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Social Capital and Suicide: Social Workers' Obligation toward Contemporary Suicide Prevention

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Abstract

According to the World Health Organization (WHO), "approximately 1 million die by suicide in the world every year and it is estimated that 1.5 million will die from suicide in 2020."To many in the social work field feels this is disturbing news that deserves far more attention both by the academics and the mass-media. This study pertains to the applications of social capital theory and its everyday practice in the social work profession. In particular, the study provides a deeper understanding and review of social capital, suicide and its application of social capital theory in the social work practice with the major goals being prevention of suicide, both micro and macro. For the most part, suicide appears to be an intimately individualistic act. Sociologists, however, often regard variation in suicide rates as a social phenomenon. The initial ideas and work of Durkheim have long formed the basis for many sociological studies of suicide with a strong reference to Durkheim theories of how social factors influence suicide rates that have received substantial empirical support. However, a more contemporary version of Durkheim's regulation/integration thesis is the theory of social capital developed by Robert Putnam. Along with Putnam, Sociologist defines social capital to the stock of trust, civic engagement and norms of reciprocity existing in a community that allow collective actions to occur. Communities are higher in social capital when their residents are generally more trusting, more co-operative and more engaged in community life. Many recent studies, especially those in the public health literature, have examined the relationship between social capital and mental health. High levels of social capital are associated with lower mortality and with fewer accidents and suicides, though suicide research continues to be limited on its direct connection to social capital. Along these lines, research is also limited in social work education and far more extensive studies are in great need. Some studies in social work education shows that education in suicide prevention and intervention in social work graduate programs are little; yet social workers' experiences and attitudes regarding suicide education are limited and in some cases, unknown. Therefore, this paper will make an in-depth comprehension of social capital theory and how it could be used in social work education programs in order to prevent suicide.

Key Words: social capital, social work, suicide, engaging, reciprocity and Putnam Theory

1. Introduction

According to the World Health Organization (WHO), approximately 1 million people die of suicide globally every year and it is estimated that by year 2020, 1.5 million people will die from suicide. Consequently, the global suicide rate is at 14 suicides per 100,000 inhabitants, 18 suicides per 100,000 for males and 11 suicides per 100,000 for females (WHO, 2011).

For the most part, suicides around the world are perceived to be an individualistic act. However, Sociologists often assume suicide as a social phenomenon. The ideas and innovative research studies of Durkheim (1951) have had a profound impact on sociological studies of suicide. Arguably, Durkehim theories about the impact of social factor on suicide rates have received ongoing considerable experimental support (Aliverdinia & Pridemore, 2009; Chandler & Tsai, 1993; Danigelis & Pope, 1979; Kushner & Sterk, 2005; Pridemore, Chamlin, & Cochran, 2007; Stack, 1980, 1983, 1987, 2000, 2001).

After the Durkheim theory of regulation/integration, a more contemporary version of his thesis is the theory of social capital developed by Robert Putnam (2001) in Bowling Alone: The Collapse and Revival of the American Community. This theory is not specially applied for reasons of suicide; instead, Putnam argues that the community benefits when its members know and interact with one another. Social capital is accumulated through social participation mechanism.

Social capital has already been used to investigate patterns of homicide, employment acquisition and academic performance, delinquency and health outcomes but there is little evidence examining the relationship between social capital and the most acute form of social dislocation suicide.

Suicide happens when a person ends his/her life forever. However, this is only part of the problem. Most of the time, people that commit suicide survive more often than die. As a result, most of them are seriously injured and need medical care. They may have serious injuries like broken bones, brain damage or organ failure. In addition, those who survive from suicide often have depression and other mental health issues long after. It also affects the health of the community. According to WHO's statistics, 50-120 million are intensely affected by the suicide or attempted suicide of a close relative. Family and friends of people who commit suicide may feel shock, anger, guilt and depression. The medical costs and lost wages associated with suicide also take their toll on the community.

Statistics show that 60 percent of world's suicides occur in Asia, so each year in Asia at least 60 million people are affected by suicide or attempted suicide (Beautrais, 2006). In spite of the high suicidal rate, this has received less attention in Asian countries because the lack of resources and competing priorities, cultural influences, religious sanctions, stigmatization of the mentally ill, political imperatives and socio-economic factors which have all played a very significant role in someone not receiving much proper attention to this demanding problem. Although there are some highlights in terms of preventive initiatives, overall efforts are uncoordinated, under-resourced and generally unevaluated (Beautrais, 2007; Vijayakumar & Rajkumar, 2007; WHO, 2011).

Due to the issues mentioned above, research on suicide seems necessary for the social work profession to focus their energies on. Unfortunately, Feldman and Freedenthal (2006) shows that education in suicide prevention and intervention in social work graduate programs are little; yet social workers' experiences and attitudes regarding suicide education are unknown. A Web-based survey of 598 social workers currently working in the field discovered that although most participants' received little, if any training in suicide prevention or intervention while in graduate schools, almost all respondents had worked with at least one suicidal client. Most of the respondents viewed their social work program's training to be inadequate in suicide prevention and intervention. That said, this research aims to define social capital theory in order for it to be applied properly with social workers that specializes in suicide prevention with suicidal people and families.

2. Definition of Social Capital

The idea of capital is particularly from the perspectives of the Marxian view of capital, human capital, and cultural capital that is often applied to economics and sociology disciplines. Recently, the study of social capital has changed the researchers' imagination, which provides another way of conceptualizing the social world (McKenzie & Harpham, 2006). To gain a better perceptive of social capital, it is vital to explain the concept of the term capital, which initially came from Marx's idea.

N. Lin (2001) defined capital as an "investment of resources with expected returns in the marketplace" (p. 3), representing that capital is seen as resources that purposely can be mobilized to make profits for the agent. On the one hand, social capital can be measured as capital because it serves as a precious resource for the goals achievement. Similarly, since it is embedded within social relationships and social structure it can also be regarded as "social" (Kay & Johnston, 2007). In other words, when trying to employ social capital in the mental health field it is vital to pay attention to the elements of the social relations and the social structure. Social capital is a debatable issue among different scholars. The definition of social capital has varied due to different theory bases and concerns. Among researchers social capital is considered as both individual and ecological (Field, 2003; Portes, 1998). A French sociologist, Bourdieu, defined social capital as: "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu, 1986, p. 249).

Because of Bourdieu's heavy abstraction, which is rooted in French social theory, the influence of Bourdieu in the development of the construct of social capital tends to be underestimated (Webber, 2004). Bourdieu's definition of social capital has been broken down into two components by Portes (1998) as follow: "(a) It is the social relationship itself that allows individuals to claim access to resources within their social networks; and (b) it involves the amount and quality of those resources" (pp. 3-4).Therefore, Bourdieu assume the concept of social capital as instrumental, which may benefit an individual by asset of participation in groups and purposeful construction of sociability (Portes, 1998). In short, Bourdieu theory of social capital is seen as a form of power relations that the powerful can remain powerful through the connection with other powerful people (Webber, 2004) and can be seen as a property of individuals.

In contrast, other scholars, such as Coleman and Putnam, considered social capital as possessions of groups and communities. Colman, an American sociologist, defined social capital as the resources that exist in family relations and in community social organizations; thus, social capital inheres in the structure of social relations between individuals and among individuals (Coleman, 1988; Field, 2003). Basically, social capital forms useful capital resources for actors through processes, such as building upon obligations, trustworthiness, expectations, creating channels for information and setting norms (Coleman, 1988; Webber, 2004). Coleman extended the scope of social capital to include the social relations of non-elite groups, unlike Bourdieu who believed that only people who hold power can gain benefits from social capital (Webber, 2004). Putnam, a prominent American political scholar, modified the communitarian view and measures on social capital at an aggregated level. Putnam affirmed social capital as "the features of social life-networks, norms and trust that enable participants to act together more effectively to pursue shared objectives" (Putnam, 1996). The characteristics of social capital include (a) "social networks and density, including personal networks and community networks; (b) civic engagement; (c) local civic identity; (d) reciprocity and norms of cooperation; and (e) trust in the community" (Mckenzie & Harpham, 2006, p. 14). Simply put, the benefits of Putnam's idea of social capital are conceptualized to have an equally impact on everyone within a particular community or group, regardless of differences in individual behavior or values (Webber, 2004). In his review of the varying definitions of social capital, suggested that the components of social capital include "trust, social norm, and reciprocity, as well as features of structures and networks and the resources embedded within them" (p. 90). In this view, the concept of social capital goes beyond the perspectives of social support and social networks because it involves trust, civic engagement and norms, which are not only related to social networks.

Lin (2001) viewed social capital as an "investment in social relations by individuals through which they gain access to embedded resources to enhance expected returns of instrumental or expressive actions" (p. 19). What significantly differentiates Lin's definition than of other scholars, such as Putnam and Coleman, is Lin's definition on social capital, which he states is a measurement of relational asset that "must be distinguished from collective assets and goods, such as culture, norms, trust, and so on" (Lin, 2001, p. 27).
According to the previous analysis, the definition of social capital is diverse with many conceptual consensuses.

3. Types of Social Capital

Even though some scholars consider social capital as contextual, others consider it as individual. Some studies have shown it as multidimensional concept (McKenzie & Harpham, 2006; Mitchell & Bossert, 2007). In this view, measures of social capital could be at both individual and ecological levels (Kay & Johnston, 2007).

Concept of social capital consists of at least two dimensions: bonding/bridging and structural/cognitive (McKenzie & Harpham, 2006; Yamaoka, 2008).

3.1 Structural and Cognitive Social Capital

Cognitive social capital reflects attitudes consisting of values, altruism, norms, reciprocity and civic responsibility (McKenzie & Harpham, 2006; Whitley & McKenzie, 2005; Yamaoka, 2008). The measurement of cognitive social capital is related to the level of trust or a sense of belonging in a community or organization (McKenzie & Harpham, 2006).

In comparison, structural social capital is characterized by behavioral aspects of network connections, including the relationships, associations, networks and institutional structures that link individuals and groups to one another (McKenzie & Harpham, 2006; Whitley & McKenzie, 2005; Yamaoka, 2008).

The measurement of structural social capital is often associated to network density (McKenzie & Harpham, 2006). For instance, membership in a sport club or an organization can be seen as an individual's structural social capital. Discrepancies regarding the property of structural and cognitive social capital still exist among scholars. Some have suggested that these types of social capital can be measured at both individual and community levels (Almedom, 2005; Yamaoka, 2008). However, some researchers have considered both structural and cognitive social capital as properties that are ecological rather than individual in nature and have suggested that they can only be measured at the community level (Whitley & McKenzie, 2005). Although ambiguities involving conceptualizations and measurement still remain in the construct of social capital, a large number of studies have shown that social capital is multidimensional (Whitley & McKenzie, 2005). Thus, studies about suicide should consider a comprehensive approach and regard social capital as both individual and ecological.

3.2 Bonding and Bridging Social Capital

Another dimension of social capital consists of bonding and bridging that is a form of strong ties. Bonding can be explain as inward-focused that concerns homogeneity, loyalty, strong norms, and exclusivity, such as people in one's own community or with a similar social identity (De Silva, Huttly, Harpham, & Kenward, 2007; McKenzie & Harpham, 2006; Whitley & McKenzie, 2005). In these relations, the ties between people are stronger and closer. Bonding social capital sometimes is not positive and sometimes may have negative effects on society, such as gang groups or organized crime (McKenzie & Harpham, 2006). In contrast, bridging social capital is defined as outward-oriented that often refers to different groups in society such as people outside one's community or with someone of a different social background (De Silva, McKenzie, Harpham, & Huttly, 2005; McKenzie & Harpham, 2006; Whitley & McKenzie, 2005). In this framework, the ties between people are weaker and more delicate (McKenzie & Harpham, 2006). Overall, it appears that the effect of bridging social capital is often positive as opposed to negative (Almedom, 2005; Lin, 2001; McKenzie & Harpham, 2006).

4. Risk Factors of Suicide

The idea that suicide is influenced by social factors was popularized by Durkheim, who argued that changes associated with modernization were related to an increase in suicide within European nations (Durkheim, 1897). Feeding off of his work, researchers have identified a number of population-level correlates of suicide, including divorce, fertility rates, education, religion, migration, and location of residence e.g., rural versus urban areas (Stack, 2000; Yip, Callanan, & Yuen, 2000). Suicide rates have also been related to trends in national economies (Lester, 2001) and employment e.g., female labor force participation, unemployment, and type of employment (Andersen, Hawgood, Klieve, Olves, & DeLeo, 2010; Blakely, Collings, & Atkinson, 2003; Stack, 2001), as well as income and health care expenditures (Neumayer, 2003; Zimmerman, 2002).

Most psychological autopsy studies of children and adolescents have limited their inquiry to psychiatric risk factors. Rudd, Joiner, and Rajab (2001) propose that risk factors of suicide can be divided into static (i.e. enduring, stable) and dynamic (i.e. alterable, inconsistent) categories and have worth in assessing suicidal ideation and attempts. Included factors among the static variables are: age (escalation of risk with age, particularly after 45 years) (Buda & Tsuang, 1990), a previous psychiatric diagnosis (Tanney, 1992), a previous history of suicidal behavior (Rudd et al., 1996), sex (males have an increased risk compared to females) (Garrison, 1992), existence of family history of suicide attempts (Roy, 1992) and a history of sexual or physical abuse (Linehan, 1993).

Included among the list of acute risk factors for suicide are: hopelessness, depression and worthlessness, identifiable stressors with a focus on loss (e.g. a divorce, loss of a job) (Yufit & Bongar, 1992), a current DSM-IV Axis I diagnosis of a mood disorder, psychotic disorder, or substance-related disorder (Rudd et al., 1993), physical health problems (Yufit & Bongar, 1992), impulse control problems (Rogers, 2001), and active suicidal thoughts (Clark & Fawcett, 1992).

5. Social Capital and Suicide

As mentioned above research constantly suggests a variety of factors associated with suicide ideation, including: social support; undesirable life events and circumstances; depression, and physical health (Gliatto & Rai, 1999; Mazza & Reynolds, 1998; Reifman & Windle, 1995; M.D. Rudd, 1990; Schutt, Meschede, & Rierdan, 1994; Vilhjalmsson, Sveinbjarnardottir, & Kristjansdottir, 1998). Although stressors generally decline an individual's social resources and thus increase distress, the impact of these distresses on suicide ideation have been shown to be buffered or moderated by these resources (Schutt, Meschede, & 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 & 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.

While the use of the term 'social capital' is quite recent (Bourdieu, 1986; Coleman, 1988; Lin, 2001; Putnam, 1993) the notion that social ties are a personal asset is basic to sociology itself (Portes, 1998). In the work of Robert Putnam, however, the term of social capital has got new life, new questions and even a degree of confusion in regard to research on the link between social ties and well-being. Putnam defines social capital as social networks and the connected norms of reciprocity and trust that come out of them. He describes two basic forms of social capital, bonding and bridging. These two were explained before, further making this difference between two crucial types of social capital. Putnam, due to his measuring of social capital, outlines a wide range of forms, including: political, workplace connections; civic and religious participation; volunteering and philanthropy; informal social connections as well as trust and reciprocity. A number of scholars criticized this spread out view of social capital (Boggs, 2001; Portes, 1998).

According to Portes (1998), in spite of the concept's growing use, it has not been defined sufficiently. No real boundaries exist as to explain the content of social capital. Lin (2001) has been attempted to qualify the term of social capital by providing a more structurally and resource-conscious understanding of it. According to Lin, social capital focuses on the resources embedded in the individual's social networks. In this point of view, the social asset is reliant on the resources contained within it. All social asset units are not equal and they are dependent on the value of the resources embedded within them (Lin, 2001). This approach suggests that social capital's impact on personal well-being will be variable across social position in spirit it reflects the social condition that the poor generally pay more for less. Thus, it is important to explore the impact of social capital on well-being among groups such as those that have a higher rate of suicide in order to discover how their suicide attempt are related to social ties and resources. 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, & Ritchey, 2007; Harpham, Grant, & Rodriguez, 2004; Moffitt, 2002; Putnam, 2001; Zhang & Goodson, 2011). Putnam, in *Bowling alone* (2001), claims that the best measure of individual and community well-being is social integration. In particular, people with more connections are healthier. Also, these benefits have been found with a multitude of social capital measures: family ties; social group participation; friendship; as well as civic affiliations and religious; and a diversity of health outcomes. 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. In addition, the amount of an individual's social ties is the best predictor of his /her level of happiness. 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 & Harpham, 2006).

Although recent researches are compiling on the link between social capital and suicide, the literature is not complete. Some research shows negative links between some forms of social capital and health related outcomes.

Specially, research findings conducted on low-income populations and communities show that individual social capital may not always benefit those who take it (Caughy, O'Campo, & Muntaner, 2003; Mitchell & LaGory, 2002) For instance, the research done by Mitchell and LaGory (2002) concludes that bonding social capital actually increases an individual's level of mental distress within poor communities. Likewise, Caughy, O'Campo and Muntaner (2003), in a study of childhood behavioral problems find that social capital in poorer neighborhoods is negatively related to preschool behavioral problems. Exclusively related to suicide, Kushner and Sterk (2005) exhibited those poor communities that are very homogeneous may not benefit from social capital between its members. It may also be the same for physical health outcomes. A study on the impact of social capital on health outcomes found that socioeconomic factors are more vital than social capital in influential health differences (Ziersch, Baum, MacDougall, & Putland, 2005). These findings support Lin's notion that social capital may not impact in the same manner, persons in different positions in the social structure. Most notably the research evidence show that deprived populations do not always benefit in meaningful ways from social capital. According to Lin (2001), social capital involves the resources that exist in social networks. Thus, for bonding social capital, if the resource base is low and the resources are highly segregated, such capital may at best 'help people to get by'. At worst, such ties can actually become imbalanced exchanges with harmful consequences. In such examples, resources either reduce quickly or the social assets become networks of contract rather than exchange (Thoits, 1995). That said bonding social capital may have limited benefit for well-being, generally for the disadvantaged. Bridging capital, on the other hand, offers an individual access to resources and opportunities not normally available. In essence, it will have a positive impact on the mental health and physical health (Fitzpatrick et al., 2007).

6. Social Capital and Social Work Practice

In order to use social capital in the social work practice, it is necessary to understand that the concept of social capital (i) is different and separate from social support and social networks, (ii) has both negative and positive elements and (iii) operates at the individual, community and institutional levels and could be applicable in all social work settings. Ideally, social work practice would take advantage of the inclusion of the multidimensional framework within social capital to improve the understanding of social support and social networks as well as the consequence of their interaction (Ersing & Loeffler, 2008; Loeffler et al., 2004; Miller-Cribbs & Farber, 2008; Mukherjee, 2008). Most social work measures and models' focus is individual-centric, assessing from the viewpoint of the person-in-environment and its attention is far away to focus on environmental interventions. Clearly, this has led to much debate on the profession regarding the commitment to and types of activism for social change and the pursuit of social justice (Reisch, 2008).

In addition to social work practice is the notion of social capital that could be used in combination with other clinical approaches. Social capital is also nicely fitted with the practice models such as life model assessment based on the ecological framework that focuses on a client's interaction with their environments (Germain & Gitterman, 1996). Cultural assessments that highlight the understanding of clients' ethnic and cultural background in the framework of their situations can be strengthened together with the structural analysis of social capital (Congress, 2002). Also in Narrative therapy that allows clients to externalize their 'stories' (White, 2007) offers a chance for clients to recognize social capital resources and challenges, understanding the interaction of individual and larger structural factors such as ethnicity or class. Within community based development, social capital resources are useful in the procedure of community development as well as in the practice of building social capital that generally is part of the community development process.

The theoretical basics of community development from a social capital point of view operates out of a 'individual benefit' contexts which Putnam and a few other experts tend to dispute; instead, Putnam argues that experts should consider a more broad way of approaching it from a 'collective benefit' model.

7. Conclusion

The aim of the current study was to define social capital theory, its relation to suicide and the usage of this theory in the social work practice. Understanding and acting on the ecological and individual determinants of suicide is even more important from a global health point of view. In fact, suicide is already one of the leading causes of death in young people in low- and middle-income countries (Patton, Coffey & Sawyer, 2009). More significantly, if the factors that fuel this outcome are in fact related to social capital, then, it is equally necessary that social workers pay more attention to this demanding social issue.

The uniqueness of this research is its sound approach to explore new areas of social work as it relates to suicide. Because of the lack of research on this topic in relations to suicide and "collective benefits," the researchers tend to explore more deeply its usages, benefits, challenges as well as new ways of applying. Since this discipline is relatively new in the social work profession, far more research must be applied when pertaining to people of different genders, ages, cultures, ethnics, nationalities as well as to incomes.

In summary, social workers should focus more on building social capital with all communities in order to prevent suicide, locally as well as globally. Clearly, the contemporary social work field is not operating in this fashion but with evidence based research and a change in university curriculums and attitudes, social workers will become more competent when interacting with suicidal clients after applying this new mode of thinking. In short, social workers become more responsive and accountable to the individual client and the communities' needs.

Reference

Aliverdinia, A., & Pridemore, W. A. (2009). Women's fatalistic suicide in Iran: a partial test of Durkheim in an Islamic Republic. *Violence Against Women, 15*(3), 307-320. doi: 10.1177/1077801208330434

Almedom, A. M. (2005). Social capital and mental health: an interdisciplinary review of primary evidence. [Research Support, Non-U.S. Gov't Review]. *Soc Sci Med, 61*(5), 943-964. doi: 10.1016/j.socscimed.2004.12.025

Andersen, K, Hawgood, J, Klieve, H., K, olves, K, & DeLeo, D (2010). Suicidein selected occupationsin Queensland :Evidence from the state suicide register. *Australian &NewZealand Journal of Psychiatry, 44, 243–249.*

Beautrais, A.L. (2006). Suicide in Asia.

Beautrais, Annette. (2007). The Contribution to Suicide Prevention of Restricting Access to Methods and Sites. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 28*(0), 1-3. doi: 10.1027/0227-5910.28.s1.1

Blakely, T.A., Collings, S.C.D., & Atkinson, J. (2003). Unemployment and suicide. Evidence for a causal association? *J Epidemiol Community Health, 57*(8), 594-600.

Boggs, C. (2001). Social capital and political fantasy: Robert Putnam's Bowling Alone. *Theory and Society, 30*(2), 281-297.

Bourdieu. (1986). The forms of capital. *Richardson, J. (ed) Handbook ofTheory and Research for the Sociology ofeducation, New York: Greenwood Press*.

Buda, M., & Tsuang, M.T. (1990). The epidemiology of suicide: Implications for clinical practice. *Suicide over the life cycle: Risk factors, assessment and treatment of suicidal patients*, 17-37.

Cattell, V. (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science & Medicine, 52*(10), 1501-1516.

Caughy, M.O.B., O'Campo, P.J., & Muntaner, C. (2003). When being alone might be better: neighborhood poverty, social capital, and child mental health. *Social Science & Medicine, 57*(2), 227-237.

Chandler, C.R., & Tsai, Y.M. (1993). Suicide in Japan and in the West. Evidence for Durkheim's theory. *International journal of comparative sociology, 34*(3-4), 244-259.

Clark, D.C., & Fawcett, J. (1992). Review of empirical risk factors for evaluation of the suicidal patient.

Coleman. (1988). Social capital in the creation of human capital. *American journal of sociology*, 95-120.

Congress, E. (2002). Cultural and ethnic issues working with culturally diverse patients and their families: Use of the culturagram to promote cultural competency in health care settings. *Social Work in Health Care, 39(3/4), pp. 249–62.*

Danigelis, N., & Pope, W. (1979). Durkheim's theory of suicide as applied to the family: An empirical test. *Social Forces, 57*(4), 1081-1106.

De Silva, M. J., Huttly, S. R., Harpham, T., & Kenward, M. G. (2007). Social capital and mental health: a comparative analysis of four low income countries. [Research Support, Non-U.S. Gov't]. *Soc Sci Med, 64*(1), 5-20. doi: 10.1016/j.socscimed.2006.08.044

De Silva, M. J., McKenzie, K., Harpham, T., & Huttly, S. R. (2005). Social capital and mental illness: a systematic review. [Review]. *J Epidemiol Community Health, 59*(8), 619-627. doi: 10.1136/jech.2004.029678

Durkheim, E. (1897). Suicide: A sociological study. *Paris, Alcan*.

Ensel, W.M., & Lin, N. (1991). The life stress paradigm and psychological distress. *Journal of Health and Social Behavior*, 321-341.

Ersing, R.L., & Loeffler, D.N. (2008). Teaching students to become effective in policy practice: Integrating social capital into social work education and practice. *Journal of Policy Practice, 7*(2-3), 226-238.

Feldman, B.N., & Freedenthal, S. (2006). Social work education in suicide intervention and prevention: An unmet need? *Suicide and Life-Threatening Behavior, 36*(4), 467-480.

Field, J. (2003). Social capital. *London ; New York: Routledge*.

Fitzpatrick, K. M., Irwin, J., Lagory, M., & Ritchey, F. (2007). Just thinking about it: social capital and suicide ideation among homeless persons. *J Health Psychol, 12*(5), 750-760. doi: 10.1177/1359105307080604.

Fitzpatrick, Kevin M., Irwin, Jessica, LaGory, Mark, & Ritchey, Ferris. (2007). Just Thinking about It. *Journal of Health Psychology, 12*(5), 750-760. doi: 10.1177/1359105307080604

Garrison, C.Z. (1992). Demographic predictors of suicide.

Germain, C.B., & Gitterman, A. (1996). *The life model of social work practice: Advances in theory & practice*: Columbia University Press.

Gliatto, M. F, & Rai, A. K (1999). Evaluation and treatment of patients with suicidal ideation. *American Family Physician, 59, 1500–1513.*

Harpham, T., Grant, E., & Rodriguez, C. (2004). Mental health and social capital in Cali, Colombia. [Research Support, U.S. Gov't, P.H.S.]. *Soc Sci Med, 58*(11), 2267-2277. doi: 10.1016/j.socscimed.2003.08.013.

Kawachi, I., & Berkman, L.F. (2001). Social ties and mental health. *Journal of Urban Health, 78*(3), 458-467.

Kay, F.M., & Johnston, R. (2007). Ubiquity and disciplinary contrasts of social capital. *Social capital, diversity, and the welfare state*, 17-40.

Kushner, H.I., & Sterk, C.E. (2005). The limits of social capital: Durkheim, suicide, and social cohesion. *Journal Information, 95*(7).

Lester, B.Y. (2001). Learnings from Durkheim and beyond: the economy and suicide. *Suicide and Life-Threatening Behavior, 31*(1), 15-31.

Lin, N. (2001). Social capital: A theory of social structure and action. *New York: Cambridge University Press*.

Linehan, M. . (1993). Cognitive-Behavioural Treatment of Borderline Personality Disorder. *New York: Guilford Press*.

Loeffler, DN, Christiansen, DC, Tracy, MB, Secret, MC, Ersing, RL, Fairchild, SR, & Sutphen, R. (2004). Social capital for social work: Toward a definition and conceptual framework. *Social Development Issues, 26*(2/3), 22-38.

Mazza, J.J., & Reynolds, W.M. (1998). A longitudinal investigation of depression, hopelessness, social support, and major and minor life events and their relation to suicidal ideation in adolescents. *Suicide and Life-Threatening Behavior, 28*(4), 358-374.

McKenzie, K., & Harpham, T. (2006). *Social capital and mental health*: Jessica Kingsley Pub.

Miller-Cribbs, J.E., & Farber, N.B. (2008). Kin networks and poverty among African Americans: Past and present. *Social Work, 53*(1), 43-51.

Mitchell, A.D., & Bossert, T.J. (2007). Measuring dimensions of social capital: Evidence from surveys in poor communities in Nicaragua. *Social Science & Medicine, 64*(1), 50-63.

Mitchell, C.U., & LaGory, M. (2002). Social capital and mental distress in an impoverished community. *City & Community, 1*(2), 199-222.

Moffitt, TE. (2002). the E-Risk Study Team. Teen-aged mothers in contemporary Britain. *Journal of Child Psychology and Psychiatry, 43*(6), 727-742.

Mukherjee, D. (2008). Reassembling the Social Environment: A Network Approack to Human Behavior. *Advances in Social Work, 8*(1), 208-218.

Neumayer, E. (2003). Are socioeconomic factors valid determinants of suicide? Controlling for national cultures of suicide with fixed-effects estimation. *Cross-Cultural Research, 37*(3), 307-329.

Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *LESSER, Eric L. Knowledge and Social Capital. Boston: Butterworth-Heinemann*, 43-67.

Pridemore, W.A., Chamlin, M.B., & Cochran, J.K. (2007). An Interrupted Time-Series Analysis of Durkheim's Social Deregulation Thesis: The Case of the Russian Federation. *Justice Quarterly, 24*(2), 271-290.

Putnam, R. (2001). Community-based social capital and educational performance. *Making good citizens: Education and civil society*, 58-95.

Putnam, R.D. (1993). with R. Leonardi and RY Nanetti (1993) Making democracy work: civic traditions in modern Italy: Princeton: Princeton University Press.

Putnam, R.D. (1996). Who killed civic life. *The American Prospect, 24*.

Putnam, R.D. (2001). *Bowling alone*: Simon & Schuster.

Reifman, A., & Windle, M. (1995). Adolescent suicidal behaviors as a function of depression, hopelessness, alcohol use, and social support: A longitudinal investigation. *American journal of community psychology, 23*(3), 329-354.

Reisch, M. (2008). From melting pot to multiculturalism: The impact of racial and ethnic diversity on social work and social justice in the USA. *British Journal of Social Work, 38*(4), 788-804.

Rogers, J.R. (2001). 37 SUICIDE RISK ASSESSMENT. *The Mental Health Desk Reference: A Practice-Based Guide to Diagnosis, Treatment, and Professional Ethics*, 259.

Roy, A. (1992). Genetics, biology, and suicide in the family.

Rudd, M.D, Joiner, T, & Rajab, M.H. (2001). Treating Suicidal Behaviour: An effective, time-limited approach. *New York: Guilford Press*.

Rudd, M.D. (1990). An integrative model of suicidal ideation. *Suicide and Life-Threatening Behavior, 20*(1), 16-30.

Rudd, M.D., Rajab, M.H., Orman, D.T., Stulman, D.A., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: preliminary results. *Journal of consulting and clinical psychology, 64*(1), 179.

Schutt, R.K., Meschede, T., & Rierdan, J. (1994). Distress, suicidal thoughts, and social support among homeless adults. *Journal of Health and Social Behavior*, 134-142.

Stack, S. (1980). The effects of marital dissolution on suicide. *Journal of Marriage and the Family*, 83-92.

Stack, S. (1983). The effect of the decline in institutionalized religion on suicide, 1954-1978. *Journal for the Scientific Study of Religion*, 239-252.

Stack, S. (1987). *The effect of female participation in the labor force on suicide: A time series analysis, 1948–1980*. Paper presented at the Sociological Forum.

Stack, S. (2000). Suicide: a 15-year review of the sociological literature part I: cultural and economic factors. *Suicide and Life-Threatening Behavior, 30*(2), 145-162.

Stack, S. (2001). Occupation and suicide. *Social Science Quarterly, 82*(2), 384-396.

Tanney, B.L. (1992). Mental disorders, psychiatric patients, and suicide.

Thoits, P.A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior*, 53-79.

Vijayakumar, L., & Rajkumar, S. (2007). Are risk factors for suicide universal? A case-control study in India. *Acta Psychiatrica Scandinavica, 99*(6), 407-411.

Vilhjalmsson, R, Sveinbjarnardottir, E, & Kristjansdottir, G. (1998). Factors associated with suicide ideation in adults. *Social Psychiatry and Psychiatric Epidemiology, 106, 97–103*.

Webber, M. (2004). Mental health and social capitals * Author's reply. *The British Journal of Psychiatry, 184*(2), 185-b-186. doi: 10.1192/bjp.184.2.185-b.

White, M. (2007). *Maps of narrative practice*: WW Norton & Company.

Whitley, R., & McKenzie, K. (2005). Social capital and psychiatry: Review of the literature. *Harvard Review of Psychiatry, 13*(2), 71-84.

WHO. (2011). Suicide prevention (SUPRE).

Yamaoka, K. (2008). Social capital and health and well-being in East Asia: a population-based study. *Social science & medicine (1982), 66*(4), 885.

Yip, P.S.F., Callanan, C., & Yuen, H.P. (2000). Urban/rural and gender differentials in suicide rates: East and West. *Journal of Affective Disorders, 57*(1), 99-106.

Yufit, RI, & Bongar, B. (1992). Suicide, stress, and coping with life cycle events. *Assessment and prediction of suicide*, 553-573.

Zhang, Jing, & Goodson, Patricia. (2011). Predictors of international students' psychosocial adjustment to life in the United States: A systematic review. *International Journal of Intercultural Relations, 35*(2), 139-162. doi: 10.1016/j.ijintrel.2010.11.011.

Ziersch, A. M., Baum, F. E., MacDougall, C., & Putland, C. (2005). Neighbourhood life and social capital: the implications for health. *Social Science & Medicine, 60*(1), 71-86.

Zimmerman, S.L. (2002). States' spending for public welfare and their suicide rates, 1960 to 1995: what is the problem? *The Journal of nervous and mental disease, 190*(6), 349-360.