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SUICIDAL POTENTIALITY IN RELATION TO PSYCHOLOGICAL CAPITAL AND EMOTIONAL CAPITAL

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Abstract
The World Health Organization estimates that almost one million people die by suicide every year worldwide. It is the second leading cause of death among adolescents. Emotional and Psychological capital as a protective factor is a booster for good mental health. In diverse life conditions growth of emotional and psychological capital draw a major impact in exploring the ways of handling different life hassles. The present study is designed to determine the relationship of emotional capital and psychological capital with suicidal potentiality among adolescent. The sample consisted of 200 (100 male & 100 female) participants. The participants were assessed with Time Questionnaire assessing suicide potential, General Self-Efficacy Scale, Beck Hopelessness Scale, Life Orientation Test-Revised, Resilience Scale and Multidimensional Measure of Emotional Intelligence. The results revealed that there is negatively significant relationship of Psychological capital and Emotional capital with suicidal potentiality. Regression analysis revealed that Emotional capital and Psychological capital are significant predictor of suicidal potential.

***Keywords: Suicidal Potentiality, Emotional Capital, Psychological Capital*.**

INTRODUCTION

Suicide is the second leading cause of death among young people after motor vehicle accidents. It is the act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome (WHO, 1998). The costs of suicide are not only loss of life, but the mental, physical and emotional stress imposed on family members and friends. Yet people are often reluctant to discuss it. This is partly due to the stigma, guilt or shame that surrounds suicide. People are often uncomfortable in discussing it. Unfortunately, this tradition of silence perpetuates harmful myths and attitudes on suicide. It can also prevent people from talking openly about the pain they feel or the help they need. Suicide can appear to be an impulsive act. But it's a complicated process, and a person may think about it for some time before taking action. Suicide is a tendency of people to get away from the problems that is so crushing by feeling that only death will stop it. It's estimated that 8 out of 10 people who attempt suicide or die by suicide hinted about or made some mention of their plans. Men are more likely to commit suicide than women but the latter are more likely to attempt (Langhinrichsen-Rohling, 2000). It has been suggested that since men are more likely to choose a violent means (guns, knives) of suicide, there is a higher 'success' rate whereas women use more "failure-prone" methods such as overdosing on medications. Reasons for this gender difference may lie in women's greater propensity to seek psychological and medical attention, suggest some psychologists. Younger women are more likely to resort to deliberate self-harm and attempted suicide, rather than suicide itself. Greater social stigma against male depression and a lack of social networks of support and help with depression are often identified as key reasons for men's disproportionately higher level of suicides, since suicide as a "cry for help" is not seen by men as an equally viable option. Typically males die from suicide three to four times more often as females. Similarly **Upadhayay** and **Singh** (2006) reported that there is a significant gender difference on the measures of suicidal ideation.

Emotional Capital is a strong predictor of mental health and psychological wellbeing. In diverse life conditions growth of emotional capital draw a major impact in exploring the ways of handling different life hassles which leads to suicidal behaviour. People who understand and manage their emotions in a meaningful way are able to guide one's thinking and actions' (Salovey and Mayer 1990). Individuals who possess the ability to maintain emotional balance using emotional skills are better adjusted to their social circle, enjoy better quality of life and are physically and psychologically healthy. Taylor (2001) argues that emotionally intelligent person can cope better with challenges and controls his/her emotions more effectively and this ability leads to psychological health**.** Low Emotional intelligence (EI) is a potential risk factor for mental and physical health including suicidal behaviour (Salovey, Bedell, & Detweiler, 1999; Woolery & Salovey, 2004). Aradilla-Herrero, Tomás-Sábado, Gómez-Benito (2013) determined the prevalence of suicide risk in a sample of nursing students. Results showed that depression and emotional attention are significant predictors of suicidal ideation. Similarly, Mehmood and Gulzar (2014) reported that Emotional intelligence is positively related to self-esteem and negatively related to depression among Pakistani adolescents which is the major risk factor for suicidal behaviour. Cha and Nock (2009) examined whether emotional intelligence decreases the likelihood of suicidal ideation and attempts among those at risk. Results revealed that EI is a protective factor for both suicidal ideation and attempts.Psychological capital, another protective factor for suicidal behaviour, represents an individual's positive psychological state in the process of growth and development. Seligman (2002) advocated positive psychology movement, emphasizing the psychology research should be focused on

people's positive emotions, positive characteristics and positive psychology, rather than just concerned person's negative symptoms. Psychological capital is a composite construct consisting of four dimensions – confidence (efficacy), hope, optimism and resilience (Luthans & Luthans, 2004). Many scientists believe that self confident people choose challenging task and endeavor to successfully accomplish their goals. It plays a critical role in important human performance determinants such as goals, aspirations, and the perceived opportunities of a given project (Bandura 2000; Maddux, 2002). A strong sense of efficacy enhances human accomplishment and personal well-being. People differ in terms of the degree to which risk and protective factors affect the likelihood that they will end their life. No one risk factor, or set of risk factors, determines increased suicidal risk. In the same way, no one protective factor, or set of protective factors, guarantees against a completed suicide. To obtain this information successfully, it is also crucial for the clinician to feel confident and comfortable asking relevant questions as part of a genuine dialogue (Rudd, Berman, Joiner, Nock, Silverman & Mandrusiak, 2006). It has been suggested that how assessors understand and interact with an individual after a suicide attempt can make a difference and either strengthen their hope for life or increase their wish to die (Vatne and Nåden, 2014). People with high self-confidence experience greater improvements in their quality of life and lead to better life. In contrast, people with low self-confidence tend toward suicide, eating disorders, delinquency, and depression in the face of moral-behavioral and emotional disorders such as stress, lack of motivation (Hassanzadeh, 2003).

Research review related to optimism suggested that optimism is also exerting a direct protective effect against suicidal ideation (Hirsch, Conner, & Duberstein, 2007; Roberts, Roberts, & Chen, 1998). Researches have demonstrated a positive relationship between optimism and well-being, which plays positive role in development of good mental health and well being, in terms of happiness. Research on optimism demonstrated a positive relation with mental well-being (Scheier & Carver, 1992) as well as life satisfaction (Seligman, 2002). When individuals experience instances of optimism, they tend to internalize positive events and externalize negative events, resulting in more positive expectancies of outcomes (Seligman, 1998). Optimism also function as a protective factor in the presence of adversity and decrease suicidal ideation (Blankstein, Lumley, & Crawford, 2007; Hirsch, Wolford, LaLonde, Brunk, & Morris, 2007). Optimism enables individuals to restore their efforts to reach goal when faced with obstacles (Scheier, Weintraub, & Carver, 1986). Cato (2012) found a significant negative relationship between optimism and suicide in sample of college students. Similarly in a recent study, Sánchez-Teruel, García-León, & Muela-Martínez (2013) showed that students high on suicidal ideation are less optimistic and have poorer social skills and less social support.

Feng, Li, and Chen (2015) explored the impact of stress on suicidal ideation by investigating the mediating effect of self-efficacy and dispositional optimism. Results show that stress has a direct effect on suicide ideation. Furthermore, self-efficacy and dispositional optimism partially weakened the relationship between stress and suicidal ideation. Roy, Sarchiapone and Carli (2007) reported that low resilience may be a risk factor for suicidal behavior. Hirsch, Conner, Duberstein (2007) found that optimism is inversely associated with suicide ideation, even after controlling for age, gender, depressive symptoms, and hopelessness. Optimism holds promise as a cognitive characteristic associated with decreased thoughts of suicide among college students. Chang, Yu, Lee, Hirsch, Kupfermann & Kahle (2013) studied an integrative model involving optimism/pessimism and future orientation as predictors of suicide risk. 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 augment the prediction of both depressive symptoms and suicidal behavior. Hope involves persevering and redirecting paths toward goals (Snyder's, 2000). Hopeful people have the desire to achieve goals and have the capability to develop various pathways or strategies toward goal accomplishment.

Snyder and colleagues (1991) have shown that hope has a significant negative correlation with anxiety, and studies demonstrate an individual's hope level protects against perceptions of vulnerability, uncontrollability, and unpredictability (Snyder, 2000). Research has also indicated that severe hopelessness may be a predictor of suicide (Beck, 1987; Fawcett, 1990). It is a common symptom of clinical depression. Depressed individuals who struggle with strong feelings of hopelessness may be at a higher risk for self-harm. Research on the cognitive theory of depression has shown that people who are depressed struggle with feelings of hopelessness and helplessness more so than people who are not depressed (Sacco & Beck, 1995). Violanti (2015) examined specific stressors that may be associated with hopelessness, a possible risk factor for suicide in this high suicide risk population. Beck , Steer, Kovacs and Garrison (1985) studied that the relationship between hopelessness and suicidal intent, these findings indicate the importance of degree of hopelessness as an indicator of long-term suicidal risk in hospitalized depressed patients. Klonsky, Kotov, Bakst, Rabinowitz, and Bromet (2012) showed that hopelessness in individuals with psychotic disorders confers information about suicide risk above and beyond history of attempted suicide. Moreover, in comparison to non-psychotic populations, even relatively modest levels of hopelessness appear to confer risk for suicide in psychotic disorders. There is considerable evidence that resilience, once believed to be a

rare dispositional trait, is state like and open to development (e.g., Bonannoet.al, 2004; Coutu, 2002; Masten & Reed, 2002; Youssef & Luthans, 2007). Protective factors can be defined as societal or psychosocial conditions or individual behaviours that lessen the likelihood that an individual will engage in suicidal behaviour.

Zheng and Wang (2014) investigated that the effects of social and psychological factors on the suicidal tendencies of Chinese medical students. Results support to a multi-factorial approach to the understanding and prevention of suicide by college students and mature coping strategies had a protective effect on suicide. A number of studies have found that social support is one of the important protective factors for suicidal behaviour among youth (Marion & Range, 2003; Westefeld et al., 2006). But there is paucity of research taking together the study variables. Hence, the present study is an attempt in this direction with the following objectives:

OBJECTIVES

1. To find out the relationship of suicidal potentiality with psychological capital and emotional capital.
2. To ascertain the contribution of psychological capital and emotional capital in suicidal potentiality.

HYPOTHESIS

1. Psychological capital and emotional capital are likely to be associated negatively with suicidal potentiality.
2. Psychological capital and emotional capital are likely to contribute substantially in suicidal potentiality.

METHOD

SampleSample for the study consisted of 200 (100 male & 100 female) participants drawn from various educational institutions of Sirsa district of Haryana. The age range of the participants varies from 16 years to 22 years with a mean age of 19 years. Majority of the participants belong to middle class families and they were having good health.

Measures

1.Time Questionnaire This Questionnaire (TQ) was developed by Robert Yufit and Bonnie Benzies (1979) to assess the ssuicidal potential. It consist 39-item structured in semi-projective technique for assessing time perspective as an indicator of potential suicide intent. The TQ consists of 3 sections-the Present, Future, and the Past-which contain both multiple choice and open-ended items. Time perspective in each section is assessed against 4 primary parameters: extent of future time projection, degree of elaboration of and involvement in specific future hopes and aspirations, consistency of these projections, and the amount of realistic change projected in the future. A high positive TQ scores, suggests projection and investment in the future, balanced attitudes about the present, and judicious recall of the past. The TTQS possible range is 74 to -123. Scores above 25 imply low suicide potential and below zero suggested high suicidal potential.

2.Multidimensional Measure of Emotional Intelligence (MMEI) The Multidimensional Measure of Emotional Intelligence was developed by Darolia (2003). The MMEI is comprised of 80 multiple choice items which measure five dimensions, 16 items per dimension; each item is answered on a five point scale i.e. very true, mostly true, somewhat true, mostly false and very false. The test has been designed so as to control response sets through the balancing of affirmative and negative statement related to Self awareness, Managing Emotions, Motivating Oneself, Empathy and Handling Relationship. For the scale alpha coefficient and test-retest reliability coefficient were worked out for all five scales. The coefficient alpha which is more meaningful for tests like MMEI ranged between .76 and .81. Test- retest coefficient ranged between .79 and .84 after an interval of 40 days. The MMEI scales were validated in term of construct validity principle component analysis revealed the construct validities of the scales are substantial, which range from .68 to .76.

3.The General Self-Efficacy Scale (GSE) This scale is developed by Matthias Jerusalem and Ralf Schwarzer in German in 1979. It assess a general sense of perceived self-efficacy with the aim in mind to predict coping with daily hassles as well as adaptation after experiencing all kinds of stressful life events. The scale is uni-dimensional and it consists 10 items in a response on a 4-point scale. Sum up the responses to all 10 items to yield the final composite score with a range from 10 to 40. The Cronbach's alphas for the scale ranged from .76 to .90, with the majority in the high .80 and criterion-related validity is documented in numerous correlation studies.

4. Beck Hopelessness Scale (BHS) The scale was developed by Beck, Weissman, Lester, & Trexler (1974). It consists of 20 true-false statements that assess an individual's negative future expectations. The total scores range from 0 to 20, with higher scores indicating higher levels of hopelessness. The different reliability coefficients were reported for different samples, in a sample of 294 hospitalized 26 patients who had recently attempted suicide, an alpha reliability coefficient of .93 was reported. In non-psychiatric sample, internal reliability was .87. The scale has also shown high test-retest reliability over a 3-week period in a non-psychiatric, undergraduate sample (Holden & Fekken, 1988). Concurrent validity has also been

supported, as the BHS has been found to correlate highly with both clinician ratings (r = .62) and other self-report measures of hopelessness (r = .60 to r = .63) (Beck et al., 1974).

5. Life Orientation Test-Revised (LOT-R) Optimism was measured by the Life Orientation Test-Revised (Scheier, Carver, & Bridges, 1994). It consists of 10 statements (3 positively worded, 3 negatively worded and 4 filler items). Respondents are asked to indicate the extent of their agreement with each of the items using the following response format: 0 = Strongly Disagree, 1 = Disagree, 2 = Neutral, 3 = Agree and 4 = Strongly Agree. Scoring for negatively worded items is done in reverse order. Scoring of these 6 items is then summed up to compute an overall optimism score with high score representing greater optimism and lower scores indicating lower optimism, often referred to as pessimism (Scheier et al., 1994). The scale has been found to be fairly stable across time with sufficient convergent and discriminant validity. The LOT is valid and it has good temporal stability over 4 weeks (r = .79), 4 month (r = .68), and 12 month (r = .60; Scheier & Carver, 1985, Scheier et al., 1994). Dispositional optimism has also adequate construct and predictive validity (Scheier & Carver, 1987).

6.Resilience Scale (Wagnild & Young, 1993) The Resilience Scale (RS) is a 25 items scale using a 7 point ratings (strongly disagree to strongly agree) to assess personal competence and acceptance of self and life. The internal consistency for the scale has been found range from .76 to .91 (Cooley, 1990; Killien & Jarrett, 1993; Klass, 1989; Wignild & Young, 1993). Test-retest reliability of this scale was found to be between .67 and .84 (Killien & Jarrettis, 1993). Several studies were supported strengthening the evidence for construct validity of the Resilience Scale (Wagnild GM. 2009, Wagnild GM, Young HM. 1993).

ProcedureThe participants were contacted personally for data collection in their respective educational institutions. After getting willingness of participants, a cordial rapport was established with them to make comfortable. They were assured about the confidentiality of the data, so that they could give their responses without any hesitation. After imparting the instructions to participants, the tests were administered in small group setting. During the test administration, only the investigator and participants were present in the testing room. The procedure was kept uniform during the data collection. All the tests were scored as per the instructions provided in respective test manual.

RESULTS AND DISSCUSION

To meet the study objectives, the data were processed for Pearson's product movement correlation and multiple regression analysis through SPSS. The perusal of Table – 1 revealed that the overall measure suicidal potential is found to be correlated negatively significant (r = - .18, p <.05) with overall psychological capital. The negative relationship between the measures suggested that the participants high on psychological capital are less prone to suicidal potentiality. Suicidal potential is correlated positively significant with hopelessness (r = .50, p < .01) and negatively significant with self efficacy (r = - .20, p <.01) and resilience (r = - .16, p <.05), the measures of psychological capital. The positive correlation between hopelessness and suicidal potentiality suggests that the participants high on hopelessness are more prone to have suicidal potentiality. The negative correlation of self-efficacy and resilience with suicidal potentiality indicated that participants high on self-efficacy and resilience are low on suicidal potentiality. The findings are in tune with some earlier research (Zubrick, Williams, Silburn & Vimpani, 2000).

Table No 1:- Correlation Matrix

	HL	OP	SE	RE	PC	SA	ME	MO	E	HR	EC	SP
HL	1	.22**	.23**	.18*	.18*	.20**	.28**	.17*	.02	.14*	.25**	.50**
OP		1	-.22**	-.26**	-.42**	-.24**	-.20**	-.28**	.01	-.18**	-.28**	-.12
SE			1	-.46**	-.71**	-.19**	-.30**	-.36**	-.14*	-.29**	-.40**	-.20**
RE				1	-.93**	-.19**	-.25**	-.40**	-.08	-.33**	-.39**	-.16*
PC					1	-.23**	-.30**	-.46**	-.09	-.36**	-.45**	-.18*
SA						1	-.48**	-.26**	-.03	-.32**	-.64**	-.21**
ME							1	-.42**	-.12	-.46**	-.77**	-.14
MO								1	-.07	-.50**	-.70**	-.19**
E									1	-.20**	-.38**	.02
HR										1	-.76**	-.16*
EC											1	-.21**
SP												1

*. Correlation is significant at the 0.05 level (2- tailed).
**. Correlation is significant at the 0.01 level (2-tailed).
HL- Hopelessness, OP-Optimism, SE- Self-Efficacy, RE- Resilience, PC- Psychological Capital. SA- Self-Awareness, MO- motivating oneself, E- Empathy, HR- Handling Relationship, EC- Emotional Capital, SP- Suicidal Potential

oneself (r = - .19, P <.01) and handling relationship (r = - .16, P <.05), the measures of emotional capital. The negatively significant correlation of self awareness, motivating oneself and handling relationship with suicidal potentiality indicated that participants high on self awareness, motivating oneself and handling relationship are low on suicidal potentiality.

Regression Analysis: In order to ascertain the extent to which weighted combination of all measures of psychological capital (hopelessness, optimism, self-efficacy and resilience) account individual differences in suicidal potentiality, stepwise multiple regression was worked out. The stepwise analysis was preferred over standard one to find a subset of those independent variables which are useful in predicting the dependent variable, by eliminating those which do not contribute additional to that already predicted by the variables in the equation. The Backward regression was conducted with parameter, P of F-to-enter = .05 and p of F-to-remove = .10.

Table No 2

Variable	R	R Square	df	F	Sig.
Hopelessness	.501	.251	198	66.68	.000

The table no 2 shows that Hopelessness (measure of Psychological Capital) is significant predictor of suicidal potential emerged with an overall multiple R of 0.501 which is significant at 0.01 probability level. Hopelessness being most potent predictor of suicidal potentiality, it entered the equation at alone. The multiple R for this variable equals to .501, which suggests that hopelessness accounts for approximately 25.1% of variance (R^2 = .251). The F being 66.68 (df = 1/198) which is highly significant (p<.001). It indicates that hopelessness is a strong predictor and account significant proportion of variance (i.e. 25.1%) in suicidal potentiality among adolescents. The finding in this direction of some earlier studies also supported the result (McLaughlin et al., 1996; Dori & Overholser, 1999).

Table No 3

Variable	R	R Square	Df	F	Sig.
Self awareness	.208	.043	198	8.98	.002
Motivating Oneself	.249	.062	197	6.514	.003

In order to ascertain the extent to which weighted combination of all measures of emotional capital (Self awareness, Motivating Oneself, Handling Relationship, Empathy and Managing Emotions) account individual differences in suicidal potentiality, stepwise and enter multiple regression was also worked out separately. The table no. 3 indicated that self-awareness and motivating oneself are significant predictor of suicidal potential emerged with an overall multiple R of 0.208 which is significant at 0.01 probability level. Self-awareness being most potent predictor of suicidal potentiality, it entered the equation at step one. The multiple R for this variable equals to .208, which suggests that Self-awareness accounts for approximately 4.3% of variance (R^2 = .043). The F being 8.98 (df = 1/198) which is highly significant (p<.01). Motivating oneself appears to be another potent predictor which took entry at step two. Multiple R increased to .249 with the entry of motivating one-self in the equation after self-awareness. The F being 6.51 (df = 2/197) which is highly significant (p<.003). It means that self-awareness and motivating oneself jointly account for approximately 6.2% of the variance in suicidal potentiality. The results of stepwise regression analysis revealed that the linear combination of self-awareness and motivating oneself account significant proportion of variance (i.e. 6.2%) in suicidal potentiality among adolescents.

DISCUSSION

In the present era suicide behaviour is a global public health problem throughout the World. The results of present study show that psychological capital and emotional capital have the positive effective to prevent the suicidal potentiality. Results revealed that there is inverse relationship between psychological capital and suicidal potentiality as well as emotional capital and suicidal potentiality. The higher the psychological capital/emotional capital related to the lower the suicidal potentiality. Both psychological capital and emotional capital may have a strong protective effect against suicidal behaviour. As per regression analysis hopelessness measure of psychological capital, and self-awareness and motivating oneself measures of emotional capital are significant predictor of suicidal potentiality. Some earlier studies also supported the results of this study, which besides the psychological, biological causes and social factors has a central role in suicide causes and distribution (Riaz Hassan, 1996). Aradilla-Herrero, Tomás-Sábado, Gómez-Benito (2013) studied to indicate that high scores on emotional attention are linked to heightened emotional susceptibility and an increased risk of suicide. The risk factors

increase the probability of negative outcomes for youth and others, and then protective factors promote positive outcomes. Protective factors enhance resilience in youths by promoting healthy development and mitigating risk factors. It promotes effective and remarkable coping skills, confidence, and self-esteem, and is generally able to make positive contributions to society. Accumulated evidences show that strengthening the protective factors in schools, homes and local communities as well as improving quality of mental health care for adolescents, can make important contributions to improving developmental outcomes of vulnerable young people (Erlangsen, Jeune, Bille-Brahe & Vaupel, 2004).

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