination of three predictor variables has successfully differentiated between low and high suicidal potential group. This set includes self-efficacy and hopelessness of psychological capital and motivating oneself of emotional capital. These three predictors have correctly differentiated between 83% cases of low and 60% cases of high suicidal potential group with an overall 71.5% correct classification of cases.