CHAPTER - I

INTRODUCTION

The incidence of suicides in the recent years has become so common that no single day passes without reading, hearing or watching an act or attempt of suicide in the media. Suicide is the second leading cause of death among young people after motor vehicle accidents. The costs of suicide are not only loss of life, but the mental, physical and emotional stress imposed on family members and friends. The word “suicide” was firstly introduced by Sir Thomas Browne in his ‘Religio Mediit’ (1642) which has evoked a variety of reactions in public minds, these reactions vary from anger, ridicule, distress, anxiety, tension, fear, sadness and stigma. ‘Suicide’ word derived from the Latin words *sui* (of oneself) and *caedere* (to kill). Thus the meaning of suicide is killing oneself. In a famous symposium on suicide, Freud (1910) declared ‘Suicide’ is a 180 degree self-murder’. The nomenclature of suicide behaviors without fatal outcome varies as well. Sometimes they are referred to as "suicidality" whereas others term these as "suicide-related behaviors" or "suicidal behavior" (Heilbron et al., 2010). Suicide can be defined simply as the destruction of oneself – self-killing or self-murder in the legal sense (Clinard and Meier, 1975). Retterstol (1993) gave a more detailed definition as “An act with a fatal outcome, which is intentionally initiated and performed by the deceased him or herself, in the knowledge or expectation of its fatal outcome, the result being measured by the actor as instrumental in bringing about desired changes in consciousness and social circumstances”. There is a wide
range of suicidal behavior, ranging from low-level suicide ideation (occasionally thinking about suicide) through to a purposeful action that actually results in death. In General, the term attempted suicide is used to describe self-harm where there is apparently an intention to kill oneself but death does not occur. A suicide attempt should possess the characteristics as self-initiated, potentially injurious behavior; presence of intent to die; and nonfatal outcome (Durkheim, 1897/1951).

Suicide is defined as an act of intentionally terminating one’s own life (Nock and Borges et al., 2008; Shneidman, 1985). However, this definition does not do justice to the complexity of the concept and the several usages of terms across studies. The nomenclature for suicidal ideation and behavior has been the subject of significant international attention and debate (De Leo et al., 2006; O’Carroll et al., 1996; Silverman et al., 2007). Suicide occurs rarely in childhood and early adolescence, but beginning at about age of 15, the suicide rate increase dramatically. It is estimated that six to ten suicide attempts occur for every suicide in the general population for adolescents it as high as fifty attempts for every life taken. Two of every three college students have thought about suicide on at least one occasion. Suicidal ideation is relatively common, certainly in clinical settings, but also more broadly among people with severe suicidal ideation, what differentiates those who attempt or die by suicide from those who do not? The answer may involve fearlessness about physical pain, physical injury, and death itself. Death is inherently fearsome and intimidating and it thus takes considerable resolve, intent, and fearlessness to enact. This does not make it laudable, but it
does make it difficult. World Health Organization (WHO) in 1998 defined suicide as, “The act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome”.

More than one lakh people in India lost their lives by committing suicide every year during decadal period 2004 - 2014 (National Crime Records Bureau, 2014, Ministry of Home Affairs, Govt. of India). It has recorded an increase of 15.8% (1,31,666 in 2014 from 1,13,697 in 2004). The population has increased by 14.6% during the decade while the rate of suicides has slightly increased by 1.0% (from 10.5 in 2004 to 10.6 in 2014). World Health Organization (2012) estimates that almost one million people completed suicide each year worldwide, representing an annual global suicide mortality rate of 16 per 100,000. The incidence of suicide among the youth (19-24) has been increasing over the years. Nock et. al., (2008) estimated that an average one death after every 20 seconds and one attempt after every one to two seconds. The pattern of suicides reported from National Crime Records Bureau (2014), showed that ‘Family Problems’ and ‘Illness’ were the major causes of suicides accounting for 21.7% and 18.0% respectively of total suicides. ‘Marriage Related Issues’ accounted for 5.1%, ‘Love Affairs’ 3.2%, ‘Drug Abuse/Addiction’ 2.8%, ‘Bankruptcy or Indebtedness’ and ‘Failure in Examination’ both are accounted for 1.8% each, ‘Unemployment’ 1.7%, ‘Poverty’ 1.3%, ‘Property Dispute’ 0.8%, and ‘Death of Near and Dear ones’ accounted 0.7%, these were other causes of suicides.
Male students aged 18 to 24 are more than twice as likely as female students to have died by suicide (Drum, Brownson, Burton, Denmark and Smith, 2009). Female graduate students aged 25 and older die by suicide at a rate similar to their male counterparts (SPRC, 2004). Males are about three times more likely to commit suicide than female, whereas female are more likely to attempt suicide than male. The explanations for this is that males use lethal methods when attempting suicide, such as shooting, while females use passive methods, such as sleep pills. There is such hopelessness among youngsters who should have so much to look forward to. Notably, young women were much more likely to kill themselves than young men. ‘Physical Abuse (Rape)’ was major causes of suicides among females than among males. Drum et al., (2009) initiated that approx. 18% of undergraduates reported having seriously considering a suicide attempt at some point, while 6% reported serious suicidal ideation in the past year.

The study by Westefeld et al (2005) found that 24% of college youth considered suicide. Gutierrez, Osman, Kopper, Barrios and Bagge, (2000) found that suicidal ideation among college students ranged from 32% to 70%. Suicide attempts by college youth was estimated between 1% to 5% (American College Health Association, 2009). A major suicide risk factor for college youth was substance or alcohol misuse (Lamis and Bagge, 2011; Westefeld et al., 2006).

**Legal aspects on suicide**

Historically, the acceptance of suicide as both rational and irrational reflected the nature of prevailing spiritual direction of a
culture. Ancient Greece viewed the act with ambivalence. Hinduism and Buddhism do not take a positive sight of suicide and Islam strictly forbids the act while Rome appears to have acceptable suicide either neutrally or perhaps even positively. In Ancient Rome, the quality of life was emphasized. According to them, the wise men live as well as they should, not as long as they can. Western thought changed radically in the fourth century, when st. Augustine proclaimed suicide or suicide attempt a crime. Later on st. Thomas Aquines suggested that it is a form of murder because it usurped God’s power over life and death. So, the western world came to regard it as crime and sin (Shneidman, 1973). The Dharmashastras, a book on the codes of living in ancient India are explicit in their condemnation of suicide. For instance, Yama Simriti (600 BC) says that the bodies of those who die by suicide should be defiled. If a person survived an attempt, he should pay a fine and if the person killed himself the sons or friends should pay the fine (Thakur, 1963). Although suicide was condemned in the Dharmashastras there is also a chapter on allowed suicide, Scriptures, such as by Manu and Kautilya, were against suicide. These sentiments were echoed for ages in India even today attempted suicide is a crime under Section 309 in the Indian Penal Code which lays down the punishment for attempted suicide, although the neighboring country of Sri Lanka removed attempted suicide as a punishable offence. Assisting and abetting suicide is also punishable offence in India. As per IPC whoever attempts to commit suicide and does any act towards the order of such offence shall be punishable with simple imprisonment for a term which may extend to one year or with fine or both. If any person
commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of also description for a term which may extend to ten years, and shall also be liable to fine.

**Early warning signs of suicide**

People are often uncomfortable in discussing about suicide and suicidal thoughts. This is partially due to the stigma, guilt or shame that surrounds suicide. Unfortunately, this tradition of silence perpetuates harmful myths and attitudes on suicide. It can also prevent people from conversation openly about the pain they feel or the help they need. Suicide can appear to be an impulsive act. But it is a complicated process, and a person may think about it for some time before taking action. Suicide is a tendency of a person to get away from the problems that are so crushing by feeling that only death will stop it. It’s estimated that 8 out of 10 people who die by suicide or attempt suicide gave a clue about or mentioned about their plans.

1. The adolescent makes suicide threats such as “I wish I was dead,” “my family would be better off without me,” “I don’t have anything to live for”.
2. An earlier suicide attempt. No matter how minor. Four out of five people who commit suicide have made last on previous attempt.
3. Preoccupation with death in music, art and personal writing.
4. Loss of family member, pet or boyfriend through death abandonment and breakup.
5. Family disruption, such as unemployment serious illness and relocation, divorce etc.
6. Disturbance in eating habits and personal hygiene.
7. Declining grades and lack of interest in school activities.
8. Withdrawal from family member and friends, feeling of alteration of significant others.
9. Giving away prized possession and otherwise getting affairs in orders.
10. Series of accident, risk taking behavior, drug or disregard for personal safety taking dangerous dares.

**Some myths about suicide**

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<th>Sr. No.</th>
<th>Myth</th>
<th>Fact</th>
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<td>1</td>
<td>A person attempting or completing suicide after says “My time is over, God is calling me.”</td>
<td>This is not true. It is because of some personal beliefs. It may be the person’s feeling that he/she has reached the end of life and nothing more can be done. Some people may be hearing voices or seeing images due to particular mental problems. Such responses by people should be taken seriously by people around him/her.</td>
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<td>2</td>
<td>Only others commit suicide. It will not happen to me.</td>
<td>Majority of the people has a fleeting thought of ending his/her life in an emergency situation, but not everyone pursues the thought. When such thought repeated constantly, increases in frequency and severity and, begin to affect day-to-day activities, suicides are likely to occur.</td>
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<td><strong>3</strong></td>
<td>If a person has attempted suicide once, he will not repeat the same.</td>
<td>This is not true, it is known that attempters are likely to completed the act in the first one or two years after the event. These persons need regular observation, an empathetic understanding and appropriate care. After a brief period of recovery, if the person goes back to contemplating death, he/she desires to be supported, observed.</td>
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<td><strong>4</strong></td>
<td>A person who talks about suicide does not commit it, but only threatens in order to draw attention.</td>
<td>While some people use minor degrees of self harm to draw attention of people around them, most people give signs at some point by talking about this aim. Such clues should be taken seriously.</td>
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<td><strong>5</strong></td>
<td>It is not possible to identify the person likely to commit suicide. Nobody can suspect his/her intention.</td>
<td>This is not always true. Majority of people give a warning sign or commit an act, which should be taken seriously talking about death desires, donating their belongings, writing sad stories, poems and songs.</td>
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<td><strong>6</strong></td>
<td>Asking about suicidal thoughts to some person may precipitate the act.</td>
<td>This is not true in fact not asking about suicide may prevent identification at high risk of suicide at an early stage.</td>
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<td><strong>7</strong></td>
<td>If once a thought of suicide come seriously in an individual, he/she will definitely complete at some time.</td>
<td>Not everyone who thinks of suicide is likely to repeat the same. However, it has been shown by systematic research that persons with history of attempted suicide are a greater risk of completing the act over the</td>
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coming few months or in the following year or two. Timely help and support can help the person to get over the death wish for the rest of his/her life.

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<th>Only poor people who cannot afford basic requirements of life commit suicide.</th>
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<td>8</td>
<td>Suicide is not a problem associated to class, age or gender. Depending on the social, environmental, economic and mental health status, anyone can commit suicide. It is seen that suicide among poor people is reported in press more frequently.</td>
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<th>Suicide runs in families. So, nothing can be done.</th>
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<td>9</td>
<td>As per research finding, there is some association for hereditary basis of suicide. There is a chance that some mental illness which cause suicidal tendencies occur in families. This general observation is not true for all suicides.</td>
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<th>Suicidal persons are always mentally ill.</th>
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<td>10</td>
<td>This is not true. However, a huge number of people attempting suicide are depressed, unhappy, sad or violent before the act. Further, mentally ill persons carry a higher risk of suicide. But, many mentally and physically healthy people also commit suicide. The inherent desire to live and battle between “to live” or “not to live”, makes these people unhappy before the act.</td>
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TYPES OF SUICIDE

Taylor (1988) defines type of suicidal behavior as any deliberate act of self-damage or potential self-damage, where the person cannot be sure of survival. Whether or not a person really intended to die is sometimes unclear or vague in both attempted and completed suicide situations, given that it is difficult to accurately determine a person’s purpose after the event. For this reason, Taylor (1988) distinguishes four types of behavior related to suicide:

- **Suicide**: the person intends to die, and does so.
- **Attempted suicide**: the person intends to die, but does not.
- **Suicidal gesture**: the person has no real intention of dying, and does not.
- **Accident**: the person does not intend to die, but does.

Durkheim (1897) also proposed different types of suicide, based on the degree of social integration – how a person is connected to society - too much integration vs. not enough integration. He distinguishes four types of behaviour related to suicide. They are detailed below:-

1. **Egoistic suicide**: This type of suicide occurs when low social integration occurred. When a person commits suicide they are not well supported in a social group. They often feel very isolated and helplessness during times in their lives when they are under stress, thought to occur in individuals who feel
societal excluded, with little social support and no integration with society, resulting from a sense of personal failure.

2. **Altruistic suicide:** This type of suicide occurs when the degree of social integration is too high and they are greatly involved in a group. All that they care about are that group norms and goals and they completely ignore their own needs and goals. They take their lives for a cause. Self sacrifice was the defining trait, where persons were so integrated into social groups that they lost sight of their individuality and became willing to give up themselves to the group's interests, even if that sacrifice was their own life. The most common cases of altruistic suicide occurred among military peoples.

3. **Anomic suicide:** Linked with societal regulation – or deregulation. This kind of suicide is related to too low of a degree of regulation. This type of suicide is committed during times of enormous stress or change. Without regulation, a person cannot set reachable goals and in turn people get tremendously frustrated. Life is too much for them to handle and it becomes meaningless to them. An example of this is when the market crashes or spikes.

4. **Fatalistic suicide:** People commit this suicide when their lives are kept under tight regulation. They often live their lives under tremendous rules and high expectations. These types of people are left feeling like they’ve lost their sense of self. The converse of anomic thought to be prevalent in instances of excessive regulation where persons have lost all direction in
life and feel that they have no control over their own destiny. This leads to instability and alienation and suicide.

**Approaches related to suicidal behaviour:** - Models predictive of suicidal intention have not been able to identify characteristics of individuals who eventually died from suicide, even though there are several studies that have identified the risk factors and provide background information on individuals who have an intention to do so (Cassells, Paterson, Dowding and Morrison, 2005; Goldstein, Black and Nasrallah, 1991; Powell, Geddes, Deeks, Goldacre and Hawton, 2000). Some theories can be use to explain what lies behind the suicide intent:-

1. **Biological approaches related to suicide**
2. **Psychological and psychiatric approaches related to suicide**
3. **Sociological approaches related to suicide**
4. **Ethological approaches related to suicide**

1. **Biological approaches related to suicide:**- Certain physiological, biochemical or genetic factors exert an important influence on the etiology of suicide and sometimes they exert their influence in combination with environmental factors. A number of studies related to adoption, twin studies, and family concordance rates for suicidality and psychopathology all support the notion of familial transmission of suicidal behavior (Fusé 1997). Here some biological aspect are discussed below:-

**Studies Related To Genes:** - A huge number of researches has focused on the serotonergic system. Joiner et al. (2005) found that
decreased levels of a 5-hydroxy-indoleacetic acid (5-HIAA) have been described through cerebrospinal fluid of suicidal persons. Some studies have reported low 5-HIAA to be associated to severity of a suicide attempt and future attempts. Additionally, low 5-HIAA has been linked to lifetime level of aggression and has been related to impulsivity, suggested that the effects on suicidal behavior may operate during impulsivity. According to postmortem analyses of the brain individuals who attempt or completed suicide have not discovered consistent results regarding serotonin transporter binding (McGuffin et al. 2001), although Pandey et al. (2002) suggested that reduction in binding is most pronounced in the ventral prefrontal cortex, including the study of teenager, relatively than adult, suicide victims. Because harm to the ventral prefrontal cortex may lead to impulsive response, reactivity to environmental stressors, and problem-solving deficiencies, its potential to affect suicidal behaviors is quite plausible.

In recent years, the serotonin transporter gene has established much consideration now days. The serotonin transporter (5-HTT) gets control over the accessibility of serotonin in the synaptic cleft. In humans, 5-HTT is determined by one gene (SLC6A4), situated on chromosome 17q12. The transcriptional control region of gene denoted as 5-HTTLPR, has been identified as having a polymorphism consisting of a 44 base pair deletion or insertion. These 2 alleles have been called the long (l) and short (s) (Lesch et al. 1996). These 2 alleles shared in individuals to form three dissimilar genotypes—the homozygous short (s/s), homozygous long (l/l), and heterozygous (s/l). Researches to date examining the relation between these various
genotypes and suicidality have usually shown mixed results. A study that followed 103 suicide attempters over the course of a year found that having the s allele increased the suicide risk, and that the frequency of the zaqs/s genotype rose as the number of suicide attempts started. In addition, Courtet et al. (2004) reported that subjects carrying the s/s genotype had significant high scores on a measure of impulsivity. Joiner et al. (2002) reported that those with a significant family history of suicidal attempt were more likely to have the s/s genotype than were those without a family history. Postmortem study by Mann et al. (2000) revealed that short alleles were more common among suicide victims than others, but this dissimilarity did not reach statistically significant. However, a recent meta-analysis (Brown and Joiner, 2005) has indicated that suicide completers are less likely to carry the s allele than are controls. Suicide attempters revealed non-significant genotype differences from controls. In particular, the serotonin transporter gene’s potential related to impulsivity warrants further more researches, as impulsivity appears to be involved in risk for suicide.

Perhaps the most commonly research related to gene with association to suicidality is the tryptophan hydroxylase (TPH) gene. TPH is the rate-limiting enzyme in the synthesis of serotonin, creation it an obvious applicant for speculation regarding suicide. This gene is located on chromosome 11q7, and two polymorphisms in exacting have been studied: A218C and A779C. According to meta-analysis, Rujescu et al. (2003) determined about the relationship between the A218C polymorphism and suicidal behavior and found that occurrence of the 218A allele was significantly correlated to
increased risk for suicide. Other studies (Bennett et al. 2000, Pooley et al. 2003) have examined the mixed results about A779C polymorphism and its relationship to suicide. Nielsen et al. (1998) evaluated suicidality in male violent and classified offenses as impulsive or non-impulsive. Interestingly, suicidal impulsive offenders were more probable to carry the 779C allele, but suicidal non-impulsive offenders were less likely to carry the 779C allele. Kunugi et al. (1999) studied that the A218C polymorphism and the A779C polymorphism have been shown to be linked, such that almost all the individuals have the same genotype for both polymorphisms. This suggests that the outcome regarding the A218C polymorphism likely hold true for the A779C polymorphism as well, and vice versa. Research is needed to identify the possible mechanisms of gene’s influence on suicidality as well as its probable moderating effect of impulsivity.

A third serotonergic gene that has been studied in relation to suicide is the 5-HT2A receptor gene. A polymorphism has been recognized on chromosome 13q14.1–14.2 and has been labeled T102C (Joiner Jr. et al., 2005). This gene suggested about the abnormalities in the 5-HT2A receptors in suicidality. However, the polymorphism has shown non-functional relationship with the receptor, Du et al. (1999) showing no relationship between genotype of the T102C polymorphism and 5-HT2A receptor density. According to these results, it is not astonishing that most studies to date have revealed no relationship between the T102C polymorphism and suicidality (Arango et al. 2003). However, these findings should not be taken to mean that the 5-HT2A receptor gene has no effect on
suicidality. It is more accurate to say that we have not yet recognized the polymorphism that regulated the effect of the 5-HT2A receptor gene on suicidal behavior.

Finally, one gene that has only recently been considered with regard to suicide is the catechol-O-methyltransferase (COMT) gene. The COMT enzyme is responsible for squalor of catecholamines (dopamine, epinephrine, and norepinephrine). A polymorphism on chromosome 22q11 codes for COMT activity and is composed of two alleles, the \(H\) allele and the \(L\) allele, which trigger high or low activity, respectively. As with most other research on candidate genes, results have been mixed. Russ et al. (2000) found no significant difference in COMT genotype between patients at high risk for suicide and controls. However, other researchers have suggested that the COMT gene is linked only with violent suicide. Rujescu et al. (2003) found that the \(L\) allele was more frequent in violent suicide attempters vs. nonviolent attempters and non-attempters. The nonviolent suicide attempters and non-attempters showed no difference in COMT genotype. Similarly, Nolan et al. (2000) stratified the results through gender and revealed that the \(L\) allele was more frequent in males with a history of suicide attempts than females. Moreover, males who carried the \(L\) allele were more likely to have made aggressive suicide attempts and more attempts overall, but this association did not hold for females. Clearly, additional researches must be conducted to re-evaluate these results, which suggest an interesting gender difference in suicide with regard to the COMT gene. The findings also suggested that the COMT gene is linked to violent behaviors.
Adoption Studies:- Researches to resolute the genetic contribution to suicidal behavior were conducted through adoption studies. The biological relatives of adoptees who had committed suicide were six times more likely to commit suicide than were the relatives of controls in Denmark (Schulsinger et al., 1979). Wender et al. (1986), in a mood disorder adoption study also conducted in Denmark, revealed that the highest suicide rates were in the biological relatives of adoptees with personality disorders characterized by impulsivity and aggression. They raised the possibility that suicide is transmitted via impulsivity/aggression personality characteristic independent of mood disorder.

Twin Studies:- Many researchers determined the genetic contribution to suicidal behavior were conducted with twin studies. Six twins studies are reviewed and found a significant difference, monozygotic (MZ) concordance rate of 18.5% twin pairs were concordant for suicide as compared to only 0.7% (Roy 1982, Roy and Segal, 2001). With such studies having clearly showed that there is some genetic component to suicidality, current researches have sought to clarify the role of genetics in suicide by studying variables that may description for this relationship. Statham et al. (1998) studied 6000 twins in Australia and revealed that the concordance rate for suicide attempts was a large amount higher in monozygotic than in dizygotic twins. If one monozygotic twin made an attempt then other twin was 3.8 times more likely to also make an attempt. Heritability was predictable at 55% for a serious suicide attempt. Glowinski et al. (2001) studied 3416 female twins and revealed a concordance rate of 25% for suicide attempts among monozygotic twins and 12.8% in dizygotic twins.
After modifying for psychiatric co-morbidity and history of abuse, the odds ratio for an attempt was alike between monozygotic (5.6) and dizygotic (4.0) twins. Heritability estimated 38%, but the small sample size affects confidence in this research. Fu et al. (2002) studied 3372 twins in the Vietnam Twin Registry and found that monozygotic twins were more likely to be concordant for a suicidal attempt (ratio = 12.1) than were dizygotic twins (ratio = 7.4). After controlling the psychiatric, historical, and demographic variables, the heritability estimate was 17.4% for suicide attempts.

**Family Studies**: Further evidence of the role of genetics in suicide is shown through family studies. Egeland and Sussex (1985) studied the Old Order Amish over a 100-year period and found that 26 people completed suicide, the majority of whom came from 4 families. Interestingly, while these four families also had a high genetic contribution for affective disorders, other families had a similarly high loading for affective disorders but no suicides, again reliable with the argument that an independent genetic component to suicide exists. In examining familial risk factors for individuals who completed suicide, a family history of suicide contributed about a twofold increase in suicide risk, even controlling for family psychiatric history, which is also a significant predictor (Qin et al. 2003, Runeson and Asberg 2003). Interestingly, Runeson and Asberg (2003) found no gender differences in the relation of family history to personal risk for suicide, while Qin et al. (2003) revealed that a family history of suicide increases risk for suicide in female more than male. Clearly, further research on the interaction between gender and family history of suicide is essential.
Studies on the parent-child transmission of suicide risk have also been utilized to identify risk factors for suicide attempts. One study found a six fold increase in risk for suicide attempt in children of suicide attempters versus non attempters. Additionally, 82% of the offspring who attempted suicide also had a mood disorder. A history of sexual abuse and increased impulsive aggression in the parent and child also increased suicide risk in the children of suicide attempters according to Brent et al. (2003). Brent et al. (2003) conduct another study, which divided the parents into three groups i.e. those who had attempted suicide and had a sibling who had attempted suicide, those who had attempted suicide but none of whom siblings had attempted suicide, and those who had not attempted suicide and whose siblings had not attempted suicide. As predictable, offspring with the highest genetic loading had the highest risk for suicide attempt, those with a moderate genetic loading had a moderate suicide attempt risk, and offspring with a low genetic loading had the lowest suicide attempt risk; greater genetic loading was associated with earlier age of first suicide attempt in offspring. Similarly Brent et al. (2003) to their prior study, impulsive aggression predicted both familial transmission of suicide attempt and earlier age at first attempt, though in contrast to the earlier study, history of physical or sexual abuse did not. These two researches of parent-child transmission of suicidal behavior illustrate the vital role of impulsive aggression as a mediator, but contribute mixed results regarding the role of childhood abuse in risk for suicidal behavior.

2. **Psychological and psychiatric approaches related to suicide:** focus on the states of mind, psyche, feeling, attitude and beliefs
concerning the world of individuals who commit or attempt suicide. Often these theories give little eminence to the broader social relations or the socio-cultural milieu of suicidal behaviour.

**The Psychodynamics of Suicide:** - Freud is regarded as the father of psychoanalytic explanations of suicide, although he never wrote a paper specifically about suicide. He explores psychodynamics of depression in 1917 research paper on, ‘Sadness and Melancholia’. In particular, he was anxious with comparing severe depression with the normal experience of mourning following a loss (Adams, 1991). Freud (1917) stated, “The analysis of melancholia shows that the ego can kill itself only if, owing to the return of the object-cathexis, it can treat itself as an object—if it is able to direct against itself the antagonism which related to an object and represented the ego’s original reaction to objects in the external world”. He articulated that mostly individual scope with the suffering of sadness and other experienced unbearable and enormous anxiety with the loss of their loved one. In the state of anger, person transforms it into self-centered and wishes to hurt oneself. Such findings achieve the optimal level, and then they have an urge to destroy the self or lead to suicidal ideation.

Freud purposed two forces which are constant dynamic balance “eros” and “Thanatos”. Eros is constructive in nature, leads toward existing and thanatos, destructive in nature or death instinct it leads towards the non-existing. There is continuous interaction among such forces throughout the existence of a person. Freud believed that the frightening experience or thought are suppressed at
the unconscious level through libidinal energy. Due to the effect of the energy used by an individual, the human being system can experience disequilibrium, with less accessible to energy for development and growth. In this condition the individual threatens the force of the living overcome by the force of death. Freud says suicide is a result of the intra psychic struggle. Zilboorg in 1937 critically viewed that the thanatos character clarified suicide. Zilboorg disagrees with Freud’s views that reprisal, anxiety, ill feeling and imaginations of runoff are repeatedly psychological triggers for suicide. He furthermore recommended that the majority of suicides are impetuous performances. He extended work on the center of attention on the inner mechanism to contain external aspects. Suicides are concerned with three psychological mechanisms i.e “the wish to kill, the wish to be killed, and the wish to die” (Menninger, 1938). The essential aspects of suicide behavior concerned additionally with aggression, rejection thoughts, defenselessness and depression are significant, and the emotional state of blame, anger, nervousness and addiction. (Litman, 1967).

Fenichel (1945) viewed suicide in depressed participants as an outcome of the relations between the ego and a sadistic superego. Particularly, the ego submits to the protecting aspects of the superego for forgiveness and reconciliation, or the ego expresses coercive and rebellious rage against the superego with a wish to destroy it. Played out in a relational milieu, the deflection of aggression toward self-serves to restore a threatened relationship via repentant self-punishment and represents an act of disciplinary abandonment against objects that have been lost or have threatened to leave (Rado 1951;

Alternative psychodynamic formulations give emphasis to the affinitive and libidinal vicissitudes of object loss related to depression and suicide as opposed to, the expression of aggression, which may be viewed as secondary. From this perspective, suicide may represent a fantasized narcissistic re-fusion with a lost love object (Fenichel 1945; Hendin 1991), serving to undo the separation or loss. According to Asch’s (1980), “much of the meaning of the usual suicidal act can be understood once we know that there is frequently a double aim of first cleansing the self, and then reuniting with an invincible love object”. Researches associated to clinical observation that individuals who experience painful separations, early losses, and unbalanced familial relationships constitute a high-risk group for suicidal behavior (Cross and Hirschfield 1986; Wasserman 1988). Theories concerned with ego implementation explained the use of particular constellations of defense mechanisms by suicidal individuals. It included aggression turned alongside the self, primitive denial, primitive idealization, splitting, regression, introjection, identification with the aggressor, and repression (Apter et al. 1989; Freud 1917; Kernberg 1975; Scholz 1973). Marcus (1988) impaired reality testing may occur in the circumstance/framework of regression associated with dysphoria and anger, often in situations of apparent abandonment or loss of self-esteem.
Object relations theory focuses on suicide as an attempt, in fantasy, to destroy bad internal objects—interjects or unwanted aspects of the self (Kernberg 1975; Klein 1934). Winnicott (1958) depicted suicide as relating a fantasy of destroying bad aspects of the self with the residue of the self-surviving, or as a destruction of the entire self when the true self is threatened with exploitation or total destruction. In a related vein, object relations theorists reported that suicidal individuals often evidence poorly integrated hostile interjects and few positive soothing interjects (Maltsberger and Buie 1980). They may project and enact interpersonally these pathological internal object relations (Asch 1980). Chance et al. (1996) suggested that higher levels of suicidal intent were related with less differentiated self and object representations and a lower level of emotional investment in relationships.

**The interpersonal-psychological theory**

In interpersonal-psychological theory of suicidal behavior, Joiner (2005) proposed that an individual will not die by suicide except he wants to die by suicide and the ability to do so. The essential constituents of suicidal ideation are distinct from suicidal behavior, the perceptions that one is estranged from others and which one is at the same time a burden on others. According to the theory, there is two perceptions are characterize the suicidal mind i.e. “I am fully estranged” and “My death will be important more than my life to others” Joiner (2005) and Van Orden et al. (2008).

Suicide theory asserts that when individual hold two precise psychological states in their minds simultaneously, and when they do
so for long enough, they develop the desire for death. The psychological states are ‘perceived burdensomeness’ and ‘a sense of low belongingness or social alienation’. Social isolation is one amongst strongest and most reliable predictors of suicidal ideation, attempts, and lethal suicidal behavior across the whole life. A low sense of belongingness is the experience that one is alienated from others, not an essential part of a family, friends and social group. Indeed, an influential case is created that, of all the risk factors of suicidal behavior, ranging from the molecular to the cultural levels, the strongest and consistent support has emerged for indices associated to social isolation (Boardman, Grimbaldeston, Handley, Jones, and Willmott, 1999). The association between belonging and suicidality has been established for a variety of various populations, as well as young adolescents, university students, aged people, and psychiatric inpatients. Suicidal ideation peaked in the summer semester among college students, and, low belonging in the summer accounted, in part, for the association between semester and suicidality (Van Orden, Witt, Bender, and Joiner , 2008). According to the theory, when this need is unmet than a state we refer to as thwarted belongingness developed a desire for death.
Figure 1. Assumptions of the interpersonal theory of suicide.

As with thwarted belongingness, perceived burdensomeness is supposed to be a dynamic cognitive affect state, as well as a dimensional phenomenon. Therefore, the levels of perceived burdensomeness are probable to vary over time, over relationships, and along a continuum of severity. Similar to perceiving that one is a burden, the desire to make others better off was found to be a more common reason for suicide attempts against episodes of self-harm without suicidal intent, and the faith that someone wishes one dead was shown to differentiate between suicidal and non-suicidal individuals (Brown, Comtois, and Linehan, 2002; Rosenbaum and Richman, 1970). Perceptions of expendability have been shown to characterize suicidal adolescents (Woznica and Shapiro, 1990). Suicidal preschoolers have been shown to be more likely to be unnecessary by their parents (Rosenthal and Rosenthal, 1984). These studies indicate that perceptions of burdensomeness may be
particularly harmful on multiple factors, rather than on a single individual. It may also be that severe perceptions of burdensomeness within a single relationship are most strongly related to suicidal ideation. Further, according to the theory, second psychological state is perceived burdensomeness which comprises two dimensions of interpersonal functioning i.e. beliefs that the self is so flawed as to be a responsibility on others and affectively burdened cognitions of self-disgust. An individual experiencing the psychological state of perceived burdensomeness would possibly categorical the liability component of the construct by stating, “I make things worse for the people in my life,” whereas someone expressing self-hatred would possibly directly state, “I hate myself” or “I am useless”. Perceived burdensomeness is that one’s existence burdens family, friends, and society. This view produced the concept that “my death will be more valuable than my life to family, friends, society, etc.” It is important to emphasize, that represents a doubt less fatal misperception. Family conflict, unemployment, and physical ill health were three of the risk factors for suicide with the healthy support for their association with suicide. These three factors are every type of negative life events. Recall that one kind of family conflict that has been shown to be related with lethal suicidal behavior is the perception that one could be a burden on family relations. Perceptions of burdensomeness on family are the key factor in Sabbath’s (1969) family systems theory of adolescent suicidal behavior. The theory emphasized the perceptions adolescents that they are expendable family members. The causative factors resulting in adolescent suicidal behavior are infective parental attitudes toward the adolescent that are taken by the adolescent that he
or she is not required within the family and, in fact, that the family would be at an advantage if the adolescent were dead. In a direct test of Sabbath’s theory, Woznica and Shapiro, (1990) found that perceptions of expendability in the family were completely interrelated with suicidal behavior in adolescents. Children who commit suicide were significantly more likely to be the product of unwanted pregnancies in a sample of preschoolers (Rosenthal and Rosenthal (1984). However, Sabbath’s theory does not account for the reality that the majority of youth who perceive that their families would be better off without them do not die by suicide.

Self-perceptions that one is a plummet on others also differentiate between people with histories of suicide attempts and people with no attempts (Brown, Dahlen, Mills, Rick, and Biblarz, 1999; Van Orden, Lynam, Hollar, and Joiner, 2006) and are also related with suicidal ideation (Brown et al., 2009; de Catanzaro, 1995; Van Orden, Lynam, Hollar, and Joiner, 2006). Filiberti et al. (2001) conducted a psychological autopsy study of terminal cancer patients who died by suicide found that self-perceptions of being a plummet on others was a key characteristic likely contributing to desire or need for suicide. In a comparison of suicide notes of individuals who made lethal versus nonlethal attempts, the presence of perceptions of burdensomeness on others differentiated between those who attempted and survived and those who attempted and died—with perceptions of burdensomeness characterizing the notes of those who died (Joiner and Pettit et al., 2002). In addition, in the same study, larger perceptions of burdensomeness in the notes predicted the use of more lethal means among the sample of notes from individuals who
died. Motto and Bostrom (1990) found that statements regarding feeling like a burden on others significantly elevated risk for suicide throughout a prospective study with a sixty day follow-up period after an evaluation of psychiatric patients at high risk for suicide. In answer to the second question concerning capability for suicide, self-preservation is a powerful enough instinct that few can overcome it by force of will. Who can have developed a fearlessness of injury, pain, and death, according to the theory, they obtain through a process of repeatedly experiencing painful and otherwise challenging events. These experiences often include previous self-injury, but can also include other experiences, such as repetitive accidental injuries; numerous physical fights; and occupations like physician and frontline soldier in which exposure to injury and pain, either directly or vicariously was common.

The interpersonal theory as posits a key role for perceptions of burdensomeness in the etiology of suicide (Sabbath, 1969). On the other hand, the interpersonal theory differs in a way that the construct is broader and in that perceptions of burdensomeness on close people, including but not limited to family members are associated with desire for suicide. DeCatanzaro (1995) revealed that perceived burdensomeness toward family was correlated with suicidal ideation among community individuals and high-suicide-risk groups. Van Orden, Lynam, Hollar, and Joiner (2006) showed that a measure of perceived burdensomeness was a vigorous predictor of suicide attempt status and of current suicidal ideation, still controlling for powerful suicide-related variables like hopelessness among psychotherapy outpatients.
As was done for thwarted belongingness, evident indicators of the dimensions of perceived burdensomeness are depicted in distress caused by unemployment, distress from incarceration, homelessness, serious physical illnesses, and direct statements in suicide verbal communications that individuals perceive that they are expendable, unwanted, or burden on others. It should be noted that in the vast majority of cases (if not all), these perceptions of liability are misperceptions agreeable to therapeutic modification. The other dimension of perceived burdensomeness is the affectively burdened construct of self-hate, with three equivalent observable indicators with empirically demonstrated associations with lethal suicidal behavior i.e. low self-esteem, self-blame and shame, and mental state of agitation.

Thus for each component of the theory has been described in isolation, provided that evidence for the independent effects of failed belongingness, perceived burdensomeness, and acquired capability on levels of suicidality. Particularly, the theory suggests that the combined incidence of perceived burdensomeness and failed belongingness is sufficient to produce the desire or need to die, suicide attempt and that this desire translates into lethal or near-lethal behavior only in the presence of the acquired capacity for lethality.

**Psychological theory of suicide**

Giddens (1971) ‘A typology of suicide', develops a theory of suicide desegregation the sociological perspectives of Emile Durkheim with the psychological views of Sigmund Freud. Giddens notes that Durkheim’s principal concern was to make clear the broad
structural or 'macro-social' conditions foundation variations in the distribution of suicide in populations. However, Giddens described the Durkheim's attempts to associate these circumstances to psychological ideas as 'fragmentary and in adequate'. Giddens interpreted the Durkheim's concept of anomic suicide as relating to situations where social norms come to exercise only a low level of authoritarian management over behavior'. Social norms govern the objectives and motivations of individuals by setting goals and process what is acceptable or valid, similarly as limit in or curtailing aspirations. Giddens defined the condition of anomie as when social norms for some reason given clear definition of aspiration, or wherever norms produce inequality between aspirations and the possibility of their implementation'. He notes that this includes most situations or circumstances in which it is possible for an individual to experience socially defined 'failure'.

Giddens notes that Freud (1964) makes an important and illuminating comparison between depressive states in his psychoanalytic theory and also the grief process related to the death of a loved person. Grief and depression are both considered to stem from feelings of loss or abandonment stimulated by another person, which then become redirected against the self. Repressed hostility or aggression is also likely to be obvious. Similar reactions can also be generated by circumstances or situations involving being slighted, neglected, frustrated or dissatisfied. Giddens suggested that one factor necessary in determining why only a particular proportion of individuals with depressive states build direct attempts at self-destruction or suicide is the conscious and unconscious meaning that
the individual ascribes to death. He considered suicide may be more likely to accompany depression when the individual regards death as having an purposeful or instrumental consequence as when death is perceived as something that can be used to achieve solutions to problems, or a specified outcome.

Giddens (1971) additionally develops Freud's concepts on the significance of guilt and shame, the latter being outlined as 'anxiety generated when the goals and self-conception personified in the ego-ideal deviate from the particular performance of the ego'. While individuals normally identified with figures that set realistic and fairly well-defined levels of attainment and which conform to their purpose circumstances, certain individuals may force demands on themselves, or have demands forced on them, which place great pressure on their ability to reach a protected and satisfied identity. Giddens suggested that in modern societies males are more likely to carry out anomic suicide; on the other hand females are more likely to engage in egoistic suicide. He also observed that it is the chore of the sociologist to study the nature and characteristics of the social institutions and processes that support anomie or egoism. Similarly, it is the task of the psychologist to study the particular motives and circumstances which force specific individuals to commit suicide when exposed to a situation of ‘anomie’.

3. Sociological Approach to suicide: - The first major contribution to the study related to suicide was made at the end of the last century by French sociologist Emile Durkheim. Durkheim’s Social integration/social regulation theory (1897) grew directly out of the
work of the 'moral statisticians'. Durkheim wanted to explain variations in the statistical distribution of suicide rates i.e. why differences in suicide rates between countries remain relatively fixed or constant, and why, when suicide rates change within a country over time, they do so in a patterned way. However, the unique feature of Durkheim's approach was his rejection of the importance of non-social factors for determining variations in rates of suicide. Durkheim (1982) defined suicide as: "the term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself/herself, which he/she knows will produce this result". Societal conditions, the general moral and psychological climate of a society, could increase or decrease the propensity for individuals to react to problems and pain by committing suicide (Bille-Brahe, 2000).

In an attempt to explain the statistical pattern, he divided suicide into three social categories: egoistic, altruistic and anomic. Egoistic suicide is committed when a person has too few ties to the society and community. These people feel separated from others, cut off from the social supports that are important to keep them functioning adaptively as social beings. Family assimilation or the lack of it could be used to explain why the unmarried were more vulnerable to suicide than the married, and why couples with children were the best protected group of all. Rural communities had more social cooperation than urban areas and thus less suicides takes place there. Altruistic suicide is viewed as response to cultural expectation, such as the act of the widow in India throwing herself on her dead husband’s funeral pyre (Durkheim). Finally, anomic suicide may be
triggered by a sudden change in person’s relation to society. Anomie, sense of disorientation, could explain the greater incidence of suicide among the divorced as compared with the married, and the great vulnerability of those who had undergone drastic changes in their economic situation. As with all sociological theorizing, Durkheim’s hypotheses in a troubled accounting for the differences among individuals in a given society in their reaction to the same demands and conditions. Not all those who unexpectedly lose their money commit suicide. It appears that Durkheim was aware of the problem for he suggested that individual temperament would interact with any of the social pressures that he found causative.

Durkheim noted that individual behavior is profoundly influenced by the way the social and collective life of a society is organized, and that each society has its own set of rules, values and norms - 'social facts' or 'institutions' - that have a constraining effect on individual behaviour (Fuse 1997). Two forces that normally maintain social order and prevent social confusion, The first is social integration, which binds individuals to society through the social norms and values of the group and the second is social regulation, which restricts people's potentially unlimited natural desires and aspirations by defining specific goals and the means of attaining them. Durkheim claimed that imbalances in any of these two social forces were the main causes of suicide, and described two key outcomes:-

1. 'excessive individualism', where people become detached from close-knit contact with others, laying the basis for what he
described as 'egoistic suicide' (a symptom of inadequate social integration)

2. 'anomie', a situation where the codes of behaviour that previously controlled people's conduct no longer apply, laying the basis for what Durkheim described as 'anomic suicide' (a symptom of inadequate social regulation).

Durkheim's theory can be regarded as a unifying theory using two key theoretical constructs i.e. social integration and social regulation that it attempts to explain the observed relationships between suicide rates and a large number of different indicators such as divorce rates, wars, rapid social change, etc. As Durkheim predicted, a large amount of empirical research has found that indicators of social integration and regulation are correlated with low or high suicide rates. Durkheim's work has formed the foundation for numerous studies examining sociological influences on suicide, especially after 1951, when the first English translation of Le Suicide was published (Giddens 1971b; Taylor 1988).

4. **Ethological approaches related to suicide**

Ethnology is the biological study of behaviour in natural setting. It may initially appear paradoxical to seek ethological analogies with regard to suicidal behaviour. Suicidal behaviour also act as a stimulus which could be interpreted as an initiate releasing mechanism which elicits a response the fixed action pattern, in other people. Alternatively, it could be interpreted as the fixed action pattern where by the behaviour it is precipitated by external stressor, being the innate releasing mechanism for that suicidal behaviour.
In ethological terms, suicidal behaviour could be interpreted as displacement activity as an initiate releasing mechanism or as a fixed action pattern. With regard to displacement activity, a persuasive theory has been postulated by Johns and Daniels (1996) about the redirection of aggression towards oneself when either it is not socially appropriate to be angry at others, or there are other powerful barriers to the expression of aggression. Stengel (1964) wrote that the suicidal attempt function as an alarm system and appeal for help it does so almost with the regularity of an initiate release mechanism. Henderson (1974) referred the attempted suicide as care eliciting behaviour and it is a developmentally primitive signal of care. Experience clinicians are well aware of the “janus face” of mixed feeling of wish to live and die experienced by suicidal subject, and measure of suicidal intent and lethality confirm this. Often the focus of the distressed person is not so much about living and dying. But rather about wish to escape from an intolerable situation.

In the last 20 years, increasing data has emerged which has clearly demonstrated an association between external stressors, behaviour and neurobiological changes. Post 1992 provided a cogent description of the development of the depressive conditions after stressors has produced changes in bio chemical neuro-anatomical substrates this model implies that the experience of depression leaves behind a memory trace that predisposes to further episodes of depression consequently, subsequent stressor do not need to be so severe when depression may be spontaneous without external stressor. Craemer and Colleagues (1997) have investigated changes in Hypothalamic-pituitary-adrenal axis (HPA) activity and brain micro
structure in association with isolation and self-injurious behaviour in monkey as well as serotonin metabolism because of the consistent observation that serotonin activity as calculated by cerebrospinal fluid 5 hydroxyindoleacetic acid (CSF5-HIAA) was low in violent suicide attempters in man (Nordstorm et al., 1994). Clinicians can be reassured that as a result of research derived from ethological principles it is easier to understanding the nexus between early adverse life events and the neurobiology associate with developmental issue it provided a bridge between sociological and psychological theories on one hand and those theories based more on the biological signs on the other even it were for that reason alone, the value of ethological approach in the area of suicide and its prevention is assured.

**Comprehensive theory of suicidal behavior:** Comprehensive models of suicide have been accessible that can account for several risk factors simultaneously, as well as the occurrence of suicidal behavior. These models are structured to describe suicidal behavior, compared with theories that are structured to explain/predict suicidal behavior. Suicidal behavior results from the simultaneously presence of risk across five domains: biology, psychosocial life actions and chronic medical illness, personality qualities, family history and genetics, and psychiatric disorder (. Blumenthal and Kupfer, 1986). This model can be graphically depicted as a Venn diagram with five overlapping circles, with the greatest risk for suicide represented by the area of overlap from all five circles. Maris (1991) proposes a comprehensive model of suicidal behavior from a developmental perspective that emphasizes the study of multiple interacting factors
within life events of individuals who die by suicide, which denoted as suicidal careers.

The interaction of factors across several domains of risk (including time) allows these models to account for differential prevalence of suicide ideation, nonlethal attempts, and suicidal behavior, with the assumption that deaths by suicide occur at the intersection of numerous facets of risk, that nonlethal attempts occur with fewer facets of risk, and that ideation occurs with even fewer. However, although the models described above are comprehensive and thereby able to account for the prevention of suicidal behavior, they are not controlled with a degree of accuracy that would allow for the falsification of the model and the forecast of suicidal behavior. Therefore, what is needed to improve prediction of suicidal behavior is a theory that is both precise—allowing scientific false ability and clinical usefulness—and comprehensive—allowing the theory to account for both suicide attempts and suicidal ideation. Shneidman’s (1998) psychic theory involves the proposals that the simultaneous presence of three factors is necessary for lethal suicidal behavior to occur—psychic, perturbation and press—and that the presence of these factors will create the strongest, and most lethal, level of desire for suicide. It is this supposition about suicidal behavior that individuals who think about suicide versus those who attempt suicide differ in terms of how much they desired suicide that is challenged by the interpersonal theory of suicide. It is this level of empirical exactitude and contrasting hypotheses open to falsification that is needed to advance the scientific study of suicidal behavior.
Factors related to suicide

In some instances, and for different reasons, suicide as the cause for death might be hidden; in some areas it is completely unreported (Bertolote and Fleishman, 2002). In many countries around the world, particularly those that are less developed (Vijayakumar et.al., 2005), basic data on the prevalence and risk factors for suicide and its immediate precursors—suicidal ideation, plans and attempts—are unavailable. Therefore, real figures may be higher than reported (Nock et.al., 2008). Recent studies in several low-and middle-income countries such as China and India suggest the occurrence of suicidal behaviors may differ distinctly from high-income countries. 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. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives. They are found at various levels: individual (genetic factors, mental disorders, personality traits), family (dysfunction, cohesion), and community (mental health services). They may be fixed (those things that cannot be changed) family history of suicide or modifiable (those things that can be changed, such as depression). Some of these identified factors have been associated with increasing an individual’s vulnerability towards suicide behaviour and are consequently described as risk factors. Another group of factors that
are associated with decreasing the tendency towards self-harming behaviour are collectively identified as protective factors. Understanding the interactive relationship between protective and risk factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention are discussed below:-

**Bio-psychological Risk Factors**

**Depression:** - Mortality studies suggested that depression considerably increases the risk of death or suicide. The risk of suicidal behavior has always been connected with depressive disorders. More than half of depressed people have suicidal thoughts, and their suicidal ideation is significantly related to the severity of depression. The most common predictive depressive symptoms for suicidal ideation in depression are mood, hopelessness, feeling of guilt, laws of interest and low self-esteem (Van Gastel et al 1997).

**Mental illness and chronic physical illness:** - The majority of suicides in psychiatric patients have a primary diagnosis of schizophrenia, major effective disorder, alcohol dependence or misuse, personality disorder (Appleby et al., 1997). Increased risk is also indicated by features of clinical history such as previous self-harm and frequent relapse or admission current clinical characteristics that increase risk are low mood, suicidal ideas or self-harm, and hopelessness (Roy, 1982, Cheng, 1995, Dennehy et 1996, Beck et al., 1985). Fawcett et al., (1990) suggested some indicator may be diagnosis specifically insomnia in depressive illness. For instance, Moscicki, (1999) suggested that gender and the presence of mental disorders play less of a role in the incidence of suicidal behaviors in
low-and middle-income countries. A chronic physical illness is an enduring health problem that will not go away like diabetes, arthritis, asthma, or cancer. Chronic physical illnesses can be managed, but they cannot be cured. People who live with a chronic illness have a greater risk of developing depression, anxiety and suicide.

**Substance misuse:** - Substance misuse increases the risk of suicide attempt and death by suicide. Alcoholism has been recognized for 40 years as a major contributor to suicide. More recently, abuse of other substances has increased alarmingly in the world. The spread of drug abuse may be responsible in part for the two to four fold increases in youth suicide over the past three decades (Rich et al., 1986; Brent et al., 1987; Shaffer et al., 1996). The risk associated with opioid abuse disorders and mixed intravenous drug use is greater than that for alcohol abuse. The risk of suicide from alcohol misuse is greater among women than men. Substance abuse, especially for alcohol, is common characteristics of patient who carry out acts of non-fatal deliberate self-harm. Severe abuse was identified in 10% of males and seven percent of female in a series of 724 deliberate self-harm patients (Hawton et. al., 1997).

Less information is available on drug abuse in suicide attempter in series of deliberate self-harm patients. Hawton (1997) assessed that 12% of males and 6% of Females who are drug abuser have completed suicide, alcohol abuse in deliberate self-harm patients, very often occur in the incidence of diagnostic co-morbidity especially with affective disorder and personality disorder (Suominen
et al., 1996). So, two month of physical and emotional support for the substance abuser confronted with laws may protect.

**Epilepsy:** Epilepsy increased the risk of suicide and suicidal behavior. Suicide risk varies across different types of epilepsy and in relation to the degree of severity of the illness. Individuals who have temporal lobe epilepsy or who have had temporal lobectomies or surgical resections have greater risk of suicide. Many studies have been conducted on the risk of suicide in people with epilepsy. White et al., (1997) conducted a follow-up study, 2000 patients receiving anticonvulsant medication that were admitted to hospital between 1931 and 1971 and followed up until (1977) were compared to the background population. Sex and age standardization was performed and period at risk was taken into account. This study found a 5.4 fold increased risk of suicide in epilepsy. Barracough (1987) found that patients with temporal lobe epilepsy had a five-fold increased risk of suicide, and patients with treatment resistant epilepsy a 25 fold increased suicide risk.

**Hopelessness:** Many characteristics of adult depression, hopelessness have been identified as indicator of suicide risk (Beck, 1972; Melges and Bowlby, 1969). Hopelessness has been defined as negative expectancies toward oneself and toward the future (Stotland, 1969). The greater sense of hopelessness and greater number of suicidal ideations is a predisposition for such emotion in the face of illness or other life stressor. The relationship of depression, hopelessness, and suicidal intent has been the focus of several studies. In a study of Kuwaiti students it was seen that pessimism, death
obsession and anxiety were the strongest predictors of suicidal ideation (Abdel-Khalek and Lester 2002). Philips, Yang, Zang, Wang and Zhou (2002) in China, It was seen that rather than the level of hopelessness it was levels of depression that lead to the attempts of suicide. Hopelessness has been shown to correlate more highly with suicidal intent among adults than has depression (Minkoff, Bergman, Beck, and Beck, 1973). Extension of this work to children is important to see if there are continuities in the characteristics of depression and suicidal intent across the developmental spectrum. Indeed, depression and suicidal intent show little or no correlation when hopelessness is controlled (Beck et al., 1975; Kovacs et al., 1975; Wetzel, 1976; Wetzel, Margulies, Davis, and Karam, 1980).

**Impulsivity and Aggression:** -Impulsivity is one of the greatest threat issues of suicide behavior at all ages. Conner, Meldrum, Wieczorek, Duberstein and Welte (2004) analyzed that impulsivity was strongly connected with suicide and suicidal ideation still after accounting intended for alcohol dependence and violent behavior. Oquendo, Galfalvy, Russo, Ellis, Grunebaum, Burke and Mann (2004) revealed that impulsivity was significant predictors of suicide and suicide ideation with notable sadness. Forteza, Lira and Gutierrez, (2003) reported impulsivity as a significant hazardous issue for equally man and woman.

Impulsivity, in addition to ‘low level of serotonin transport ‘is connected with aggressive suicide behavior and aggression. Aggression Multiple epidemiologic and family studies have identified a strong relationship between aggression and suicide (Conner,
Swogger and Houston, 2009; Romanov, Hatakka, Keskinen, Laaksonen, Kaprio, Rose and Koskenvuo, 1994). Apter, Bleich, King, Korn, Fluch, Kotler and Cohen 1993) analyzed that suicidal and non-suicidal psychiatric patient on aggressive and non-aggressive participant and reported that merely two of the aggressive subjects had not been admitted for a suicidal attempt. Danger of suicide was reported to be significantly associated with the level of impulsivity and annoyance; therefore aggressive and impulsive person may well express aggression externally as well as inwardly.

Research suggested that a common neurobiology of suicide and other forms of aggressive behavior associated with suicide (Mann and Currier, 2009). Lower levels of central serotonin are associated with suicide attempts and specifically more lethal suicide attempts after controlling for psychiatric illness (Mann, and Malone, 1997; Ninan, Van Kammen, Scheinin, Linnoila, Bunney, and Goodwin, 1984). A study of the relationship between aggression and suicide completion, different approaches have been taken. One of them compared medically serious suicide attempters (MSSAs) to healthy controls. Trait aggression was significantly higher in the MSA group, (Doihara, Kawanishi, Yamada, Sato, Hasegawa, Furuno, et al. 2008). However, that study did not include a non-medically serious suicide attempters (NMSSAs) control group. In another study designated to look for differences among those with specific psychiatric pathologies, personality-disordered individuals, particularly those who are more aggressive, impulsive and who have a co-morbid depressive disorder were found to have a higher risk for more frequently and medically-severe suicidal behavior in comparison to
individuals with Major Depressive Disorder (MDD) or Bipolar Depression (BD) alone (Black, Bell, Hulbert and Nasrallah, 1988; McGlashan, 1987).

In a different perspective on the relation between suicide and aggression, several studies focused on choices of methods for the suicide attempt. They found that the use of violent methods of suicide is a behavioral indicator of a higher level of lifetime impulsive-aggressive behaviors (Dumais, Lesage, Lalovic, Séguin, Tousignant, Chawky, and Turecki, 2005) and is more often used by male than female, and in suicide completers affected by psychosis. Others even suggested that aggression may be indirectly associated to high suicidal attempts. Conner, Duberstein, Conwell, Seidlitz and Caine (2001) found that violence during the last year of life is more frequent among suicide victims than accident victims. On the other hand, Soloff and colleagues (2005) found that high lethality and low lethality suicide attempters with borderline personality disorder (BPD) were not different in their levels of aggression.

**Violence:** Suicide and violence are both multi-determined acts that are influenced by environmental factors, psychiatric diagnosis and biological predispositions. Some environmental factors have been shown to underlie both behaviours, including the early loss of one’s parents, violence in the home (Botsis et, al, 1995), a deviant family environment (Plutchick, 1995), unemployment (Platt, 1984), overcrowding (Cox et.al 1984), the accessibility of lethal means, and the availability of alcohol and other drugs (Fagan, 1993; Hendin, 1995). A vast number of studies have also offered convincing
evidence connecting psychiatric illness and violent behaviour (Swanson et al., 1990; Hodgins, 1992; Link et al. 1992; Hodgins et al., 1996; Eronen et al., 1996).

Violent and suicidal behavior may also be linked through an underlying pre disposition, Asberg and colleagues (1976), The first to report this link, found low cerebrospinal fluid (CSF) levels of the 5-HIAA) in depressed suicide attempter compared with depressed non-attempter and normal controls it was later shown that CSF 5-HIAA was lower in impulsive suicide attempter than in suicide attempter who had planned the act (Traskman et al.,1981). This negative correlation between serotonin levels and violent behaviour led investigating to discover that low CSF 5-HIAA level are also present in those who commit other impulsive acts, such as arson (Virkkunen et al, 1987).

**Stress:** - It is known that a wide variety of stressful events may serve as a trigger for suicide. For instance, interpersonal problems with family members or other members are a typical stressor experienced by those who made serious suicide attempts (Chen, Wu, Yousuf, and Yip, 2012; Bastia and Kar, 2009). Feng, Li, and Chen (2015) explored that the impact of stress on suicidal ideation by investigating the mediating effect of dispositional optimism and self-efficacy. Results showed that stress has a direct effect on suicidal behaviour and suicidal ideation. Furthermore, dispositional optimism and self-efficacy partially weakened the relationship between stress and suicidal ideation.
Empirical research suggests that early and chronic life event stresses, particularly within the family milieu, are related with pre-pubertal suicidal behaviour (Pfeffer et al. 1993). Events that lead to family instability, such as moves, loss of relatives, death, illness of significant caretakers, may increase the likelihood for suicidal behaviour among pre-pubertal children. Pfeffer and colleagues (1993) identified that life event stress in pre-school period increased the risk of future suicidal behaviour in children and adolescents. Perhaps early life event stress during critical periods of brain development affects risk for suicidal behaviour.

Results of empirical research suggest that certain factors are associated with suicidal behaviour throughout the life cycle. Specifically, studies of adult suicide victims (Egland and Sussex, 1985), adolescent suicide victims (Brent et. al, 1988) and pre-pubertal suicidal children (Pfeffer et al., 1994) point out that suicidal behaviour aggregates in families. They found that children who attempts suicide, in contrast to non –suicidal pre-pubertal children in a community had a higher prevalence of suicide and suicide attempts among their parents and siblings.

Weis and Speridakos (2011) determined that hope enhancement strategies were associated with increased hopefulness, improved life satisfaction, and decreased psychological distress among participants. In results analysis of 27 studies involving two thousand one hundred and fifty four participants found significant, but small, effect sizes for hopefulness and life satisfaction and found
no overall relationship between decreased psychological distress and hope enhancement strategies.

**Family history of suicide:** Family history of suicidal attempts enhanced the suicide risk and suicidal behaviour. Suicide or suicidal attempt in a family is a painful situation for all members. Children and adolescents are at greater chances of occurrence of psychiatric complications as bereft by suicide. Epidemiological studies have consistently demonstrated a significantly higher risk of suicidal behavior among family members of suicide victims and suicidal attempters (Gould et al., 1996; Kendler et al., 1996). A renowned case is the novelist Ernest Hemingway's family, in which five members over four generations died from completed suicides. Studies of twins have shown that monozygotic twin pairs have significantly greater concordance for both attempted and completed suicide than dizygotic twin pairs (Glowinski et al., 2001; Roy et al., 1991), while one adoption study showed that suicide is common among biological relatives of adopted suicides than among biological relatives of adopted controls (Wender et al., 1986). Qin et al., (2003) included that 21,168 suicides during a 17-year period in Denmark and demonstrated that suicide mortality in the first-degree relatives of suicide victims is about 3.5 times. They also revealed that individual with a family history of completed suicide, when compared with those without family history of suicide, are at a 2.1-fold increased suicide risk after controlling in individual socioeconomic status and psychiatric history. It suggested that suicidality in families may be genetically transmitted.
At the same time, suicide tends to occur in families with psychiatric history. A family history of suicide has been implicated as a significant risk factor for suicide, and the rate of suicide was twice as high in the families of suicide victims as in comparison families (Runeson and Åsberg, 2003). With respect to the Hemingway family, the family members, including the novelist himself, suffered psychological or substance abuse disorders. Previous studies have confirmed that psychiatric disorders are more common among kinsfolk of people who are suicidal, and people with a family history of psychiatric illness are an increased risk for attempted or completed suicide (Gould et al., 1996; Wagner, 1997). In the milieu of other risk factors, there is an approximately 1.3 relative risk for attempted suicide associated with a family history of psychiatric illness leading to hospitalization (Qin et al., 2003). Agerbo et al., (2002) found that an increased risk was associated with a parent's psychiatric history. Qin et. al. (2002) conducted another study that included 4,262 suicide victims and 80,238 population-based controls. They demonstrated that a completed suicide and a hospitalized psychiatric disorder in a parent or sibling act independently as risk factors for suicide. Their effects could not be explained by socioeconomic, demographic and psychiatric status differences in the population. Results showed that a family history of psychiatric illness significantly related with an individual's psychiatric status, increasing suicide risk only in people without a psychiatric hospitalization history, while a family history of completed suicide significantly increased suicide risk independently of a family history of psychiatric disorders or mental illness. These results suggested that suicide clusters in families are independent of
family of psychiatric disorders, and that a family history of psychiatric illness increases suicide risk through increasing the risk for mental disorder, while a family history of completed suicide significantly increases suicide risk. Sethi and Bhargava (2003) have conducted a study in India on a group of children and adolescents who have a history of suicidal death in family and found that they were at high risk of depression, stress disorder and social maladjustment. There was six times greater probabilities of having suicide intuition in the child of suicidal attempted person. Suicidal behavior of the chief person in the family also enhances the risk for future suicidal attempt in children. In India many studies conducted to show the impact of family history as a major role in suicide attempt.

**Personality traits:** There may be increased suicide risk related with particular personality factors. Some of identified traits as risk are: feeling of hopelessness, high score on phobic, low self-esteem, aggressive behavior, uniqueness seeking behavior, impulsiveness, fear of humiliation, feeling of being failure and also the trait of introversion has been associated with greatest risk of suicide particularly in youngsters. Nevertheless, it can be stated with reasonable confidence that suicide risk is higher in a wide range of personality traits including neuroticism, extroversion, irritability, anger, anxiety, hostility, attention deficit hyperactivity disorder (ADHD) and eating disorders such as low problem solving skills and anorexia nervosa and bulimia. Seo, Jung, Jeong, Kim, Lee, Kim, Yim, and Jun (2014) conduct a study to identify personality traits associated with suicidal behavior in 1183 patients with depression. It suggested that depressed patients with a history of suicidal behavior
differ from non-attempters with regard to personality traits, especially the character dimension of self-directedness. Limited studies are available relating to individual and personality traits contributing to suicide behavior in developing world.

**Sexuality and Suicide:** Sexual feeling and behavior and some of their consequences, such as pregnancy, are powerful human experiences which can be both the source of great joy and happiness as well as the cause of much distress and sadness. The links between sexuality and death, including death by suicide are common palace in human culture, be it in the arts or in psychological and philosophical thinking. There is evidence that childbirth has a protective effect against deliberate self-harm during the first year after delivery. Appleby and Turnbull (1995) studied consecutive female attempters aged 15-44 presenting at a general hospital over a 6-month period, under 4% of whom had a baby in the previous year. The rate of deliberate self-harm was less than half that of non-pregnant women: 1.25 against 2.57 per 1,000 and the authors speculate that as in the case of completed suicide, the presence of young children may increase the women’s feeling of self-worth, possibly based on her perception of being needed (Appleby and Turnbull, 1995; Appleby, 1996). It is interesting to find such reduction in the risk of deliberate self-harm at a time when the prevalence of psychiatric disorders is known to be increased (Brockington, 1998). Gabrielson et al. (1970) based on a cohort of teenage mothers aged up to 17 years, suggested an increase in the prevalence of deliberate self-harm after childbirth, but the large majority of episodes of self-harm had occurred over a
period of several years, rather than in the first post-partum year, and so comparison with more recent investigations is not possible.

**Age Factor: Older People:** Feeling of hopelessness are common in older people but serious suicidal thoughts much rarer. Although the very elderly might have a slightly increased frequency of suicidal feelings compared with the younger elderly (Jorm et al. 1995; Forsell et al. 1997), older people in general have a similar frequency of suicidal thoughts to the younger population (Paykel et al, 1974). Most, but not all, studies have shown suicidal feelings to be commoner in older women. In a community survey of the Swedish elderly, Forsell and colleagues (1997) confirmed that depressive symptoms were the main determinant of suicidal thinking even in those without depression. An older person’s wish to die may increase the risk of death: a UK study found that an expressed wish to die was a predictor of mortality equal in magnitude to depression (Dewey et al. 1993).

**Environmental Risk Factors**

**Unemployment and Poverty:** Unemployment is linked to elevated risk of suicide. Occupational social class and suicide are inversely linked that the lower the social class, the higher the risk of suicidal behaviour. Despite of this, the highest proportional mortality rates for suicide are found in farmers and medical doctors, with female doctors having a higher risk of suicide than male. Employment in the police force was not found to be a risk factor for suicidal behaviour. Poverty and deprivation are also linked to suicide risk at an ecological level.
Areas with greater levels of socio-economic status (lower) have higher suicide rates.

Individual cross-sectional studies reveal an increased rate of suicide and deliberate self-harm among the unemployed. Although the micro risk estimates are high particularly with respect to deliberate self-harm, suggesting a casual impact of unemployment, the evidence from several studies highlights a possible role for self-selection in accounting for the relationship between unemployment and deliberate self-harm. While aggregate cross-sectional studies do not present convincing evidence of an association between unemployment and suicide, rates of unemployment and deliberate self-harm across geographical areas within the same country do appear to be more closely associated. Platt and colleagues (1992) found significantly higher suicide risk among the unemployed compared to the employed in Italy (3.4 among men and 2.2 among women). Andrian (1996) reported significant, but lower risks in France (2.3 among men and 1.9 among women), however, the economically inactive were included with the employed. Hawton and Rose (1986) and Hawton and colleagues (1988) found a weak association between male and female unemployment rates in the general population and the proportion of economically active men or women, respectively, who were unemployed at the time of deliberate self-harm. Platt and Kreitmen (1984) found a significant and positive correlation between unemployment and deliberate self-harm.

**Job or financial loss:** Researches indicated that job and financial stresses increased suicides rate among middle-aged men and women.
It’s been three decades since the height of the farm crisis, when farmer suicide rates were at all the time high in India. Environmental stressors are a big contributing factor, with extreme drought, excessive snowfall and all around unpredictable weather affecting crops. When economics falter, farmer suicides increase, and experts worry that the farm crisis is far from over. While efforts are being made among many groups, individuals and organizations, rural-agricultural behavioral health remains an under-researched, underfunded field, with a lot of surrounding stigma. Farmer suicides account for 11.2% of all suicides in India (National Crime Reports Bureau, 2014). Activists and scholars have offered a number of conflicting reasons for farmer suicides, such as weather effect, high debt burdens, hereditarily modified crops, governmental policies, mental health, personal issues and family problems (Gruère and Sengupta, 2011; Schurman, 2013; Das, 2011). According to National crime Bureau record (2014) ‘Bankruptcy or Indebtedness’ and ‘Family problems’ are major causes of farmer suicides, accounting for 20.6% and 20.1% respectively of total farmer suicides during 2014. The prominent causes of farmer suicides were ‘Farming Related Issues’ (17.2%), ‘Failure of Crop’ (16.8%) and ‘Illness’ (13.2%). During 2014, major cause of suicides in male farmers were ‘Bankruptcy or Indebtedness’ and ‘Family Problems’, accounting for 21.5% and 20.0% respectively of total farmer suicides(male). ‘Farming Related Issues’ followed by ‘Family Problems’, ‘Marriage Related Issues’ and ‘Bankruptcy or Indebtedness’ were major causes of suicides by female farmers, accounting for 21.4% (101 out of 472 suicides), 20.6% (97 suicides), 12.3% (58 suicides) and 10.8% (51 suicides).
Farmers belonging to 30 years - below 60 years of age group have accounted for 65.7% of total farmer suicides during 2014. A total of 59 farmers (below 18 years of age) have also committed suicides during 2014.

**Easy access to lethal means:-** The National Action Alliance for Suicide Prevention recognized the Research Prioritization Task Force (2010) to identify interventions capable of reducing the suicide rate by 20% over a 5-year period. A suicidal person’s access to highly lethal means of suicide can be reduced through physically impeding access (using gun locks and bridge barriers); reducing the lethality or toxicity of a given method (reducing carbon monoxide [CO] content of motor vehicle exhaust); or reducing “cognitive access,” (Florentine and Crane, 2010) that is, reducing a particular method’s appeal or cognitive salience (dispiriting media coverage of an emerging suicide method). They focus largely on the first two methods. Reducing access to lethal means saves lives when individual who cannot readily obtain a highly lethal method either attempt with a method less likely to prove fatal or do not attempt at all. Most of the suicidal crises are short-lived. A survey of people who had seriously pained taking suicide in the past year found that about 30%, the suicidal period lasted under an hour. (Drum, Brownson, Denmark, Smith, 2009) Surveys of attempters have found that the interval between deciding on suicide and actually attempting was ten minutes or less for 24%–74% of attempters (Williams, Davidson and Montgomery, 1980; Simon, Swann, Powell, Potter, Kresnow and O’Carroll, 2001; Deisenhammer, Ing, Strauss, Kemmler, Hinterhuber and Weiss, 2009).
Relational or social loss: - The death of a close family member is one of the greatest of life stresses (Holmes and Rahe, 1967). Considering that the process of normal adjustment to the loss of a close relationship can be as long as 4 years (Zisook and Shuchter, 1986) and even longer term squeal may be observed in clinical practice the collective morbidity resulting from completed suicide is clearly deserving of attention. Also standardized and task specific bereavement outcome instruments have been used to measure the intensity of grief reaction, psychological and physical health and social adjustment. Farberow and colleagues (1987) was significant in tracking changes over 30 month in large group of persons bereaved through suicide and natural death and comparing them to non-bereaved controls. Cleiren (1993) was also important in elucidating the effects of various demographic and psychosocial variables along with mode of death on the outcome of bereavement. Subsequent research continued to increase understanding of the psychosocial factors influencing the outcome of suicide bereavement (Cleiren et al 1996 Seguion et al 1995). They found that better predictors of bereavement outcome than mode of death include age of deceases, kinship lost, age gender and culture of the bereaved, their attitude to the laws and the quality of their relationship with deceased.

Social-cultural Risk Factors

The family is considered to have an important role to play in the development and maintenance of bonding forms of capital that support positive developmental trajectories. The family is also thought to play a role in bridging and linking forms of capital that
expand the child and their family into the wider social circumstance. When undertaking this review it also required ensuring that the role and impact of social environments particularly relevant to children and young people are explored (for example, the school environment).

More than two thirds of suicides happen in initial attempt. In a developing countries incidence of suicide are likely to be higher. The combination of facts behind this is due to lack of medical conveniences and people in these countries usually tend to use extremely fatal way to attempt suicide. In developed countries several suicidal attempts would possibly not have resulted in complete suicides because of easy availability of medical facility. Richard (2002) Observed and found that only 65 percent beds are available in mental hospitals in the developing world, while 41 percent of the developing countries lacking of treatment facilities for serious mental disorders in community health care and 37 percent have no primary health care services. Furthermore in India there are merely about 3500 psychiatrists are available to treat a billion of people. The majority of psychiatrists are available in the cities. The limited availability of these medical facilities may leads to more suicide attempts. De Silva, Kasturiaratchi and Abeysinghe (2002) conducted a study in Sri Lanka; they revealed that the entire island is served by only 55 psychiatrists and majority of them are available in cities. The rate of fatality in Sri Lanka is very high as rates for pesticides such as parquet and organophosphates are greater than 60%. Management of acute self-poisoning at present time is very weak; it is assumed that a
good management protocol would have significantly reduced mortality rate.

Across all age groups, genders and in a broad range of geographical locations, several diagnoses of mental illness, affective disorders, schizophrenia, personality disorders and childhood disorders, and a history of psychiatric treatment have been established as risk factors for completed suicide. In schizophrenia and borderline personality disorder suicide risk appears to be well-known around the time of first diagnosis. For bipolar disorder and schizophrenia, the important risk of suicide is exacerbated by other risk factors, such as a history of suicide attempts, other psychiatric diagnoses, drug or alcohol abuse, anxiety, bereavement, severity of symptoms and hopelessness.

The family is a predominant source of influence on the adolescent’s suicidal behaviour (Wagner, 1997). Lewinsohn and colleagues (1994) followed a group of 1500 high school students for 1 year and established that those adolescents who reported having attempted suicide also showed a significantly lower level of family support. The difficulty in planning preventive service based on risk factor is their low specificity. Although previous self-harm is strongly associated with suicide the majority of patients who harm themselves do not commit suicide. This mean that targeting suicide prevention measures on patients with the history of self-harm could be seen as wasteful of resources one of the priority of research is therefore to improve prediction of suicide and the one way of achieving this is by understanding how risk factor interacts service
may also accept the need to intensify their treatment of many know suicide in order to prevent a comparatively small number of suicide however as most likely suicide prevention measures e.g. closer supervision, are aspect of good general care, there would be many benefits to the most needy psychiatric patient as a whole.

Loss of an employment and main economic setback, which frequently lead to debit traps, has been recognized as a key cause for suicide. Especially in emergent nations where there is absent or incomplete welfare and social safety for persons to go down reverse on. Stone (2002) observed that families attempting suicide *en masse* due to economic difficulties is not a curious happening, particularly in India. Silva and Pushpakumara (1989), Gunawardena (2002), Phillips, Yang, Wang, Zhou and Zhang (2002) has revealed that poverty, bankruptcy and joblessness are major risk factor for suicide. Furthermore WHO recognized poverty as a most important factor in suicide, followed by strain, mental disease and substance abuse Alperstein and Raman (2003) studied higher suicide rates particularly among the adolescence have been linked with elevated rates of joblessness. Phillips, Liu and Zhang (1999) conducted a study in China where gambling was found a main social trouble for centuries it is not unusual for individuals to attempt suicide due to failure to pay gambling debts. Though there are no accurate statistics about this, an anecdotal record shows that gambling has been rising asian opportunity to the economy, particularly in rural China. Lari and Alaghehbandan (2003) conducted a study in Iran and concluded that seventy percent of the suicides were attempted by those people who having low socio-economic status.
**Psychological Protective Factors**

**Psychological capital:** - Psychological capital represents an individual’s psychological positive state in the process of growth and development. At the end of last century, the 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, the level of family cohesion, the perceived level of family support and the level of stress and conflict within the family that have positive impact on suicide. The establishment of a non-threatening and non-violent emotional climate and level of control or coercion are also critical components of the family psychological capital. Many of these factors have been shown empirically to be associated with child well-being and protect them from suicide.

**Confidence/ Self-efficacy:** - 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). They include cognitive,
motivational, affective and selection processes. A strong sense of efficacy increases human achievement and personal well-being in many ways. Based on the studies, people with high self-efficacy experience greater improvements in their quality of life. 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).

**Optimism:** Optimism is the dimension of psychological capital (Luthan, Luthans, and Luthans, 2004); optimists tend to take credit for positive occurrences in their lives while providing external, temporary, situation specific explanations to negative occurrences. PsyCap 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 suicide 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). A number of researches have demonstrated a positive
relationship between optimism and well-being. Optimism also function as a protective factor in the presence of adversity and decrease suicidal ideation (Blankstein, Lumley, and Crawford, 2007; Hirsch, Wolford, LaLonde, Brunk, and Morris, 2007; Hirsch and Conner, 2010; Hirsch et al., 2007b), suggested that risk factors are more likely to relate to poor outcomes among those with an impoverished optimism. Cato (2012) revealed that there is a significant negative relationship between optimism and suicide among 30 African American college students (ages 18-28 years). 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.

Hirsch, Conner, and Duberstein (2007) found that optimism is inversely associated with suicide ideation after controlling for age, gender, depressive symptoms, and hopelessness. Optimism holds promise as a cognitive trait associated with decreased thoughts of suicide among college students. Chang, Yu, Lee, Hirsch, Kupfermann and Kahle (2013) examined an integrative model involving optimism/pessimism and future orientation as predictors of suicide risk and behaviour. Future orientation was found to add significant incremental validity to the prediction of depressive symptoms, but not of suicidal behavior. Noteworthy, the optimism/pessimism × future orientation interaction was found to significantly supplement the prediction of both depressive symptoms and suicidal behavior.
**Hope**: Hope is commonly used in everyday language, but within the context of positive psychology, has a specific meaning with substantial theoretical support. Hope is defined as the feeling of trust emerging from the individual’s hope and expectations that are more than zero at realizing an aim about the future (Rideout and Montemuro, 1986). Even though high hope is found to be associated with reduced suicidal ideation, it does not necessarily establish the positive effect of hope as a resilience factor. It may simply demonstrate a reduced risk to its associated risk factor (such as hopelessness) which results in reduced suicidal ideation. A handful of studies have postulated that hope as being the protective factor of suicidality. More recently, Davidson and Wingate (2013) elucidated hope in predicting lower levels of suicidal risks specifically in a clinical sample. They found that hope only lowered one’s level of burdensomeness and thwarted belongingness but not suicidal ideation. In addition, hope was also found to provide a protective influence against the effect of rumination in predicting suicidal ideation (Tucker et al., 2013). Tucker and colleagues have ascertained that individuals with goals are able to develop (pathway) and motivated (agency) to achieve those goals while less likely to ruminate their problems which in turn decreases the experience of depression and suicidal ideation when negative life events occur. In addition, hopeful individuals were less likely to experience suicidal behavior with increasing levels of depression (Hirsch, Visser, Chang, & Jeglic, 2012). The latter however, postulated that Asian samples did not show significance in which hope buffers the association between depression and suicidal behavior due to a minute sample
size. Besides that, Chang, Yu, Kahle, Jeglic, and Hirsch (2013) have also successfully postulated that hope lowers the risk of suicidal risks (hopelessness and suicidal behavior) while accounting for a significant amounts of variance in suicidal risk in a Latino student sample. However, the latter suggested future studies to clarify the status of hope as potential predictor of suicidal risk in other ethnic or race groups.

Low hope (characterized by having a lack of positive expectancies for the future) may easily be taken as hopelessness—a state of having increased negative expectancies for the future (Beck, Weissman, Lester and Trexler, 1974; Stotland, 1969). Hope and hopelessness have been considered to be similar constructs since both tap future-oriented expectancies (Farran, Herth and Popovich, 1995; Grewal and Porter, 2007), making them appear to be opposite ends of a single bipolar spectrum. 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. Beck et al., (1985), found that hopelessness is associated with other psychiatric disorders also sensitiveness the patient to suicidal behavior. 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).

Research showed that severe hopelessness may be a predictor of suicide (Beck, 1987; Fawcett, 1990). If a person feels hopeless that he or she will attempt to commit suicide. What it does tell us, however, is that helpless and depressed individuals might be at a higher risk for self-harm. They ought to receive treatment from a trained mental health professional. Beck, Steer, Kovacs and Garrison (1985) in a study related to the relationship between hopelessness and suicidal intention, and it indicated the importance of degree of hopelessness as a predicator of long-term suicidal risk in depressed patients. Klonsky, Kotov, Bakst, Rabinowitz, and Bromet (2012) showed that hopelessness in people with psychotic disorders confers information about suicide risk among individuals who have a history of attempted suicide. Moreover, even relatively modest levels of hopelessness appear to confer risk for suicide in psychotic disorders. Ialongo (2004) revealed that African American children’s self-reports of depressed mood as early as grade four may prove useful in predicting adolescent/young adult suicide attempts among females. No family demographics or teacher reported child aggressive behavior proved equal to child self-reported depressive symptoms in predicting suicide attempts.
**Resilience:** A protective factor that is receiving increasing amounts of attention in the field of suicidology is resilience. 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. Resilience is derived from the Latin word ‘resilio’ and means ‘to jump back’ (Manyena, 2006). The ability of some people or communities to withstand and recover from severe adversity or stressful life events is termed resilience. Resilience is an interactive concept that is concerned with the combination of serious risk experiences and a relatively positive psychological outcome despite those experiences (Rutter, 2006). Therefore a focus on protective factors supplementing the focus on risk factors can improve our ability to develop protective and comprehensive strategies in suicide prevention and to focus the attention on the resources to remedy the problem. An important value added of applying a resilience perspective is to have a reasonable balance between a problem-oriented perspective and a resource perspective. A recent review of studies examining psychological factors that moderate the impact of various risk factors on suicidality suggests the existence of a broad array of factors that confer resilience to suicidality (Johnson, Wood et al. 2011). The review found strong evidence for a protective role of positivity of attributional style (the tendency to understand negative events as being due to causes that are external, likely to change, and specific) and agency (the sense that one is in control and is the initiator of one’s own actions), and
moderate evidence for a protective role of problem-solving ability, problem-solving confidence, high self-esteem, general social support, family support, and perceived attachment to caregivers.

Resilience is considered to be part of a combination of personal and contextual resources that enable an individual to adjust effectively to challenges and life situations (Walsh, 2002). Resilience research has attempted to identify risk factors, the accumulation of which makes inappropriate coping behaviours more likely, together with those factors at the individual, family and environmental levels which help to insulate people from turning to inappropriate behaviours during stressful periods of personal adversity. 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). Two types of judgments must be made before being able to classify an individual as resilient (Masten, 1999). First, the individual must have experienced some kind of adverse or threatening circumstances. Second, is the degree in which the individual was able to overcome and/or thrive under the hazards that he or she faced. 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 an eerie ability to improvise’. Low resilience may be a risk factor for suicidal behavior (Roy, Sarchiapone and Carli , 2007).

Coping skills: - Problem-solving based coping skills may be protective against suicidal behavior and attempted suicide. There is
conflicting facts on the interplay between the suicide risk factor of hopeless and problem-solving-based coping skills. One study showed that problem solving coping may arbitrate against hopelessness among adults who have attempted suicide even as another demonstrated that hopelessness can mediate against the protective effect of problem-solving-based coping. Various coping skills requiring a constituent of self-agency appear to be protective against suicidal behavior among adolescents, including self-control, self-efficacy, positive future thinking, social adjustment skills and sublimation. Being in control of emotions, feelings, thoughts and behavior can mediate against suicide risk related with sexual abuse among adolescents.

**Reasons for living:** - High levels of reasons for living, future orientation and optimism protect against suicidal behavior and attempt among those with depression. Hopefulness is protective factor against suicide risk among African-American women exposed to poverty and domestic violence. There is some evidence that the patient of previously attempted suicide can develop positive coping strategies to protect themselves against future suicidal behaviour. More above said, resilience is better predictor of suicidal prevention than the amount of exposure to stressful life events and circumstances.

**Social Protective Factors**

**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.

The relationship between social capital and health is usually theorized to be a positive one; i.e., the higher the stocks of social capital, the better the health status of a population. Spellerberg (2001) found that social capital can encompass negative characteristics as well as excessive bonding whereby non-group members are actively excluded or discriminated against. Mohan and Mohan (2002) reported that social capital has been linked to positive externalities such as better health, employment rates, and social interaction.

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. Researches 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,
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.

One of the most particular interests within the social capital literature is the relationship between social assets, both physical and mental health (Cattell, 2001; De Silva et al., 2005; Fitzpatrick, Irwin, Lagory, and Ritchey, 2007; Harpham, Grant, and Rodriguez, 2004; Moffitt, 2002; Putnam, 2001; Zhang and Goodson, 2011). Putnam, on the subject of mental health, contends that individuals with more social ties are less likely to experience sadness, low self-esteem, loneliness and all indicators of depressive disorders that are the main predictor for suicide. Kawachi and Berkman (2001) explore the link between social capital and mental health by employing assistance from their previous work on social networks and find similar results. A reliable relationship has been found between social capital and mental health among several researchers (De Silva et al., 2007; Lin, 2001; McKenzie and Harpham, 2006).
The social circumstance is a crucial factor in understanding risk for suicide (Hjelmeland, 2011) and to make sense of the tremendously high rates of suicide in old aged males, especially in U.S., Canada and many European countries (Canetto, 1992). In fact, the only randomized intervention suggesting that reduction of suicides, though not conducted specifically with older adults, have been posited to work by enabling at-risk individuals to feel more connected to others and cared for (Motto and Bostrom, 2001; Fleischmann et al., 2008). There are a number of quasi-experimental studies related to interventions designed to increase social connectedness i.e., the degree to which older adults are connected to family, friends, and other communities with results suggesting that this is a promising strategy for reducing late-life suicide rates (Oyama et al., 2008; De Leo, Buono and Dwyer, 2002; Lapierre et al., 2011).

Social capital has been associated to a variety of health outcomes such as access to health care, binge drinking, food security, leisure time, physical inactivity, violent crime and homicide, child behaviour problems, tuberculosis case rates, walking activity, life expectancy, life satisfaction, and suicide rates (Kawachi et al. 2004).

Ecological studies have found that social capital is connected with lower rates of suicide and higher levels of life satisfaction (Helliwell 2003). Researchers concluded that for neighborhoods with higher social capital, members report better individual and self-rated health (Wen et al., 2003). However, the concept of social capital indicators to mental health outcomes, suggested that the concept of social capital may have value for examining the social factors of suicide.
Physical activity and health: - There is some evidence that an attitude towards sport as a healthy participation and activity in sports activity is protective against suicidal behaviour among adolescents. A perception of positive health and physical activity may be protective effect on suicide among females who have experienced sexual abuse.

Family connectedness: - People who are well integrated with their families and community have a good support system to fall back on in times of crisis. Their strong connections with family and society where experiences are enriching are seen as having any importance any protective influence with regard to suicide. Connectedness to family, school, and peers has consistently been associated with the diminished risky behaviors. This was seen in a study conducted by Anteghini, Fonseca, Ireland and Blum (2001) in Brazil where both boys and girls the protective factors included having good family relationship, feelings like by friends and teachers. Blum, Halcon, Beturing, Pate, Campell, forester and Vnema (2003) conducted survey on adolescents from Nine Caribbean countries found strong connection with family and school provide the best protective factors. Good or positive relationships with parents mitigate against suicide risk, especially in adolescents and including those who experienced sexual abuse. Positive family relationships also provide a protective effect for adolescents including the patient of learning disabilities. Further a study of adolescent suggested that positive maternal coping strategies can have a protective effect on female.

Marriage is also a protective factor against suicide. There is also some evidence suggested that marriage has a protective effect
against socio-economic inequalities related to suicide, particularly for men. It is important to consider other impenetrable variables including the finding that married men were less likely than non-married men to have problems with gambling, sex, drugs, and using psychiatric medicine.

**Supportive schools:** Supportive school environment together with access to healthcare professionals, are important protective factors among adolescents who have experienced sexual abuse, those with learning disabilities and those who identify as gay, lesbian, and bisexual. Suicide rates are lower where there is ongoing support for people who have attempted suicide. These include emotional support at the individual as well as group level. They also include working with families of the attempters study have shown that when interventions programs have been implemented in communities and where there has been constant touch between the health care providers and families there have been reduced rates of suicide. The support provided to families and individuals were on going in nature and regular can have a protective effect.

**Social support and Social values:** Societies where there is acceptance of suicidal feelings as a common human experience and where there is no social stigma associate with seeking psychiatric help. In Srilanka there has been intense campaigning against suicide and the promotion of help seeking behavior as seen a reduction in the rates of suicide. Social support in general is protective against suicide among women who have experienced domestic abuse. Traditional social values may have a protective effect among adolescent girls
against suicidal behaviour, although individualistic values may have a protective among adolescent boys.

**Good life skill:-** Adequate skill in problem solving, conflict resolution and ability to resolve disputes in a non-violent manner greatly reduce the suicidal risk. Apter, Gothelf, Offer, Ratzoni, Orbach, Tyano and Pfeffer (1997) study in Israel on adolescence it was seen that individuals who used sublimation as a form of ego self-defense mechanism had fewer aggressive tendencies and the use of it was identified as a protective factor. Life skill training in school for children leads to a reduction in suicide attempts.

**Religious participation:-** There is a wide range of evidence to suggest that religious contribution may be a protective factor against suicidal behaviour and attempt. However, the protective effect of religious contribution can vary according to the level of secularisation within community, cultural and social integration. Moral sanctions against suicide can be promoted by religious community may have wider protective effect on the non-religious community where the religious members are in the majority. Religious observance does not confer equal protection on individuals. Other factors, the observance of traditional cultural rituals, may have a stronger protective outcome. The manners in which individuals related to their God (in terms of religious coping style) may additional emphasize different levels of protective factors within a single religious community.

**Exposure to suicidal behavior:-** In a study related to suicidal behavior found that exposure to accounts of suicidal behavior in the media and, to a lesser amount, exposure to the suicidal behavior of
friends or associates may be protective against nearly suicide attempts. However, it is important to note that there is also a body of confirmation of the suicide risks associated with media reporting.

Value of life:- The value of life as an end in itself is not only shared by most people, but also considered the most fundamental value. Therefore, suicide threatens our deepest convictions about the ‘sanctity of life’ or ‘rational suicide’ has been invoked by some commentators, which suggested other views of life’s purity. It is exceedingly difficult to rid ourselves of sense of threat, because the phenomenon of suicide is logically and ethically confusing. Justifying the value of life and the supposed moral duty to go on living is challenging. Our belief in the value of life is further offended by the relative failure to prevent suicide, also through treatment or social changes; suicide is disturbingly everywhere across ages and cultures. And the optimism felt after successful prevention in individual cases is offset by others under professional care, who nevertheless takes their own lives.

The problem of the incommensurability of the values of life and death is circumvented only at the price of introducing other controversial moral or theological values. Ascribing value to life rather than to life of a certain quality has the advantages of universality and independence of subjective belief. Moreover, proponents of the quality-of-life theory have to concede that life is a necessary condition to the valuable life, and therefore has indirect value. These remarks pertain to our approach to suicide because they have far-reaching ethical implications. There are good reasons to
prevent a person from committing suicide even if he/she genuinely believes that her life has lost all value. These reasons appeal to the value of life itself, from which a new meaning might be formed. In other words, even if philosophically speaking only the meaningful life is valuable, life itself should be ethically respected and enhanced as the only way to attain that meaningfulness.

**Local communication:** - Supportive school environments, including access to healthcare professionals, are important protective factors among adolescents suicide including those who have experienced sexual abuse, those with learning disabilities and those whom identified as lesbian, gay, transgendered and bisexual.

**Trust and safety:** - When children have support from adults within negative environments, including when adults provide consistent care and ongoing supervision, positive communication between children and their parents/care-givers can be clear and open then trust and safety feeling were developed. Support from adults can help children to develop social relationship skills that give support for positive mental health. When children are raised in supportive environments at home and at their early childhood service that offer loving, safe, consistent care and support, children have the opportunity to develop the close relationships. Close relationships with family and peers give children a sense of trust and are significant for children’s positive mental health and wellbeing.

**Neighborhood connection:** - It has long been recognized that the places in which people live, work and play have direct and indirect
impacts on individual-level and population-level health outcomes. These ‘place effects’ occur independently of individual-level demographic characteristics, such as age, sex and ethnicity, but are mediated by behaviours, social position, health-care access and other physiological parameters that allow neighborhood contexts to influence individual health and well-being outcomes (Kawachi and Berkman 2003). In very wide terms, three types of neighborhood characteristics might be important for residents’ health: physical, socio-cultural and community resource access like recreational facilities.

**Tolerance and diversity:** Tolerance as a moral virtue does not need us to accept other people's beliefs or behaviors. Tolerance required us to respect every person's human self-respect and human rights, including legitimate freedom of conscience. Freedom of conscience is the liberty to make personal moral choices as long as those choices do not disobey on the rights of others or undermine the common good. Our own freedom of conscience may lead to take issue with other people’s moral choices, even apparently “personal” ones. We might, out of a genuine concern for their welfare, try to influence them that they are mistaken in their beliefs, thoughts and behavior that they are hurting themselves or others in ways they may not understand. For example, when a grown-up child decides to move in with his or her finance prior to marriage, some parents may feel conscience-led to encourage their child to reconsider that decision, perhaps in the religious precepts that the divorce rate is significantly higher for couples who live together before they are married. However, the virtue of tolerance would in such cases keep us from coercively
interfering with the freedom of other adults to make decisions about their own lives. However, a problem with “diversity” as an ethical category is that it is all-inclusive, encompassing all differences. Suicide bombers are part of diversity. Psychological theories suggest that people who are unable to tolerate and adjust negative emotions may get involved with suicidal behaviors (Lynch et. al., 2004). As a factor that helps handling emotions and excitement, tolerance has an important and effective role.

**Social policies:** Efficient performance of social and public strategy that pertain to alcohol use. All these factors such as family regulations, urbanization, use of pesticide, social security and welfare all contribute in reduction of suicidal incidence in the society.

**Cultural and religious beliefs:** Strong traditional and spiritual belief that reduces suicide or suicidal ideation and support self-protection is perceived as one of preventive factor to protect from suicide. In many religion suicide is not acceptable and considered as a sin i.e Islam and Christian especially Catholics banned on taking one’s own life which have a greater inhibitory influence on suicidal behavior. Manian (2003) analyze that Islamic and Latin American countries which is mainly Catholic seems to tolerate with no ambiguity. Suicidal rates in Islamic countries are extremely low such as in Kuwait the incidence of suicide is 0.1 per 100000. A study conducted by Alem, Kedede, Jacobson and Kuwait (1999) in Ethiopia showed that lifetime suicide attempt among Christians was 3.9% as compared to Muslims that is 2.9%. This data recommended that due to strict prohibitions in Islam for suicide has a strong protective effect on its supporters and is
capable to inhibit suicidal ideation. Daradkeh (1992) in Jordan studied the effect of religious festivals on the suicide rate in the month of Ramadan during 1986 to 1991 and reported low rate of suicides. It was confirmed by the findings that religious actions reduce the Para suicide rate, but the protective effect does not persist into the month of Ramadan. A study in India by Vijay Kumar (2002) reported the religiosity as a strong protective factor against suicidal behavior. It was also showed that there was less belief in god among suicide attempters, also changed their religious association and hardly joined the place of worship as compared to controls. As stated by Rao (2003) suicide is respected when seen as sacrifice and also viewed as height of generosity in philosophy of Hindu and religious scriptures of Hindu are full of incidents where suicide is acceptable and only solution. In India following a leader in death is also not an unusual event, in Chennai (1987) following the death of famous politician and movie star having lots of fans there was series of suicides among normal population. Suicide is used as a source of social protest from several decades in India. There are so many cases where men and women attempted suicide over linguistic and political issues. For example, when in Southern India where different languages were spoken, Hindi was imposed as the national language then during protest some Indian youth committed suicide.

**Emotional Protective Factors**

**Emotional Capital:** -Emotional Capital is a 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).

Emotional intelligence is an umbrella term that captures a large collection of interpersonal and intrapersonal skills. Human organism attains emotional balance and social adjustment by using certain self-preferred and cultural specific strategies and coping skills. Individuals who possess the ability to maintain emotional balance by emotional skills are better adjusted to their social circle, enjoy quality of life and are physically and psychologically healthy. Taylor (2001) argues that emotionally intelligent person can cope better with problems and controls his/her emotions more effectively and this ability leads to psychological health. Low EI is a potential risk factor for mental and physical health including suicidal behavior (Mayer and Salovey, 1997; Salovey, Bedell and Detweiler, 1999; Salovey, Mayer, Goldman, Turvey and Palfai, 1995; Stone, Marco, Cruise, Cox, and Neale, 1996; Woolery and Salovey, 2004).
Aradilla-Herrero, Tomás-Sábado, Gómez-Benito (2013) determined that depression and emotional attention are significant predictors of suicidal ideation among nursing students. Similarly, Mehmood and Gulzar (2014) reported that Emotional intelligence is negatively related to depression and positively related to self-esteem among Pakistani adolescents which is the most important risk factor for suicidal behavior. Cha and Nock (2009) examined whether emotional intelligence (EI), decreases the likelihood of suicidal ideation and attempts among those suicide attempter. Results found that EI is a protective factor for both suicidal ideation and attempts. A recent study showed that people with high Emotional intelligence have more successful exposure because they know when to express their feelings and mood states (Mohammadi, TorabiS and Ghrayy, 2008). Even though the few studies that have been conducted in this regard have confirmed Emotional intelligence as a protective factor (Cha and Nock, 2009, Berktin et.al., 2008, Ahmadian et.al., 2009). Ghoreishi and Mousavinasab, (2008) revealed that the incidence of suicide attempt is two times higher among Iranian women than Iranian men and the drug poisoning was the most popular used method for suicide attampt.

Self-awareness: Self-awareness is the ability to focus attention on self as an object (Carver, 2003; Duval and Silvia, 2001) has had a major influence on the connection of social and clinical psychology. Duval and Wicklund (1972) found that self-focused attention promotes self-evaluation; a huge number of researches have connected self-awareness to aversive, dysfunctional, and negative outcomes (Ingram, 1990; Wells and Matthews, 1994). It's no surprise,
then, that how self-awareness is treated in the social-clinical literature revealed self-awareness theories of depression (Pyszczynski and Greenberg, 1987), alcoholism (Hull, 1981), and socially irresponsible behavior (Prentke-Dunn and Rogers, 1989); models of how self-awareness increases negative affect and reduces well-being (Fejfar and Hoyle, 2000; Mor and Winquist, 2002); and how self-awareness promotes suicide, masochism, and self-destructive behavior in escape theory of suicide (Baumeister, 1991). When people's experiences fall short of their expectations, they over and over again blame themselves. This self-critical tendency is overstated when people are highly self-aware (Duval and Wicklund, 1973). Without self-awareness, people could not recognize that their perspectives might different from another's viewpoint (Shibutani, 1961). A person cannot understand that self and others differ or that others might have different needs, thoughts, and properties—without first comprehending that the self exists as a bounded, situated entity. Self-awareness also decreases intrinsic motivation and interest (Plant and Ryan, 1985). Research found that a primary component of optimal experience reduced self-awareness (Csikszentmihalyi, 1990; Csikszentmihalyi and Figurski, 1982). When self-awareness is increased, the person feels less integrated with the activity, and the intensity of positive affect declines (Silvia, 2002).

Motivating Oneself: - People who have high standards and expectations are extra vulnerable to suicide when progress toward goals is abruptly frustrated. People who attribute failure and disappointment to their own shortcomings may come to sight themselves as worthless, unlovable, and incompetent. In adults,
suicide is often related to work or interpersonal problems. At that time motivating oneself play a role as a protective factor for suicide prevention. Around the world, student burnout is caused by high rates of physical and emotional exhaustion, a sense of being depersonalized, and a shrunken sense of personal achievement. According to Times of India newspaper (29 December 2015), Kota, Rajasthan is a cauldron for all these feelings, with other factors like the fear of letting down one's family, or not having any career alternatives. A day after Kota district administration undertook a major exercise to de-stress coaching students to curb the spate of suicides and directed institutes to organize activities like painting and singing as part of its 'Masti ki Pathshala' campaign on Saturday, a 14-year-old boy committed suicide on Sunday, sending shock waves in this educational hub. With this, 30 students have killed themselves in the city this year.

**Empathy:** -Empathy is the experience or skill of understanding another person's condition from their perspective. You place yourself in their shoes and feel what they are feeling. Empathy is known to increase pro-social (helping) behaviors. Counseling training, suicide intervention training, and suicide intervention experience have all been shown to contribute positively to suicide intervention ability. However, though each factor shows some level of contribution, none of the factors stands alone and the factors together still only account for a small portion of individual differences in suicide intervention skill. In the search for factors that contribute to suicide intervention ability, the role of empathy has been relatively ignored. Research (e.g., Bohart and Greenberg, 1997; Goldstein and Michaels, 1985)
does support the importance of empathy in counseling skill, and counseling skill is needed to respond appropriately to individuals who are suicidal (Neimeyer and Diamond, 1983; Neimeyer and Pfeiffer, 1994a); therefore, it is logical that empathy will positively impact suicide intervention skill. Moreover, there is some evidence that college students’ levels of empathy do impact how they view peers’ emotional difficulties and the behaviors resulting from these difficulties and how likely they are to provide assistance to the peer experiencing difficulty (Knott and Range, 2001; Mueller and Waas, 2002). High empathy students tend to take the emotional difficulties of their peers more seriously, even when suicide is not mentioned directly, and they are more likely to provide assistance to their peers experiencing difficulty. Possibly, the most important finding emerges from the Mueller and Waas (2002) study, “that empathy may be a significant contributor to previously reported gender differences, and that increasing young adults’ empathy toward peers exhibiting early at-risk characteristics may be an important intervention objective for prevention programs”. Finally, Knott and Range (2001) also found that empathy was moderately related to social acceptance of those who were suicidal.

**Managing Emotions:** - The ability to be open to feelings, and to adjust them in oneself and others so as to promote personal understanding and growth. A pervasive pessimistic anticipation about the future is more important than other negative emotions (anger, depression) in predicting suicide and suicidal behaviour. A suicidal person is convinced that nothing whatsoever can improve the
situation or that no one else can help. Then the management of emotion is very helpful in the prevention to suicide.

**Presence of community institutions and intervention centers:** Social organizations such as spiritual place, adolescents’ centers for people to meet and resolve their problems, conflicts and presence of crises intervention centers in which people can move during their hard time reduces the rate of suicide. It was shown in a study by Marecek and Ratnayeke (2001) in Sri Lanka where intervention was given as emotional support, financial help, and a platform for women to meet and support each other. After four years of intercession a fall in the suicidal rates was noticed in the intervention accepted villages as compare to other regions where 6% of increment was reported at the same time. Similarly, in India where 2.1% of suicides are committed by students due to failing in exams, availability of helpline centers leads to lower the suicide rate. The facility of 24-hour helpline at the time of annual exam results declaration also resulted in lower the suicidal rates.

From above mentioned risk and protective factors it is clear that these factors play an important role in suicide and suicidal ideation. Many of these factors have been shown empirically to be associated with child well-being. Protective factors may reduce suicide risk by helping people cope with negative life events, even when those proceedings continue over a period of time. The ability to cope or solve problems reduces the chance that a person will become besieged, depressed, or anxious. Protective factors do not entirely remove risk, however, especially when there is a personal, family
history of depression or other mental disorders but they may help to reduce that risk (Ellis and Lamis, 2007; Westefeld et al., 2006).

**Rationale of the study: -**

Suicide is a global health problem and the field of suicide has attracted considerable attention in recent years. Since ancient time there has been researcher’s interest in understanding psychological process believed to influence the health. The empirical attempts have been made continuously for understanding the nature of suicide, its antecedents, causes and prevention. Several governments around the world have established suicide prevention programs. Because the cost of suicide are not only loss of life, but the mental, physical and emotional stress imposed on family members and friends. Suicidal behaviour ensures results of an interaction of socio-cultural, developmental, psychiatric, psychological and family environmental factors (Bridge, Goldstein and Brent, 2006). Suicide remains an important and major cause of death in various populations' samples varying in age, nationality, and clinical severity. It cuts through all boundaries and across psychiatric diagnoses; it also characterizes non-psychiatric populations. Non-fatal suicidal behavior is also associated with a great deal of suffering and risk. The increased attitude to suicide has resulted in a massive expansion in research, which has occurred on all fronts, including, psychiatry, psychological, social sciences, biology and genetics.

Suicidal ideation and suicidal behaviour among students in the age of adolescence is a worldwide problem that warrants considerable attention. 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. Developmental and neurobiological substrates are combined with the conflicting demands from parents, teachers, and friends. High level of parental expectations, academic demands, adjustment to new situations, school and college environment, peer pressure, break-up with boy / girl are some of the most common events in the life of a student which for some, may lead to serious consequences resulting in suicidal behaviour. Kumar and Singh (2006), this stressful life leads to depression, anxiety which ultimately sometimes causes of suicide and suicidal attempts among students.

In review of literature a number of researches have been documented on risk and protective factors of suicide and suicidal behaviour. According to the Centre of Parenting and Research (2007) interaction between risk and protective factors eventually determines whether outcomes are negative or positive. These two factors could be viewed as two edge of the same dimension (Schoon, 2006; Luthar and Cicchetti, 2000). Psychological models of suicidal behaviour pointed out that the interaction between various etiological components, including life-stress, personality variables, family factors and specific contextual factors are responsible for suicidal behaviour (Carballo, 2006). A stressful life event can produce mental pain, depression, and hopelessness. 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, the level of family cohesion, the perceived level
of family support and the low level of stress and conflict within the family that have positive impact on suicide prevention.

One of the most investigated topic in relation to suicidal behaviour in adolescence in social or family variables (Wayner, 1997; Brent, 1995). A number of studies have found that social support, such as having an emotional connection to friends and family, being involved in extra-curricular activities, is one of the important protective factors for college youths (Marion and Range, 2003; Westefeld et.al, 2006). Persons with good communication skills may gain support from friends and family; others may use suicidal behavior as a means of communication. When social communication is blocked, however, the person may feel “trapped” (Williams, 1997). The pernicious combination of unbearable mental pain and inability to signal one’s distress to others can lead to a serious attempt to kill oneself. Emotional Capital is a 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. Human organism attains emotional balance and social adjustment by using certain self-preferred and cultural specific strategies and coping skills. Individuals who possess the ability to maintain emotional balance by emotional skills are better adjusted to their social circle, enjoy quality of life and are physically and psychologically healthy.

While these factors do not abolish the possibility of suicide, especially in someone with risk factors, protective factors for suicide have not been studied as thoroughly as risk factors, so less is known
about them. Psychological, social and emotional capital/factors are also pertinent to the understanding of suicide. Although suicide and suicidal behaviour has been extensively studied but major problem still remain to be solved. The review of literature shows that there is a paucity of research on these protective factors of suicide potential. Thus, the present study is an attempt in this direction taking together these variables i.e. psychological, social and emotional capital. 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”

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.