Hopelessness, depression and suicidal ideation among young adults in urban and rural areas

This thesis is submitted in partial fulfillment of the requirements for the Degree of Doctor of Philosophy in Psychology

Faculty of Biological Sciences, University of Dhaka, Dhaka-1000

Submitted by:

Jebin Nahar

Registration No: 111

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Department of Psychology

University of Dhaka

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Supervisor's Certificate

This is to certify that I have read the thesis entitled "**Hopelessness, depression and suicidal ideation among young adults in urban and rural areas"** submitted by **Ms. Jebin Nahar** (Reg.No.111/2018-19) in partial fulfillment of the requirements for the award of Ph.D. Degree in Psychology, Faculty of Biological Sciences of University of Dhaka and it is an original study carried out by her under my supervision and guidance.

.

Professor Dr. Mahfuza Khanam

Supervisor

Department of Psychology

Faculty of Biological Sciences

University of Dhaka, Dhaka, Bangladesh

Email: mahfuza.khanam@du.ac.bd

Declaration

The work embodied in the dissertation entitled "**Hopelessness, depression and suicidal ideation among young adults in urban and rural areas**" was conducted at the Department of Psychology, University of Dhaka, in partial fulfillment of the required for the award of Ph.D. degree of University of Dhaka. The work has not been submitted in part or full to this or any other university or institution, for any degree or diploma.

Jebin Nahar

Registration No: 111: 2018-2019

Department of Psychology

University of Dhaka

Dedicated

To

My Parents, Husband and Daughters (Nishat Tasneem and Tahsina Tasneem)

Abstract

The purpose of the study was to investigate the relation among hopelessness, depression and suicidal ideation among young adults in urban and rural areas of Bangladesh. A mixed method, comprising a cross sectional survey design and qualitative component were used in the present study. Data was collected from 384 young adults. Colleges were selected following random sampling technique and respondents were selected by using convenient sampling technique. Among the total sample 344 were non-clinical and 40 were clinical adult respondents from different areas of Dhaka city and Chowgacha upozilla under Jashore district. The Bangla version of Hopelessness scale, depression scale and suicidal ideation scale were used to measure the hopelessness, depression and suicidal ideation. The obtained data were analyzed by using Pearson Product Moment correlation, stepwise multiple regression and ANOVA. Results showed that suicidal ideation was positively correlated with hopelessness and depression. The result of multiple stepwise linear regression was calculated to find out whether suicidal ideation can be predicted by hopelessness and depression. Result reveals that hopelessness is a significant predictor of suicidal ideation ($\beta = .60$; $p < 0.001$).Whereas the results of simple regression were calculated to find out whether depression predicts suicidal ideation among young adults. A significant regression equation was found ($F= 189.75$), with an R^2 of 0.33. Model R, Std. Beta 0.16, 0.57, that is independent measure depression indicated as the significant predictor of suicidal ideation. The ANOVA results showed that there is a significant difference in hopelessness between two types of participants ($F=30.26, p<0.1$). On the other hand, no significant difference in hopelessness is found according to residential status and gender. No two ways interaction and no three ways interaction among types of participants, resident status and gender were found statistically significant in hopelessness. Results also indicates a significant difference in depression

according to type of participants (*F=34.80, p<0.1*). But it shows that depression scores does not vary significantly according to resident status and gender. Moreover, in case of depression, no two ways or three ways interaction was found to be significant. Findings also reveal that there is a significant difference in suicidal ideation between two types of participants (*F=33.89,p<.01),* resident status (*F=5.15, p<.01)* and gender (*F=5.76, p<.01).* Two way interactions between resident status and gender has found to be significant (*F=3.93, p<0.1)* in suicidal ideation. No two way interactions between types of participant and resident status and between types of participant and gender are found statistically significant and no three way interactions among types of participant, resident status and gender are found to be significant in suicidal ideation.

The analysis of focus group discussion indicates that hopelessness, depression, unexpected result in examination, family conflicts, low socio-economical condition, relationship break-up, social isolation, financial crisis, bulling and sexual violence are the important causes of suicidal ideation.

The present study reveals an urgent need that for betterment of the students and identifying their problems and to provide them counseling services health care providers, educators, mental health professional and policy makers should take proper steps.

Keywords: Hopelessness, , Depression, Suicidal ideation, Young adults

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CHAPTER-I
Introduction

Hopelessness, depression and suicidal ideation among young adults in urban and rural areas

Introduction

Suicide is a neglected global public health problem and Bangladesh is not an exception. Unfortunately, suicide also often fails to be prioritized as a major public health problem. Approximately, one million people commit suicide every year worldwide. A 65% increase in the rate of suicide during the past 45 years has been occurred around the world (World Health Organization, 2004). Sixty percent of all cases of suicide in the world occur in Asia and 39.6 per 100,000 in Bangladesh. Suicide can occur at any point of the lifespan, and is the second most frequent, and in some countries the leading cause of death among young people aged 15-24 years (World Health Organization, 2015). In addition, around 20-30 times as many suicide attempts occur (Wasserman, 2001).

World Health Organization (WHO) estimates for the year 2020 and based on current trends approximately 1.53 million people will die from suicide and 10-20 times more people will attempt suicide worldwide which represents on average 1 death per 20 second and 1 attempt every 1-2 seconds (Feroz & et al.,2012; Khan 2005; Ali & et al.,2014). Now-a-days, suicide has become a daily occurrence event in Bangladesh. About 10,000 persons are dying by suicide per year in the country (World Health Organization 2014; Mashreky et al., 2013; Shahnaz et al., 2017; Begum et al., 2017a) which was reported by WHO. It is the fourth leading cause of overall injury-related deaths and second important cause of injury-associated death in age groups of 20-39 years in Bangladesh (Mashreky et al., 2013).

Bangladesh is a densely populated country and its economy is rising in South Asia having more incidence rate of suicide than the other Asian countries. Current review reveals that suicide rate in South Asia is high compared to the global average, and still there is scarce

of reliable data on suicide rates in South Asia (Jordans & et al., 2014). Till now there is no national suicide surveillance system. Besides no nationwide study on suicidal risk factors has been yet initiated (Khan 2005; Arafat 2017; Shah et al., 2017; Chowdhury et al., 2018). Furthermore, it is still a criminal offence in the legal system (Arafat, 2017).

Young age is a period of life where in attaining ones a personal goal is a primary necessity (Phipps, Long, Wood & Cassmeyer, 1991). In today's society, young people are in competition with society and this results greater expectation from one's self. Fright of failure also contributes to the psychological pressures on young. Sense of hopelessness, need for others and isolation are risk factors for suicide in young (Hockenberry & Wilson, 2007). Beck and Steer believe that hopelessness is a psychological state that can be the basis of certain psychological disorders and presents as a negative attitude towards self in the future (1988). The response of young people towards an uncertain future presents as loss of hope that results in dangerous behavior.

Hopelessness is another risk factor that predicts suicide ideation in young adults. Hopelessness is the experience of despair or extreme pessimism about the future (Beck, 1979). According to Schneidman (1996), hopelessness-helplessness is the most common emotion experienced among suicide people. Numerous studies have found a link between feelings of hopelessness and suicidal ideation, attempts and completions. (Abramson et al., 1998; Beck, Steer & Brown,1993; Chioqueta& Stiles, 2005; Evans et al., 2004; Konick & Gutierrez, 2005; Pinto & Whisman, 1996; Kuo, Gallo & Eaton, 2004; Simons & Murphy, 1985; Smith et al., 2006; Spirito & Esposito-Smythers, 2005). Hirsch et al. (2007) and Weber et al. (1997) have shown that there is significant association between hopelessness and suicide ideation among college students, where high levels of hopelessness are linked to high levels of suicidal ideation. For years, research has supported the notion (Beck, Steer, Kovacs,

& Garrison, 1985; Dixon, Heppner & Rudd, 1994; Gibb et al., 2006; Heisel, Flett & Hewitt, 2003; Lipschitz, 1995; Stephenson et al., 2006). Clearly, hopelessness is also a risk factor predictive of suicidal ideation.

Hopelessness is one of the major components of Beck's negative cognitive trait i.e. negative cognitions about future. Non-fulfillment of one's own expectations and the expectations of significant others is a serious matter which could potentially result in loss of face which in turn leads to loss of confidence and support from one's family and these results in hopelessness. Previous research has shown that hopelessness was related to adolescent suicidal ideation. Several studies found that there was a significant relationship between hopelessness and suicidality (Rutter PA and AE Behrendt, 2004) and hopelessness was found to be the strongest of cognitive variables in concurrent association with suicidal ideation (Stewart SM et al., 2005). Researchers also reported that hopelessness was the best predictor of suicidal ideation in students and adolescents experiencing bipolar disorder (Smith J M et al., 2006). However, there is a high association with hopelessness in the long-term suicide risk.

Hopelessness:

Hopelessness is a belief that conditions will not enhance later on includes the desire of negative results consolidated with desires, that those negative results are out of one's control (Abramson, Alloy, &Metalsky, 1989). According to the hopelessness theory of suicide (Cornette, Abramson, & Bardone, 2000), a negative subjective life works as helplessness for the development of hopelessness. Hopelessness is a proximal reason for the manifestation of depression, including suicidal thoughts and behaviour (Orden et al., 2008).

Hopelessness has been characterized in a different way. Engel (1968) have characterized it as an emotional state showing the feeling of difficulty, the inclination that life is too much to deal with, and disregard. The person turns out to be extremely inactive and cannot anticipate constantly being in an alternate situation. The lack of care results from his failure to adapt to the present and from a conviction that nothing will ever change. In Scotland's (1969) definition, hopelessness has been determined as a system of negative expectations concerning oneself and one's future life (Bruss, 1988). Hopelessness means a sense of impossibility, negative hopes for the future, loss of control in connection to the future, inactive acknowledgment or the worthlessness of wanting to accomplish goals (Campbell, 1987).

Hopelessness and Its relation with Hope and Despair

Despair means an absence of hope, while hopelessness implies an offensive type of despair, where all hope is lost (Mc Gee, 1984). Many authors have depicted hopelessness as being orientated to or focusing on the past (Bruss, 1988; Cutcliffe, 1997; Collins & Cutcliffe, 2003; Engel, 1968). Mc Naught and Spicer (2000) emphasized that hopelessness has not been characterized as having any desires without bounds but as having negative desires without bounds and recommend that the future of hope does not really mean the absence of hopelessness; the capacity to take control and end one's own suffering can give an individual hope without moderating hopelessness.

Dynamics of Hopelessness

Farran, Herth, and Popovich (1995), researched on hope and hopelessness and stated that the developmental roots of hopelessness lies in intra-personal, interpersonal and

environmental/sociological experiences. As situational determinants of hopelessness, those associated with a person's life stage, sickness and treatment settings have been illustrated, and also three levels of hopelessness (and hope). On the lowest, no hopelessness is being experienced. The middle level of hopelessness might be experienced as people's troublesome life experiences. These feelings of hopelessness are short-lived in nature and with activation of e-sources, they can be managed and they may even come out with increase in physical, mental, and spiritual or personal satisfaction. On the third level, hopelessness is more certain and people have given up to the test. In its most extreme form, this pathological level of hopelessness is shown as dysfunctional behaviour including the feeling of depression and suicidal ideation (Beck et al., 1975). Hopelessness as a trait has been described in cognitive behavioral theories (Beck et al., 1985; Abramson et al., 1989), where hopelessness has been thought to be an etiological element as forerunner for the onset or running of depression.

Hopelessness: Facet of Depression or Distinct Entity

Hopelessness a major manifestation of depression has been determined as a system of negative anticipations concerning oneself and one's future. Hope is an essential determinant of subjective prosperity (Stotland, 1969). Lack of hope is related to different signs of psychological morbidity. Psychological variables related to hopelessness in the general population include depression, suicidal ideation, and alexithymia which mean a poor capacity to perceive and verbalize feelings and remotely situated state of mind (Haatainen et al., 2004). A few studies proposed that hopelessness may be even a more intense risk component of suicidality than depression (Beck et al., 1993; Salter & Platt, 1990).

Impact of Hopelessness on Suicidal Ideation

Hopelessness is one of the significant parts of Beck's negative cognitive trait i.e. negative insights about future. When confronted with a negative occasion, people with an antagonistic speculation process are vulnerable to depression because they will derive that contrary outcomes will take after this pessimistic occasion and that event of the occasion implies that the people themselves are useless or defective (Mc Ginn, 2000).The expressiveness of hopelessness in conjunction with a mental disorder, for example, depression represents an exceptionally dangerous cautioning sign and should be considered as serious. It is a kind of feeling that conditions can never improve, that there is no resolution for a problem, and for several inclinations that dying by suicide would be better than living. Most of the people who feel hopeless have depression, and untreated depression is the main reason for suicide. There is a high relationship with hopelessness in long-term suicide risk.

As per Beck's formulation, hopelessness is a centre norm for depression and serves as the connection amongst depression and suicide. Moreover, hopelessness related to another psychiatric issue likewise inclines the patient to suicidal behavior. The central part of hopelessness is the development of suicidal ideation (Bedrosian& Beck, 1979; Dyer &Kreitman, 1984; Minkoff et al., 1973; Nekanda-Trepka, et al. 1983). Wetzel et al. (1980) reviewed tending to the relationship between depression, hopelessness, and suicidal ideation. They revealed that the dominant nature encouraged the association between hopelessness and suicide plan.

The Hopelessness Theory of Depression

The hopelessness theory was developed, in large measure, as a response to limitations in Seligman's (1972) learned helplessness theory of depression. This earlier model of depression was based in part on the finding that dogs that were repeatedly exposed to

uncontrollable shocks would cease to attempt to escape even when this possibility was later made available to them (Overmier & Seligman, 1967; Seligman & Maier, 1967). In brief, this theory posits that repeated exposure to uncontrollable and aversive environmental stimuli leads gradually to the belief that the aversive situation is inescapable and a sense of helplessness ensues regarding the situation. This helplessness, in turn, results in depression. This model was limited in that it was unable to explain why certain individuals become depressed when confronted with an uncontrollable stressor whereas others did not (Abramson, Seligman, & Teasdale, 1978).Which was initially termed a reformulation of the theory of learned helplessness, Abramson and colleagues (1978) drew on attribution theory to address this issue. They proposed that the causal attribution formed by individuals in response to a negative life event influences their risk for becoming depressed. It was hypothesized that individuals form causal attributions along three different dimensions, from internal to external, stable to unstable, and from global to specific. According to this reformulated theory, those who attribute a negative event to internal, stable, and global causes were at greater likelihood of developing depression. This theory would predict, for example, that an individual who has an argument with an acquaintance is more likely to become depressed if they interpret this event as a product of their poor interpersonal ability (internal), which they believe will never change (stable) and will negatively influence all their other social interactions (global). In contrast, the individual is at lower risk for depression if they attribute the same event to the acquaintance's irritability (external), brought about by having a bad day (unstable), and believes this is uncharacteristic of their other social interactions (specific).

This theory was later revised in a more fully articulated form as the hopelessness theory of depression (Abramson et al., 1989). What follows below is a summary of the etiological chain detailed in this theory, including its subsequent extensions, to account for depressogenic risk, progressing from more distal to more proximal processes.

Depression

Depression is a serious health problem that can affect people of all ages, including children and adolescents. At any given time, up to 15 percent of children and adolescents have some symptoms of depression and the incidence of depressive disorders markedly increases after puberty. Adolescent depressive disorders often have a chronic, waxing and waning course, and there is a severe risk of depression persisting into adulthood. Depression impacts growth and development, school performance, and peer or family relationships, and it can be fatal. Major depressive disorder is a leading cause of youth suicidal behavior and suicide. In the United States the prevalence has been shown to be as high as 8.3 percent. This is similar to findings in European countries. It is well recognized that adolescence is a major transitional period in a person's life including unusually large cognitive, emotional, social, and physical changes. Current neurobiological research indicates that adolescents, around puberty in particular, may be overly sensitive to stress as compared with children and adults. Adolescence has been described as a sensitive period due to brain development, a phase in the life-span where vulnerability towards development of depression is heightened. In general, adolescents experience stressful situations such as those concerning family relations, school performance, interpersonal relationships (friends and romantic partners), and financial restraints. If demands of these situations exceed the individuals' capacity to cope, there will be an increased risk of depression, anxiety, and/or drug and alcohol abuse. According to UNICEF report (2010) it is estimated that around 20 per cent of the world's adolescents have

a mental health or behavioral problem. Depression is the single largest contributor to the global burden of disease for people aged 15–19 in middle-to-high income countries. Globally, an estimated 71,000 adolescents commit suicide annually, while up to 40 times as many make suicide attempts. The prevalence of mental disorders among adolescents has increased in the past 20–30 years; the increase is attributed to disrupted family structures, growing youth unemployment and families' unrealistic educational and vocational aspirations for their children.

Symptoms of depression

Depression symptoms include:

- Feelings of sadness or unhappiness¬Irritability or frustration, even over small matters
- Loss of interest or pleasure in normal activities
- Reduced sex drive-Insomnia or excessive sleeping
- Changes in appetite
- Depression often causes decreased appetite and weight loss, but in some cases it causes increased cravings for food and weight gain
- Agitation or restlessness for example, pacing, hand-wringing or an inability to sit still-Irritability or angry outbursts
- Slowed thinking, speaking or body movements
- Indecisiveness, distractibility and decreased concentration
- Fatigue, tiredness and loss of energy - even small tasks may seem to require a lot of effort
- Feelings of worthlessness or guilt, fixating on past failures or blaming yourself when things aren't going right
- Trouble thinking, concentrating, making decisions and remembering things

- Frequent thoughts of death, dying or suicide
- Crying spells for no apparent reason
- Unexplained physical problems, such as back pain or headaches Depression affects each person in different ways, so symptoms caused by depression vary from person to person. Inherited traits, age, gender and cultural background all play a role in how depression may affect you.

Depression as a Theoretical Construct

Depression is a construct that is the part of a more extensive class of mental thoughts. Ought to establish researchers choose that melancholy contains an alternate group of syndromes (e.g.; suicide ideation, as opposed to disgraceful mood, is the characterizing highlight of depression), the nature of depression itself would change, the attributes of individuals diagnosed with depression would be distinctive and epidemiological information on the predominance of depression would be changed (Ingram & Siegle, 2002).

Depression as a Clinical Syndrome

DSM-IV-TR is the way to deal with the psychological disorder; the disorder is perceived as discrete substances that happen autonomously of other discrete disorders, despite the fact that these other discrete disorders can also happen and offer ascent to co-morbidity. In this manner, depression is one of numerous particular classifies of disorder (Ingram & Siegle, 2002).

Types of Depression

There are several kinds of depressive disorders:

Major depression disorder: Major depression involves at least five of the symptoms listed below for a two-week period. Such an episode is disabling and will interfere with the ability to work, study, eat, and sleep. Major depressive episodes may occur once or twice in a lifetime, or they may recur frequently. They may also take place spontaneously, during or after the death of a loved one, a romantic breakup, a medical illness, or other life event. Some people with major depression may feel that life is not worth living and some will attempt to end their lives.

Depression DSM-5 Diagnostic Criteria

A. The DSM-5 outlines the following criterion to make a diagnosis of depression. The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.

9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

D. The occurrence of the major depressive episode is not better explained by schizoaffective, schizophreniform disorder, delusional disorder or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Persistent Depressive Disorder: PDD is a form of depression that usually continues for at least two years. Although it is less severe than major depression, it involves the same symptoms; sad mood combined with low energy, poor appetite or overeating, and insomnia or oversleeping. It can show up as stress, irritability, and mild anhedonia, which is the inability to derive pleasure from most activities.

Psychotic Depression: Psychotic depression is taken very seriously by mental health professionals because the individual suffering from it is at an increased risk of self-harm.

The suicide rate in people with psychotic depression, when they are ill and in their acute phase, is much higher than it is with major depression," says Anthony J. Rothschild, MD, the Irving S. and Betty Brudnick Endowed Chair, Professor of Psychiatry at the University of Massachusetts Medical School in Worcester, Massachusetts and the author of the *Clinical Manual for the Diagnosis and Treatment of Psychotic Depression.*

Seasonal Affective Disorder (SAD): It is a type of recurring major depression with a seasonal pattern. According to the Diagnostic and Statistical Manual of Mental Disorders DSM-5 (APA, 2013), criteria for depression with a seasonal pattern include having depression that begins and ends during a specific season every year (with full remittance during other seasons) for at least two years and having more seasons of depression than seasons without depression over a lifetime. Seasonal pattern disorders occur most frequently in winter although they can also occur in summer.

Symptoms of SAD

Symptoms of winter seasonal pattern disorders center on sad mood and low energy (S. K. Elmore, 1991; J.M. Gilland et al., 2008; N. Hairon, 2007; B. K. Timby and N. E. Smith, 2005; C. Zauderer and C. A. Ganzer, 2015). Information for the lay public identify that people with SAD can feel sad, irritable, and may cry frequently; and they are tired and lethargic, have difficulty concentrating, sleep more than normal, lack energy, decrease their activity levels, withdraw from social situations, crave carbohydrates and sugars, and tend to gain weight due to overeating (National Health Service, J. Blaszczak, 2013; Mayo Clinic, Medicine Net.com).

Conversely, in addition to irritability, symptoms of the less frequently occurring summer seasonal pattern disorder center on poor appetite with associated weight loss, insomnia, agitation, restlessness, anxiety, and even episodes of violent behavior (R. Dryden-Edwards, 2015; D.Oren, 2014). It is important to note that seasonal pattern disorders vary in severity. Some individuals may experience a milder form of SAD known as subsyndromal S-SAD (Canadian Mental Health Association, 2009; S.Kasper et al., 1989; R. W. Lam et al., 2001), or most commonly as winter blues.” However, others can be severely incapacitated and unable to function. In some instances, symptoms of SAD can be as severe as those

experienced by in-patients with non seasonal depression (T. Dalgleish et al., 2010; N. E. Rosenthal et al., 2009). Like all depressive disorders, thoughts of suicide may be present (R. Lam and A. Levit, 1990; N. Praschak-Rieder et al., 1997). Health professionals must always implement suicide assessments with people they believe have or might have SAD.

Causes of Depression

The causes may be different for everyone and are very complex. Some causes include:

Genetics: Depression tends to run in families. So, if someone in your immediate family (parent or brother/sister) has Depression, you are more likely to develop Depression than someone without Depression in his or her family.

Trauma and Stress: Experiencing major stressors (e.g., relationship breakup, job loss) or significant trauma (e.g., death of a loved one, abuse, or neglect; especially as a child) can trigger Depression in certain people. Research has found that the impact of stressors may depend on your genetics, as some people's genetics make them more vulnerable to stress than others.

Illness: Certain medical conditions and medications can sometimes lead to depression.

Patterns of Negative Thinking: Teens are usually exposed to pessimistic thinking. Depression can also be developed among them especially from their parents, and who learn to feel helpless instead of how to overcome challenges.

Impact of Depression on Suicidal Ideation

Depression is prevalent in all cultures (Kessler et al., 2003; Simon et al., 2002; The WHO World Mental Health Survey Consortium, 2004; Vincente et al., 2004; Weissman et al., 1996; Williams, et al., 2002), leads to considerable burden (Murray & Lopez, 1996;

Murray & Lopez, 1997) and impairment in social functioning, low productivity, lost income (Bolton et al., 2004; Pincus, K. et al., 2003) and is a major cause of premature death, mainly through suicide.

Hence suicide is a major public and mental health problem in Asia. Asian researchers have inclined to give more focus on the relationship of suicidal phenomena with socio-cultural factors such as family conflicts, social issues rather than with psychological factors like depression. The scarcity of research on the association between mental disorders and suicide in Asian was revealed in a recent global analysis, which reports only 1.3% of the cases from this continent (Bertolote, Fleischmaougnn, DE Leo & Wasserman, 2003). Although suicides occur in mild to moderate depression, the crucial and causal role of depression in suicide is less pronounced in Asia (Lakshmi, 2005; Hawton, Van Heeringen, 2000; Lee et al., 2007).

However, increasing the severity of depression escalates the like hood of the suicidal ideation. Suicide attempts and suicidal behavior (Fennig & Hadas,2010; Goldney, Wilson, Dal Grande, Fisher & Mc Farlance,2000; Lonnqvist,2000; Roberts & Chen,1995; Girish et al.,2008; Pezawas et al.,2002; Rihmer,2007; Vijayakumar et al., 1999).

Different factors increase the risk of attempting suicide among the youths which range from the lowest risk level factors to the highest ones and are put in categories such as personal, family, demographic, social environment and daily stress factors. Low risk factors originate from small matters in family and educational environment and end in now and then feelings of sadness without the individual's having depression previously. In addition, those who are in the middle ground of risk for attempting suicide have some suicidal thoughts, usual depression symptoms, anxiety and temper control problems. Those who have the high risk for attempting suicide may be exiled from their homes, have no meaning for continuing their life and think it would be better if they had died. They hate their family members and

educational environment are often absentees in their classes (American academy of Paediatrics, 2000).

Suicidal Ideation

Suicidal ideation is known as suicidal thought and is thoughts about how to kill one. Those might be as particular as a detailed arrangement, however without the suicidal act itself. Although most people who experience suicidal ideation do not confer suicide, some do move specifically to attempt suicide. The suicidal ideation range varies from fleeting thoughts to certain planning, role-playing, and unsuccessful tries which could be each deliberately made to fail or are completely meant to achieve success but are dissatisfied via discovery. Appropriately speaking, suicidal ideation suggests that wanting to take one's own life or considering suicide while not primarily making arrangements to commit suicide (Gliatto& Rai, 1999).

Suicidal ideation is considered a predictor of suicide attempts (Wichstrom L, 2000). In this sense, suicidal ideation could be considered a first step to increase completed suicide risk (Gould MS et al., 1996). Therefore, it's important to consider suicidal behaviors as a continuum construct following a pattern of ideation, planning, attempts and completed suicide and to identify its beginning. Onset age of suicidality is between 10 and 15 years (Borges G et al., 2007).

Besides contributing to lethal outcome, suicidal ideation in early adolescence can produce negative consequences to a life time. Adolescents who reported suicidal ideation have a higher probability of presenting an axis I disorder - according to the Diagnostic and

Statistical Manual of Mental Disorders, 4th edition; problem behaviors and poorer coping abilities, low self-esteem levels and interpersonal relations (Reinherz HZ et al., 2006).

Suicidal behavior

Suicidal behavior refers to a range of behaviors that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself. The inclusion of ideation in suicidal behavior is a complex issue about which there is meaningful ongoing academic dialogue. The decision to include ideation in suicidal behavior was made for the purpose of simplicity since the diversity of research sources included in this report is not consistent in their positions on ideation.

Suicidal Attempt

The suicidal attempt is any demonstration of self-injury intentionally going for self destruction (Stengel & Cook, 1958). Suicide attempt includes those circumstances in which an individual has played out a real or appearing life-threatening behavior with the purpose of exploring his life or giving the presence of such goal, but which has not resulted in death. A suicidal attempt in the past research referred to a non-deadly act by the individual himself.

Suicidal Thought

Suicidal thought is called as suicidal ideations are thoughts about how to kill oneself, which can range from a stepwise plan to a transitory thought and does exclude the last plan of killing oneself. The majority of individuals who encounter suicidal ideation do not carry it through. Some might be that, makes suicide attempts. Some suicidal ideations can be intentionally wanted to discover or fail, while others may be precisely wanted to succeed. As indicated by a Finnish research, more than one-fifth of individuals who really died by suicide

had talked about their aim with a doctor or other health care proficient during their last session (Gliatoo & Rai, 1999).

Suicidal ideation among Young Adults

Suicidal behaviors are enlisted as leading causes of death worldwide, especially among adolescents and young adults (Kochanek KD et al., 2009). Data from different sources have echoed the same findings that suicide is the second leading cause of death among young adults ages 18–25 (Center for Disease Control and Prevention Suicide Prevention, 2021), next to the leading cause of injury (Center for Disease Control and Prevention Suicide Prevention, 2019). As its own developmental period, the period from ages 18–25 is sometimes referred to as “emerging adulthood”, “the frontier of adulthood”, or “the novice phase” (Massachusetts Institute of Technology, 2003). From the lifespan perspective, this young adulthood signifies an important life stage transiting from children or adolescents to adults who can fulfill cultural expectations such as becoming financially independent and starting their own families. Youth in this age group experience many transitions, including graduating from high school, leaving home for college, facing school difficulties, looking for jobs, starting careers, forming new intimate relationships, making new friends, developing their own identity, moving from place to place for opportunities, changing living circumstances, and having family turmoil, to name but a few. With high expectations at the societal level, young adults may encounter stressful situations that trigger mental health problems such as anxiety, anger, confusion, depression, disappointment, hopelessness, insecurity, isolation, loss, stress, sadness, and withdrawal (Furlong A.2003; Orbach I., 2006; Patton G.C et al., 2016). All these mental health challenges are associated with an increased risk of suicide and suicidal behaviors. Protective factors such as financial resources, access to health care, social support from families and friends, and effective communication can reduce

the likelihood of suicide. In contrast, risk factors such as a depletion of financial resources, lack of health care, unsuccessful coping strategies, social isolation, and failure at conflict resolution may accelerate negative consequences such as suicide and suicidal behaviors.

In developed countries, three times as many men die of suicide than women do, but in developing countries the male-to-female ratio is much lower at 1.5 men to each woman (WHO, 2013). However, due to social and cultural stigma, actual rate of suicide is believed to be under-reported in developing country. Despite the scope and seriousness of the problem, relatively little is known about the prevalence, correlates, or treatment of suicidal behavior (i.e., suicidal ideation, plans, and attempts) in developing country like Bangladesh. Suicide takes approximately 10,000 lives each year, and is one of the major causes of death in young adult females in Bangladesh (Mashreky SR et al., 2013). Additionally, love affairs and depression tend to be concerns of young adults attempting to end their lives.

Signs and Symptoms of Suicidal Ideation

Behavioral Symptoms:

- Talking about killing oneself or harming oneself
- Talking about death and dying
- Seeking out items that could be used in a suicide attempt
- Loss of interest in daily activities
- Writing stories, poems, or internet postings about death and dying
- Increased drug or alcohol usage
- Getting affairs in order – making out a will, giving away favorite possessions, making arrangements for family members

- Saying goodbye – calling or visiting friends and loved ones and saying goodbye as if they won't be seen again
- Withdrawing from friends and family members
- Increasing social isolation
- Desire to be left alone
- Reckless driving
- Unsafe sex
- Sudden sense of calm and happiness after being severely depressed
- Taking unnecessary risks

Physical Symptoms:

- Neglecting physical appearance
- Changes in sleeping or eating habits
- Weight loss or gain

Cognitive Symptoms:

- Preoccupation with thoughts of death and dying
- Belief that one is helpless or trapped
- Belief that nothing will improve
- Belief that one is a "burden" to others

Psychosocial Symptoms:

- Hopelessness
- Worthlessness
- Shame
- Self-hatred
- Guilt
- Drastic mood changes

- Sudden changes in personality – going from withdrawn to outgoing
- Feeling that the future is a bleak place
- Feeling as though there is nothing to look forward to
- Untreated mental illnesses

Causes of Suicidal Ideation

Suicide ideation can occur when a person feels that they are no longer able to cope with an overwhelming situation. This could stem from financial problems, the death of a loved one, the end of a relationship, or a debilitating illness or health condition.

Some other common situations or life events that might cause suicidal thoughts include grief, sexual abuse, financial problems, remorse, rejection, and unemployment.

The following risk factors may increase the chance of suicide ideation:

- A family history of violence or suicide
- A family history of child abuse, neglect, or trauma
- A history of mental health issues
- A feeling of hopelessness
- Knowing, identifying, or being associated with someone who has completed suicide
- Engaging in reckless or impulsive behavior
- A feeling of seclusion or loneliness
- Identifying as LGBTQIA+ with no family or home support
- Not being able to access care for mental health issues
- A loss of work, friends, finances, or a loved one
- Having a physical illness or health condition
- Possessing a gun or other lethal methods

- Not seeking help due to fear or stigma
- Stress due to discrimination and prejudice
- Historical trauma, such as the destruction of communities and cultures
- Having attempted suicide before
- Experiencing bullying or trauma
- Exposure to graphic or sensationalized accounts of suicide
- Exposure to suicidal behavior in others
- Experiencing legal problems or debt
- Being under the influence of drugs or alcohol

Conditions that researchers have linked to a higher risk of suicide ideation include:

- Depression
- Schizophrenia
- Bipolar disorder
- Some personality traits, such as aggression
- Conditions that affect relationships
- Traumatic brain injury
- Conditions that involve chronic pain
- Alcohol or drug dependence
- Borderline personality disorder
- Post-traumatic stress disorder

Risk factors for suicidal ideation among young adults

Hereditary: People those are naturally belonging to families with mental illness or suicidal thoughts are at a higher risk of creating suicidal thoughts or emotional sickness themselves. However, there is a hereditary part to suicidal ideation and maladjustment. Not

everyone who has a family history will create suicidal ideations, nor each one of the individuals who have suicidal ideation has a family history of the disorder (Cannon, & Hudzik**,** 2014).

Physical risk factor: The physical cause is a kind of thought process that particularly changes the structure and capacity of the cerebrum through low levels of the neurotransmitters “dopamine and serotonin”, and it can build the risk for emotional instability, including those that cause suicidal thoughts and behaviour (Goodwin, & Jamision, 2007).

Environmental risk Factor: Those who are barraged with rehashed, negative life occasions and experience steady levels of major stress that overpower their capacity to adapt are at higher threat of suicide. Also, those presented to other people who passed on by suicide are at more serious risk for creating suicidal ideation themselves. The most common situations or lives occasions that may bring about suicidal thought are the pain, sexual abuse, financial issues, regret, dismissal, relationship, separation and unemployment (Rockefeller, 2017). Another study showed that relationship breakups, parental divorce, death of a loved one, military deployment of a parent, academic failure, and physical/sexual child abuse are events often cited as occurring prior to a suicidal attempt. (Kidd, S., et al., 2006).

Psychological Risk Factor: Mental health problems and psychiatric disorders are known to be a risk factor for suicidal behavior among adolescents. In one study, Shaffer and Craft (1999) found that over 90% of adolescents who committed suicide had suffered from one or more psychiatric disorders (such as anxiety, depression, post-traumatic stress disorder, or schizophrenia).These psychiatric disorders place youth at an increased risk of suicide, but any combination of these disorders can increase the risk of suicide substantially. Depression is the most common disorder associated with adolescent suicide and suicidal behaviors, and

often co-exists with other diagnosed disorders. For example, prior suicide attempts by the adolescent increase the chances of subsequent suicidal behaviors and death.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) (online). (2010).

The epidemiology of suicide in Bangladesh

This study set out to explore the epidemiology of suicide in Bangladesh. A cross-sectional study was carried out during 2003 (January to December). This encompassed a population of 819,429 of all age-groups and sexes. Data was collected by face-to-face interviews at a household level. Suicide was found to be the leading cause of death by injury in the age group of 10-19 years. Adolescent females (10-19 years age group) were found to be the most vulnerable. Overall, the suicide rate was 7.3 (95% CI 5.6-9.5) per 100,000 per year and the highest rate was found in the age group of 60+ years. The rate of suicide was found to be 17-fold higher (95% CI 5.36-54.64) in the rural population, compared to urban rates. Adolescent suicide rate in rural areas was 20.1 (95% CI 12.6-31.7) per 100,000. The rate was 17.7 (95% CI 8.6-34.9) and 22.7 (95% CI 12-42) among males and females respectively. Poisoning was found as the most frequent method of suicide. The majority of the suicide victims were found to be very poor and illiterate. Suicide is a major public health problem in Bangladesh. Age, place of residence, economic status and literacy were the major associating factors related to suicide. Adolescents, elderly and those residing in rural regions were the most vulnerable groups.

Another recent epidemiological finding is the variation in the characteristics of youth suicide between Asian and Western countries. In rural China, southern India, Sri Lanka and Singapore, the gender differences for suicide are reversed from those in the West, with young women being at higher risk for suicide than young men; the mode of suicide attempts differs

accordingly, consisting mostly of the impulsive use of pesticides (Law, S.; Liu, P., 2008). Unlike Western suicidal youth, female attempters in China do not appear to have major mental illnesses (Phillips, M.R et al., 2002).

Mortality Due to Suicide in Rural and Urban Bangladesh

Population-based surveillance in a rural community in southwest Bangladesh revealed that suicide is a major cause of mortality, especially in young females. Mortality from suicide occurred at a rate of 39.6 per 100,000 populations per year from 1983-2002. Among young people, 10-19 years old, suicide accounted for 42% of deaths; 89% of suicide-associated deaths in this age group were in females. Suicide-associated death rates from this surveillance area are substantially higher than rates reported elsewhere in Asia, warranting further studies aimed at identifying risk factors for suicide and strategies for prevention.

Suicide is one of the three leading causes of death among 15-44 year old people globally (WHO, 2013). Health and demographic surveillance data from 6,953 households in Abhoynagar and Keshobpur, rural and semi-urban sub districts of Jessore District in southwest Bangladesh, collected by ICDDRB during 1983-2002, were analyzed to explore the magnitude and characteristics of suicide and also victim tended to young; 41% were less than 20 years. Surviving family members were interviewed using a standardized data collection form to define cause of death (verbal autopsy) for 3,237 deaths. Of those, 2,061 deaths were in people 10 years old; 161 (8%) were determined to be due to suicide, defined as a self-inflicted cause of death. Mental illness was rarely reported as a cause of suicide. It is possible that in developing countries like our Bangladesh psychiatric diseases are underestimated and family head was unwilling to disclose it because of stigmata of mental illness.

Table-1: Suicide Mortality of young adults aged 15-24 in selected countries and areas

Country / area in ESCAP region	***Suicides per 100000*** **Year**	**Males**	**Females**	**Male to Females Ratio**
Bangladesh	1980-1996	9.3	19.6	0.5
China (rural)	1992	17.4	36.7	0.5
China(Urban)	1992	5.6	10.6	0.5
Hong Kong	1994	9.5	8.7	1.1
Singapore	1994	11.7	10.2	1.1
Sri Lanka	1986	77.0	48.0	1.6
Republic of Korea	1994	11.0	5.9	1.9
Japan	1994	12.0	5.1	2.4
Australia	1990-1992	26.0	5.0	5.0
New Zealand	1990-1993	39.0	6.0	6.0

Source: Ruzicka 1998

Factors Associated with Increased Risk for Suicide:

The following factors are mainly associated with increased risk of suicide:

Suicidal thoughts/behaviors

- Suicidal ideas (current or previous)
- Suicidal plans (current or previous)
- Suicide attempts (including aborted or interrupted attempts)
- Lethality of suicidal plans or attempts
- Suicidal intent

Psychiatric diagnoses

- Major depressive disorder
- Bipolar disorder (primarily in depressive or mixed episodes)
- Schizophrenia
- Anorexia nervosa
- Alcohol use disorder
- Other substance use disorders
- Cluster B personality disorders(particularly borderline personality disorder)
- Co morbidity of axis I and/or axis I Disorders

Physical illnesses

- Diseases of the nervous system
- Multiple sclerosis Huntington’s disease
- Brain and spinal cord injury
- Seizure disorders
- Malignant neoplasm

- HIV/AIDS
- Peptic ulcer disease
- Chronic obstructive pulmonary disease, especially in men
- Chronic hemodialysis-treated renal failure
- Systemic lupus erythematous
- Pain syndromes
- Functional impairment

Psychosocial features

- Recent lack of social support (including living alone)
- Unemployment
- Drop in socioeconomic status
- Poor relationship with family
- Domestic partner violence
- Recent stressful life event

Childhood traumas

- Sexual abuse
- Physical abuse

Genetic and familial effects

- Family history of suicide (particularly in first-degree relatives)
- Family history of mental illness, including substance use disorders

Psychological features

- Hopelessness
- Psychic pain
- Severe or unremitting anxiety
- Panic attacks
- Shame or humiliation
- Psychological turmoil
- Decreased self-esteem
- Extreme narcissistic vulnerability
- Behavioral features
- Impulsiveness
- Aggression, including violence against others
- Agitation

Cognitive features

- Loss of executive function
- Thought constriction (tunnel vision)
- Polarized thinking
- Closed-mindedness

Demographic features

- Male gender
- Widowed, divorced, or single marital status, particularly for men
- Elderly age group (age group with greatest proportionate risk for suicide)

- Adolescent and young adult age groups (age groups with highest numbers of suicides)
- White race
- Gay, lesbian, or bisexual orientation

Additional features

- Access to firearms
- Substance intoxication (in the absence of a formal substance use disorder diagnosis)
- Unstable or poor therapeutic relationship

Source: Assessing and treating suicidal behaviors: a quick reference guide

Structure of Suicidal Behavior

Suicide is a complex public health problem of global dimension. Suicidal behavior is a heterogeneous problem and represents a certain form of communication. It is often a consequence of the ‘cry for help’ as an authentic expression as well as an effort to find out a solution for simultaneously unbearable and unchangeable life situation. Suicidal behaviour (SB) shows marked differences between genders, age groups, geographic regions and socio-political realities, and variably associates with different risk factors, underscoring likely etiological heterogeneity. Although there is no effective algorithm to predict suicide in clinical practice, improved recognition and understanding of clinical, psychological, sociological, and biological factors may facilitate the detection of high-risk individuals and assist in treatment selection. Psychotherapeutic, pharmacological, or neuromodulatory treatments of mental disorders can often prevent SB; additionally, regular follow-up of suicide attempters by mental health services is key to prevent future Suicidal behaviour.

Figure-1 presents some background factors and triggering factors for suicidal behaviour mentioned in the report.

Factors and Processes	
Socio-economic factors Economics crisis Gender Inequity Social support Education Culture Social Security Unemployment Poverty Social fragmentation Social isolation Family support Broken family Education of Parents Family members Step mother/ father Parents separation	**Behavior** Poor relationship with family Domestic partner violence Recent stressful life event Alcohol dependence Shame or humiliation Psychological turmoil Decreased self-esteem Extreme narcissistic vulnerability Behavioral features Impulsiveness Aggression, including violence against others Agitation
Cognitive features Loss of executive function Thought constriction (tunnel vision) Polarized thinking Closed-mindedness Guilty feelings	**Genetic and familial effects** Family history of suicide (particularly in first-degree relatives) Family history of mental illness, including substance use disorders

Triggering factors
Stress, depression , sexual and physical abuse, drug abuse, violence, chronic disease, Mental pressure (love broken , academic result)

Suicidal Behavior

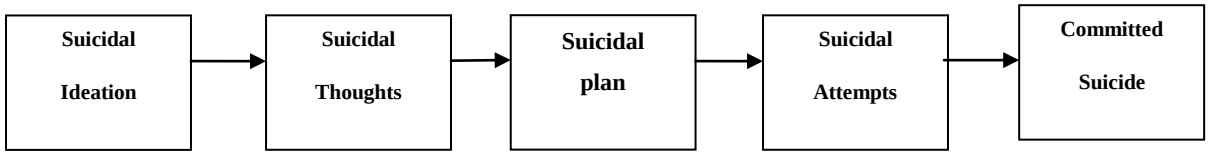


Figure-1: Suicidal process

Socio-economic Characteristics

The second paradigm focuses on the structural level of for example unemployment, poverty since parental disadvantaged position in society are often seen as precursors of abuse and neglect (Garbarino, 1992; Krishnan & Morrison, 1995). In Denmark suicides among adolescents aged 15 to 19 years have been related to parental unemployment (Christoffersen et al., 2003a; Krarup, 1988; Sommer, 1987; Vange, 1986). The levels of unemployment, the educational level in the population, or the degree of polarization between rich and poor people are factors that are obvious beyond immediate control of the family, although the individual parent will blame himself/ herself for being unemployed, poor or marginalized (Sennett & Cobb, 1972).

Parental low socioeconomic status (SES), poverty and educational under achievement were most at risk for offspring's suicidal behavior (Andrews & Lewinsohn, 1992; Beautrais et al., 1998c; Bucca&Fele, 1994; Dubow et al., 1989; Fergusson, 1995; Fergusson et al., 2000; Gould et al., 1996). It is not fully understood whether there is a causal link between unemployment and suicidal behavior, and it is suggested that the association between unemployment and suicidal behavior reflects other correlated factors that contribute to risks of both unemployment and suicidal behavior. Psychiatric disorder could both increase risk of suicidal behavior and increase the risk of unemployment according to the 'healthy worker selection' processes (Agerbo, 2005; Beautrais et al., 1998b; Li & Sung, 1999; Mc Michael, 1976; Sheikh, 2000).

Gender perspective and suicidal Ideation

Differences in age-standardized suicide rates can be found across WHO regions. Suicide rates in the African (12.0 per 100 000), European (12.9 per 100 000), and South-East

Asia (13.4 per 100 000) regions were higher than the global average (10.5 per 100 000) in 2016. The lowest suicide rate was in the Eastern Mediterranean region (4.3 per 100 000). The South-East Asia Region had a much higher female age-standardized suicide rate (11.5 per 100 000) compared to the global female average (7.5 per 100 000). In males, the regions of Africa (16.6 per 100 000), the Americas (14.5 per 100 000), South-East Asia (15.4 per 100,000), and especially Europe (21.2 per 100,000), all had suicide rates which were higher than the global male average (13.7 per 100 000).

While most of the world's suicides occurred in low-and-middle-income countries (79%), high-income countries had the highest age-standardized suicide rate (11.5 per 100 000). Lower-middle-income countries had a slightly lower rate (11.4 per 100 000), and low-income and upper-middle-income countries had lower rates (10.8 per 100 000 and 9.0 per 100 000 respectively). Females in lower-middle-income countries had the highest suicide rate (9.1 per 100 000) compared to females in other income level groupings. Males in high-income countries had the highest rate (17.2 per 100000) as compared to males in other income level groupings (Suicide in the world: Global Health Estimates, 2017).

Suicide was the second leading cause of death in young people aged 15-29 years for both sexes, after road injury. More deaths were due to suicide in this age group than to interpersonal violence. For females and males, respectively, suicide was the second and third leading cause of death in this age group.

Jameson K. Hirsch, Kenneth R. Conner, and Paul R. Duberstein (2007), studied on "Optimism and Suicide Ideation among Young Adult College Students". Participants were 284 undergraduate students (185 female, 99 males) recruited from a large Western University

and a rural Eastern college. The ages of the students ranged from 18–57 years. The sample was predominantly White and the rest being African American, Hispanic, and Asian students. Beck Scale for Suicide Ideation (BSS; Beck, Kovacs and Weissman, 1979), the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester et al., 1974) and Beck Depression Inventory- II (BDI-II; Beck, Steer, & Brown, 1996). It was found that female gender was significantly negatively correlated with optimism and positively associated with depression. Dispositional optimism was significantly negatively correlated with depression, hopelessness, and suicide ideation.

Another study conducted in Malaysia showed that suicidal ideation was higher among males compared with females (Ibrahim et al., 2017). On the other hand, a study from China mainland showed that girls were significantly more likely than boys to report both suicidal ideation and attempts (Cui S et al., 2011).

Among the females, negative life event was significantly associated with suicidal ideation, which was not found in males. People who encountered negative life events often experience psychological problems which contribute to suicidal ideation. The difference between males and females could be explained by the fact that females were more vulnerable when they experienced negative life events compared with males. And the role of female as a socially disadvantaged group made them more susceptible to crisis and negative emotions in setbacks, which made them more likely to have suicidal ideation. Another cause to differ across gender was life satisfaction. Previous study showed that life satisfaction was inversely correlated with suicidal ideation among college students and this correlation tended to be stronger among the seniors than younger people (Liu YX et al., 2012).

According to Gilligan (2004), girls tend to suicidal behavior as a language that commands attention and respect and as an expression of a desire for relationship, while boys turn to violence as an alternative to feeling helpless and powerless. Thus, shifting the interpretation of the suicidal behavior to the relational communication of the violent intention might enable adolescent girls to verbally express their psychological distress. Moreover, strengthening healthy resistance and courage in young children (boys and girls) will prevent violence and enable these young adolescents to say what they feel and to know how to stay in a relationship with others instead of turning to suicidal behaviors.

Relationship between Hopelessness and depression

Beck's (1967) cognitive theory of depression also posits that irrational negative thoughts, stressors, and incidents that create a feeling of being helpless to change a situation contribute to the emotional and cognitive frame of depression. Beck and his colleagues (Beck, A.T.et al., 1975) also suggested that a person with depression will remain stable and will not have suicidal tendencies unless they develop irrational beliefs and feelings of hopelessness.

Hopelessness is defined as one's tendency to possess a negative point of view or a set of negative expectations for the future (Perczel-Forintos, D.;et al., 2010). Individuals who have feelings of hopelessness are often characterized by possessing a negative view about the future and believe that nothing will turn out right for them, that they will never succeed at what they try to do, that their important goals can never be attained, and that their worst problems will never be solved (Beck, A.T. and Steer,1988). In addition to depression, several studies have suggested that hopelessness may play an important role in suicidal thoughts, suicide attempts, completed suicide, low life satisfaction, and some psychiatric disorders for both normal and clinical populations (Cheung, Y.B.et.al., 2006; Kuo, W.H.; G; et al., 2004;

Mystakidou, K.; T. et al.; 2008; Szanto, K.; Reynolds, 1998). Studies have also shown that higher levels of hopelessness are associated with undesirable health problems, such as cardiovascular diseases and high blood pressure (Anda, R et al., 1993 and Everson, S.A et al.; 2000). Available evidence also suggests that hopelessness is a psychological construct with a major role in the relationship between suicide and depression (Sharma, K et al., 2016, Abramson, L.Y.et al., 1998; Beck, A.T et al., 1989 Beck, A.T.; Weissman et al., 1974; Dyer, J.A.T et al., 1984). Moreover, previous research has revealed that mortality rates are higher among those with high levels of hopelessness when compared to those with lower levels of hopelessness (Dong, X. et al., 2014).

The implication of hopelessness in the etiology of suicide was mentioned in the discussion of depression. The most recent suicide research has specified that hopelessness is a better indicator of suicide than depression (Beck et al., 1985; Dyer & Kreitman, 1984; Minkoff, Bergman, Beck & Beck, 1973). Minkoff et al. (1973) found that the amount of suicide intent was more highly correlated with hopelessness than depression.

Beck et al. (1985) conducted a longitudinal study of suicide ideators. High hopelessness scores correctly identified 91% of eventual suicides. When hopelessness was controlled, depression was not significantly related to suicide intent.

Higher hopelessness scores were found for suicide attempters than fornon attempters as well (Goldne, 1981; Topol & Reznikoff, 1982). Further, Dyer and Kreitman (1984) demonstrated that the relationship between depression and suicide intent is dependent on the relationship between hopelessness and suicide intent. Hopelessness, thus, appears to be a potent predictor of suicidal behavior.

Relationship between Hopelessness and suicidal ideation

Hopelessness may serve as a mediator between depressive symptoms and suicidality (Rosellini & Bagge, 2014; Woosley, Lichstein, Taylor, Riedel, & Bush, 2014), indicating that hopelessness may be able to explain the relationship between depressive symptoms and suicidality.

Importantly, Beck and colleagues (1974) identified hopelessness as the key variable that links depression and suicidality in adults, and later suggested that hopelessness may be more informative than the presence of depressive symptoms in examining suicidal ideation (Steer et al., 1993). Current research has also examined hopelessness as a predictor of suicidality (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999), with Labelle and colleagues (2013) finding that hopelessness is predictive of suicidal ideation, even after controlling for depressive symptoms.

Despite the findings in the adult literature, historically there has been a paucity of such research among youth (Steer, Kumar, & Beck, 1993). However, given the findings of previous research that highlight the importance of the role of hopelessness in suicidality, researchers have recently begun to more thoroughly examine the role of hopelessness on suicidality in adolescents. There now exists a growing evidence base to support the role of hopelessness in adolescent suicidal behavior (Groholt, Ekeberg, & Haldorsen, 2006; De Camp & Bakken, 2016; Horwitz, Berona, Czyz, Yeguez, & King, 2017). For instance, De Camp and Bakken (2016) report that adolescents who feel a greater sense of hopelessness are at an increased risk for suicide. Further, Bergen and colleagues (2003) discovered a significant association between hopelessness and risk for suicide, including ideation. In a study by Horwitz and colleagues (2017) exploring the influence of hopelessness on suicidal behavior, the findings indicated that a lack of positive expectations for one's future, as

opposed to the presence of negative expectations, is indicative of future suicidal behavior among adolescents. Indeed, Stewart and colleagues (2005) found hopelessness to be the strongest contributor to concurrent suicidal ideation in adolescents. These findings hold true even when controlling for depression (Nock & Kazdin, 2002; Labelle et al., 2013).

Literature review:

Hopelessness and Suicidal Ideation

Hopelessness is another risk factor that predicts suicide ideation in young adults. Hopelessness is the experience of despair or extreme pessimism about the future (Beck, 1979).

According to Schneidman (1996), hopelessness-helplessness is the most common emotion experienced among suicidal people. Numerous studies have found a link between feelings of hopelessness and suicide ideation, attempts, and completions (Abramson et al., 1998; Beck, Steer, & Brown, 1993; Chioqueta& Stiles, 2005; Evans et al., 2004; Konick & Gutierrez, 2005; Pinto & Whisman, 1996; Kuo, Gallo, & Eaton, 2004; Simons& Murphy, 1985; Smith et al., 2006; Spirito & Esposito-Smythers, 2005).

Hirsch et al. (2007) and Weber et al. (1997) have shown that there is a significant association between hopelessness and suicide ideation among college students, where high levels of hopelessness are linked to high levels of suicide ideation. For years, research has supported the notion that hopelessness is a significant predictor of suicide ideation among college students (Beck, Steer, Kovacs, & Garrison, 1985; Dixon, Heppner, & Rudd, 1994; Gibb et al., 2006; Heisel, Flett, & Hewitt, 2003; Lipschitz, 1995; Stephenson et al., 2006). Clearly, hopelessness is also a risk factor predictive of suicidal ideation.

While numerous predictors and risk factors have been found (e.g., interpersonal stressors (Johnson et al., 2002), history of physical or sexual abuse (Cash & Bridge, 2009), family or peer-related conflict (Kodish et al., 2016), mental illness (Cash & Bridge, 2009), comorbid presentation of these factors (Vander Stoep et al., 2011), a substantive body of literature has surrounded the theory that cognitive variables (e.g., rumination, thinking errors, poor self-efficacy, etc.) may have strong ties with suicidality (Burke et al., 2016; Stewart et al., 2005). Early literature examining suicidality from this cognitive framework has suggested that hopelessness, in particular, may be a key variable in understanding suicidal behavior (Beck, Kovacs, & Weissman, 1975).

More recent literature has continued to explore the role of hopelessness as a cognitive risk factor and has consistently found that hopelessness plays a significant role in suicidal behaviors among adults (Mc Cullumsmith et al., 2014; Kuo, Gallo, & Eaton, 2004; Brown, Beck, Steer, & Grisham, 2000), and has been linked with suicidal ideation (Smith, Alloy, & Abramson, 2006), suicidal intent (Dyer & Kreitman, 1984; Wang, Jiang, Cheung, Sun, & Chan, 2015) and subsequent suicide attempts (Beck, Brown, Berchick, Stewart, & Steer, 1990).

Research has also suggested that hopelessness may serve as a mediator between depressive symptoms and suicidality (Rosellini & Bagge, 2014; Woosley, Lichstein, Taylor, Riedel, & Bush, 2014) indicating that hopelessness may be able to explain the relationship between depressive symptoms and suicidality.

Importantly, Beck and colleagues (1974) identified hopelessness as the key variable that links depression and suicidality in adults, and later suggested that hopelessness may be more informative than the presence of depressive symptoms in examining suicidal ideation (Steer et al., 1993).

Esposito CL and Spirito A et al. (2003) are studies showing that adolescent suicidal ideation was related to family dysfunction, family discord, poor family environment, family rigidity, family conflicts and poor adaptability.

Lee TY et al., 2006 and Wong IN et al., (2002) are Studies also showed that low levels of family cohesion and support as well as high levels of parent-adolescent conflict were positively related to depression and suicidal ideation. However, a study by Mitchell and Rosenthal (1992) yielded inconsistent results. They evaluated families of both suicidal and non-suicidal psychiatric inpatient adolescents and found no significant group difference in terms of the mean family rigidity score.

Sil and Basu (2007) examined the role of hope, hopelessness and reasons for living in the development of suicidal ideation in college students. Significant relationships were found between trait hope, hopelessness, and different dimensions of reasons for living and suicidal ideation.

Abdollahi, A., & Abu, T. M. (2015) studied on the moderating role of spirituality between hopelessness, spirituality, and suicidal ideation, 202 Iranian depressed adolescent inpatients completed measures of patient health, suicidal ideation, hopelessness, and core spiritual experience. Structural equation modeling indicated that depressed inpatients high in hopelessness, but also high in spirituality, had less suicidal ideation than others. These findings reinforce the importance of spirituality as a protective factor against hopelessness and suicidal ideation.

Khan (2011) had intended to analyse the part of depression and hopelessness in suicide ideation on 100 male and 100 females in the age scope of 15-17 years completed, tools used to collect data were Beck’s Suicide Ideation Scale, Beck’s Depression Inventory, and Beck’s Hopelessness Scale. The findings suggested that suicidal ideation, depression, and

hopelessness were correlated. The result also uncovered that suicidal ideation corresponded with depression.

Given that there are numerous factors associated with suicidal ideation, it is important to utilize conceptual frameworks that are capable of explaining the process by which various variables interact with one another to produce suicidal thoughts and feelings (Ferguson, Woodward & Horwood, 2000). The Escape Theory of Suicide (Baumeister, 1990) is one such conceptual framework. The Escape Theory of Suicide provides a theoretical framework for explaining the process by which perfectionism, stress, negative self-attribution, heightened self-awareness, depression, anxiety, hopelessness, and limited reasons for living interact to produce suicidal ideation (Baumeister, 1990).

Kandel, D.B., et al., (1991) the interrelationships of depression and suicide with adolescent drug use, delinquency, eating disorders, and the risk factors for these different problems were investigated among 597 9th and 11th graders in an urban high school. Suicidal youths are ill-adjusted and display a lack of attachment and commitment to family and school. Causal models indicate that poor interpersonal interactions with parents, absence of peer interactions, and life events lead to depression, which in turn leads to suicidal ideation. Understanding the dynamics of suicidal ideation in adolescence has important public health implications, since ideation is a strong predictor of attempts, especially among females.

Many factors can lead an adolescent to suicidal behavior, and these can be divided into two categories: psychological problems (loneliness, worry, hopelessness) (Galaif ER et al.; 2007 and Mahfoud ZR,2005); and social-environmental factors such as low, or lack of, parentalor peer support, harmful alcohol and drug use, smoking (Mahfoud ZR, et al.,2005;

Makhija NJ et al., 2007; Muula AS,2007 and Kaur J et al., 2014), and being bullied or sexually abused (Galaif ER et al., 2007; Mueller AS et al and Montoro R, et al., 2015).

In contrast, parental support, supervision, understanding adolescents' problems and worry, and peer support at schools have all been recognized as protective factors against suicidal ideation (Cheng Y et al., 2009).

Beck AT et al., 1990; Maris RW et al.,1992; and Van Orden KA et al .(2010) are Studies also found that the simultaneous presence of the first two components leads the person to want to commit suicide, whilst the third component empowers the person to commit suicide without fear of death. People must acquire the capability to commit suicide. The more often a person attempts to commit suicide, the more its taboo and the fear and pain associated with self-harm diminish and consequently the easier it is to commit suicide. In this theory, some risk factors for lethal suicide are empirically described, such as mental disorders, previous suicide attempts, social isolation, family conflict, childhood abuse, hopelessness, etc.

Depression and Suicidal ideation

According to Fergusson D. M et al.; (1995) Community surveys have found particularly high levels of suicidal ideation after the ear adolescent phase of development with females usually reporting higher rates of ideation than males (Garrison CZ et al., 1991, Swanson JW et al.; 1992, Lewinsohn PM et al.;1994, Canetto SS 1997, Marcenko Mo et al.;1999). There is also a well-recognized link between depression and suicidal ideation, with depression significantly increasing the likelihood of suicidal ideation (Roberts RE et al.; 1995). Because depression is such an important risk factor, adolescent depression has become a key research focus for suicide prevention among young people (Burns JM et al.; 2000).

During adolescence the prevalence of depression among females increases markedly, while the rise for males is more modest (Kandel DB et al., 1982; Nolen-Hoeksema S et al., 1994 and Merten B, 1990). The female: male ratio for clinical depression changes from approximate equivalence in childhood, to a female preponderance of 2:1 and this approximate ratio continues into adulthood.

Garrison CZ et.al.(1989) and Roberts Retal.(1990) also found that females report higher mean levels of depressive symptomatology and a greater proportion of females scored above standard cut-off points for identifying depression compared with males. Despite a range of promising hypotheses, the reason for this increase in rates of depression for females is not clear (Bebbington PE. 1998).

According to Canetto SS. (1997) the higher levels of depressive symptomatology for females compared with males is one possible explanation for the higher rate of female suicidal ideation. Alternatively gender itself might increase the risk for suicidal ideation quite independently from levels of depression. For example, even with the same level of depression females may be at greater risk of suicidal ideation than males. Indeed some commentators have speculated that females are more likely than males to express ideation in response to even quite low levels of depressive symptomatology and that this trend is more evident among young people in developed countries .

Among a large sample of American adolescents (N = 2,189; 58.3% male; 13–18 years old), Jacobson et al. (2011) found that restrictive emotionality correlated positively with depressive symptoms and suicide ideation/intent. Further, those obtaining higher scores on a measure of restrictive emotionality were more likely to report elevated depression scores;

three times more likely to report suicide ideation (after controlling for depressive symptoms); and more than twice as likely to report attempting suicide (again, after controlling for depressive symptoms). These researchers did not examine the association between the other GRCS-A factors (e.g., NSA) and suicide ideation/intent. Thus, it is unknown how these other facets of GRC link with both depression and indicators of suicidality.

Research suggests that there has been a shift in the onset of depression to a younger age, with onset occurring between the ages of 15 and 19 years old (Burke, Burke, Rae, & Regier, 1991). As stated by Hou, & Ng (2014), those who experience symptoms of mental illness are at greater risk of maladaptation later on in life, and are at greater risk for repeated and prolonged experience of symptoms (CDC, 2009). Experience of one depressive episode can increase an individual's risk of symptoms relapsing by 50% (CDC, 2009). It is not completely clear if the onset of depression symptoms occurring at younger ages is increasing the prevalence of depression and related factors in university students, but the prevalence of mental illness in college students is continually increasing despite efforts to implement mental health care in universities (Ohayon et al., 2014).

Research done by Ohayon et al.(2014) supports that the rates of depression in young adults are increasing. Reviews of 36 different universities counseling centers indicate an overall increase in anxiety, eating disorders, fear, alcohol abuse, substance abuse, anger, and hostility among college students (Potter et al., 2004). There are strong correlational relationships between the increased risk factors college students experience and the increased rates of suicidal ideation and depression: these relationships are most likely due to stressful life events, but can also be influenced or caused by an individual being predisposed to development of depression (Kendler, Karkowski, & Prescott, 1999).

Beck et al. (1985) claimed that hopelessness as an important psychological construct for understanding suicide in last 25 years. Hopelessness can affect to depression and in turn predicting suicide act. Furthermore, hopelessness associated with other psychiatric disorders also predisposes the patient to suicidal behavior (Beck et al., 1985). Wetzel et al., (1980) found that the significant evidence supported the linkage of hopelessness and suicide intent. Besides that, Beck et al., (1988) reported that hopelessness was predictive of actual suicide.

Minkoff et al., (1973) found that the intensity of suicidal intent was more highly correlated with hopelessness than with depression. However, if depression was controlled, hopelessness does not consistently predict suicide ideation (Esposito et al. 2003).

Academic performance as important measure for adolescents to evaluated their self at school. Failure to do the best may affect to adolescents feeling towards themselves. In turn, the effect may cause to suicide attempts. Toero et al. (2001) reported significant relationship between the pressure to excel in school and suicidal behaviors among children and adolescents. The study showed students usually experience the high level of stress during examination periods. Furthermore, East Asian researchers indicated that the stress-suicidal ideation almost come from family lifestyle and cultural demands for academic excellence. Parents for example, always put the highest expectations to their children to score in examination. Even Asians give priority to academic achievement since it can bring success in the future (Gloria & Ho, 2003; Sue & Okazaki, 1990). If failed to fulfill the target may be cause to loss of confidence and depression (Yeh & Huang, 1996).

A longitudinal study indicates that adolescents may develop the depressed feelings when received negative feedback regarding their academic performance (Fauber et al; Kellam

et al. 1983). Depression associated with suicidal ideation and suicidal behavior in adolescents (Brand et al. 1996; Brent et al. 1999). De Man (1999) found reducing of depression effect when received adequate social support for example, will minimize the suicide ideation. Similarly, Stewart et al. (1999) found that both academic stress and depression may predict the suicide ideation. In short, academic stress positively related to depression and in turn to suicide ideation.

Khan (2011) research had intended to analyse the part of depression and hopelessness in suicide ideation on 100 male and 100 females in the age scope of 15-17 years completed, tools used to collect data were Beck’s Suicide Ideation Scale, Beck’s Depression Inventory, and Beck’s Hopelessness Scale. The findings suggested that deliberate of suicide ideation, depression, and hopelessness were correlated.

Major depression, bipolar disorder, and alcohol use disorders were found to significantly increase risk of suicidal ideation; substance abuse, panic disorder, and general anxiety disorder were found to significantly increase risk for suicide attempts (Dong X et al., 2015). Suicides take place in all parts of the world and throughout life and can be seen in a wide range of populations, ranging from healthy people who respond to stressful life events to those with severe mental illness (Sayil I et al., 2000). It is stated that suicide is a public health problem with universal importance because about one million people die every year from suicide worldwide. Although suicides are preventable, one individual in every 40 s dies somewhere in the world because of suicide, and many people are attempting suicide (WHO 2014). It is stated that approximately 45% of the people who died as a result of the suicide refer to the primary care physician within the 1st month of their death (Ahmedani BK et al.,

2014). The fact that suicide is a preventable cause of death makes it very important to evaluate the suicide risk.

Manjula M et al., (2018) study dealt with examining the prevalence of depression, suicidal risk in school going adolescents and to understand the stressors, coping methods used in relation to severity of depression and socio-demographic variables. In the study Stratified Random sampling was used to select the 7 schools (8-10 grades) and 10 pre-university colleges (11 and 12 grades) from South Bangalore. Sample comprised of 1428 adolescents. Assessment tools used included Beck depression inventory, Checklist for stress, coping and suicidal behaviors, Suicidal probability scale, and Adolescent coping orientation to problems experienced inventory. It was observed that about 30% of the sample had moderate to severe depression, 3% reported suicidal behaviors and 0.7% had moderate to severe suicide risk. Older adolescents and girls had higher severity of depression. Suicidal risk was higher in males. Younger adolescents used more emotion focused coping strategies. Those with suicidal behaviors had higher scores on depression, hopelessness, suicidal ideation, and risk.

Depression and suicidality have a significant relationship, in that depression is one of the strongest and consistent predictors of suicidal ideation and attempts in adolescents. Risk of suicide in individuals with depression is 25 times more than the nondepressed (American Association of Suicidology, 2014; Ang RP et al., and Lalwani S et al., 2004) Suicide is a leading cause of death and shows the highest hazard at the ages of 15–19 years among young people in India (Aaron R et al., 2004). The prevalence levels of suicidal ideation (lifetime and last year) and suicide attempt (lifetime and last year) were 21.7%, 11.7%, 8%, and 3.5%, respectively (Sidhartha et al., 2006). Another study reported 15% and 9% of suicidal ideation and attempts in young adults. (Singh S et al., 2012). Similarly, Borges et al. (2008) reported

lifetime ideation, plan, and attempt in 11.5%, 3.9%, and 3.1% Mexican adolescent samples, respectively. A higher rate of suicidal ideation was reported in Pakistani college students (31.4%) and youth from Turkey (23%, suicidal ideation and 2.5%, suicidal attempts) (Eskin, M. et al., 2007, Khokher S et al., 2005). Across the studies, in a 12-month period, about 5.2%–8.4% of suicidal ideation and 2.5%–3.2% of suicidal attempts were reported (King RA et al., 2001, Fordwood SR et al., 2007). Severity of depression, hopelessness, suicidal ideation, death wish, female gender, age (older adolescence), externalizing behaviors, low self-esteem, and emotional self efficacy were found to significantly contribute to suicidal attempts (Borges G et al., 2008; Khokher S et al., 2005; Blum R et al., 2012; King RA et al., 2001, Fordwood SR et al., 2007; Robert V et al., 2015; Schmidt P et al., 2002) However, 60% of the depressive suicides had only mild-to-moderate severity, (Vijaykumar L et al., 2007) and the findings were inconsistent with respect to gender in India (Das PP et al., 2008 and Suresh Kumar PN et al., 2004). High suicidal intentionality and lethality was associated with planning the attempt and efforts to conceal the same, whereas impulsive attempts with low intentionality and lethality were seen more in adolescents and young adults with emotionally unstable personality traits (Sarkar P et al., 2006).

A study was conducted on “Relationship of suicide ideation with depression and hopelessness”. The sample comprised of 200 participants (100 males and 100 females) in the age range of 15- 19 years. The participants were provided with the following scales: Beck's Suicide Ideation Scale, Beck's Depression Inventory and Beck's Hopelessness Scale. The correlation between suicide ideation, depression and hopelessness was found to be positive and the correlation between suicide ideation and depression remained significant for males. (Ibadat K., 2011)

Sharif et al. (2014) conducted a study on “Depression and suicidal ideation among university students”. The study utilized a survey using simple random sampling methodology involving 65 respondents chosen at random residential colleges. Adult Suicidal Ideation (1988) and Reynolds Adolescent Depression Scale (1981) by William Reynolds were used as measuring scale. The overall findings of the study showed that there are no significant differences in the level of depression based on gender. However there are significant differences in suicidal ideation based on gender.

Rationale of the Study

Suicide is the second cause of death among persons aged 15-34 years (Centers for Disease Control and Prevention, 2013). Suicide can occur at any stage in the lifespan, and in some countries it is the leading cause of death among young people aged 15–24 years (World Health Organization, 2015). In addition, around 20–30 times as many suicide attempts occur (Wasserman, 2001).

An Indian study reported that the suicide rate was highest within the 15-29 years age group (38 per 100,000 population) followed by the 30-44 years group (34 per 100,000 population). Other studies in India conjointly indicated that young adults are at magnified risk, with ages 20-24 years followed by 25-29 years showing the highest rates of suicide in a psychological autopsy study (Khan, Anand, Devi & Murthy, 2005). Two-thirds of women who completed suicide was above 25 years (Banerjee et al., 1990; Nandi et al., 1979).This trend are additionally seen in attempted suicidal cases.

Dhaka is the capital city of Bangladesh. It is the top most urban area of Bangladesh. Most of renowned colleges and universities are situated in Dhaka. A large number of students

are studying in Dhaka compare to other divisional cities of Bangladesh. Students of well diversified culture read in Dhaka. Besides, number of depressed students is more in Dhaka. Moreover, most of the leading Hospitals are also situated in Dhaka. Most of the Critical patients come to Hospitals of Dhaka for treatment compare to other hospitals situated outside Dhaka. As such, both clinical and non-clinical respondents are abundantly available in Dhaka than to other urban areas of Bangladesh. Therefore, to have a rich research study I choose Dhaka city as my urban area of study.

Jashore has the highest suicide rates in Bangladesh. The rate of suicide is increasing in Jashore day by day. As per research report of ICDDR, (2003), it is observed that 39.6 persons (Per lakh) are committing suicide in Jashore. As a result, there has been extreme anxiety among the people of the area. Generally, poor performance in exam, relationship break-up, family feuds, depression at work, and many other reasons have increased the tendency to commit suicide. Most people have killed themselves by hanging and drinking poison. People from different socially established professions are leaning towards this trend. Many others have tried to commit suicide. That is why I have chosen this district as my research zone. 62 percent of university students in Bangladesh have an idea about mental health. The remaining 38 percent of students do not have a proper understanding of mental health. The trend of suicide is increasing in our country lately. In particular, the tendency to commit suicide is high among students. In 2021 alone, 101 students committed suicide in various higher education institutions, including universities. Among them, the number of students in the age group of 22-25 years is high. Unemployment, stress, financial crisis, family problems, depression with studies, deterioration of relationships, severe depression is responsible for this!

The findings of the study will contribute in acquiring new dimension of knowledge in case of Bangladesh whatever the findings are. It will also help to meet up the thrust of scientific inquisitiveness. Moreover, similar study was conducted in western world. So, the present study will help us to make a comparison among the findings of western world and Bangladesh. In addition to that this study will create avenue in awareness build-up among the young adults of Bangladesh as various stakeholders such as psychiatric, doctors, social workers, clinical psychologist, psychologists, nurses, therapists, NGOs and Government service provider of the country will be invited to participate in the final seminar on research report. Subsequently, the aforesaid stakeholders can use this research output for prevention of suicidal behavior in young people of Bangladesh by increasing awareness through workshop, seminar, print and electronic media etc. Mental health professionals will be able to identify suicidal tendency in very early stage and provide treatment to the potentially suicidal young adults due to dysfunctional families. This will improve functioning within the suicidal young adults' family. Whereas, parents and care giver will understand the necessity of counseling and psychiatric treatment for their child. The study will also be helpful for the young adults to address their symptoms of suicidal behavior specially ideation, thoughts, plan, attempt, committed Suicide.

Statement of the Problem

The problem under investigation in the present study was "Hopelessness, depression and suicidal Ideation among young adults in urban and rural areas ".

Objectives:

The General objective of the study

The aim of the present study was to investigate the relationship among hopelessness, depression and suicidal ideation among young adults in urban and rural areas. The specific objectives of this study were:

1. To find out the relation among hopelessness, depression and suicidal ideation.
2. To explore whether hopelessness and depression can predict suicidal ideation among young adults.
3. To assess variation in hopelessness, depression and suicidal according to types of participants, resident status and gender.
4. To explore the difference in hopelessness, depression and suicidal ideation between clinical and non-clinical respondents.
5. To investigate the difference in hopelessness, depression and suicidal ideation among urban and rural young adults.
6. To find out the gender difference in hopelessness, depression and suicidal ideation.
7. To find out the main causes of suicidal ideation perceived by young adults.

CHAPTER-II
Method

Method

Sample

In the present study, the sample was consisted of 384 respondents. Among them 344 were non-clinical and 40 were clinical adult respondents. They were selected from different colleges of Dhaka city and Chowgacha upazila under Jashore district. Out of them 172 were boys and 172 were girls under non-clinical category. They were again sub-divided according to their place of residence. 43 boy and 43 girl respondents were selected from rural areas and 43 boy and 43 girls were from urban areas. In case of clinical respondents, 20 (10 boy and 10 girl) were selected from Dhaka and 20 (10 boy and 10 girl) were from Chowgacha upazila under Jashore district. The non-clinical respondents were selected using purposive and convenient sampling technique. Their age range was 18 to 25 years. Most of them belong to middle income groups. The distribution of sample is presented in Table 2.

Table-2

Distribution of sample according to status of the sample, gender and areas of residence

Respondents	**Gender**	**Urban**	**Rural**	**Total**
Non –Clinical Respondents	Boys	**College**	**College**	
		86	86	172
	Girls	86	86	172
Clinical Respondents	Boys	10	10	20
	Girls	10	10	20
Total		192	192	384

The sample size was calculated by using the following formula. The proportion was estimated with 5% discrepancy with 95% confidence level:

$$\mathbf{n} = \frac{\mathbf{z}^2\mathbf{pq}}{\mathbf{d}^2}$$

Here,

n= the desired sample size

z = the standard normal deviate, usually set at 1.96, corresponds to the 95% confidence level.

p= the proportion in the target population estimated to have a particular characteristics and desire accuracy at 50%

q= 1-p

= 1-0.5 = 0.5

d= degree of accuracy desired, usually set at 0.05

So the sample size will be:

$$n = \frac{(1.96)^2 (0.5) (0.5)}{(0.05)^2}$$

= 384.16

Sample selection technique

At first the researcher collected the names of colleges of Dhaka and Jashore (Chowgachha upzaila) Division from the official website of Bangladesh Bureau of Educational Information and Statistics (BANBEIS).

Thereafter, 8 Colleges were selected following random sampling technique and respondents were selected by using convenient sampling technique. Among the 8 colleges, 4 boys' and 4 girls' colleges each were selected from Dhaka and Jashore District (Chowgachha upzaila).

Total 172 respondents in the age group 18-25 years were selected by using convenient sampling technique from four colleges in Dhaka city. Moreover, total 172 respondents of the

age group 18-25 years were also selected by using convenient sampling technique from four colleges in Chowgacha upazila under Jashore district.

Besides this, 40 clinical respondents in the age group 18-25 years were selected by using convenient sampling technique from mental health centers, Dhaka Medical College Hospital (DMCH) and Jashore Medical College Hospital. The clients who were referred by psychiatrist upon diagnosis were selected for the study. The respondents were diagnosed by the psychiatrist based on DSM-5. Out of 40 clinical respondents, no respondent was under medication. They visited the respective hospitals for the first time.

Table-3

Demographic Characteristics of the Respondents

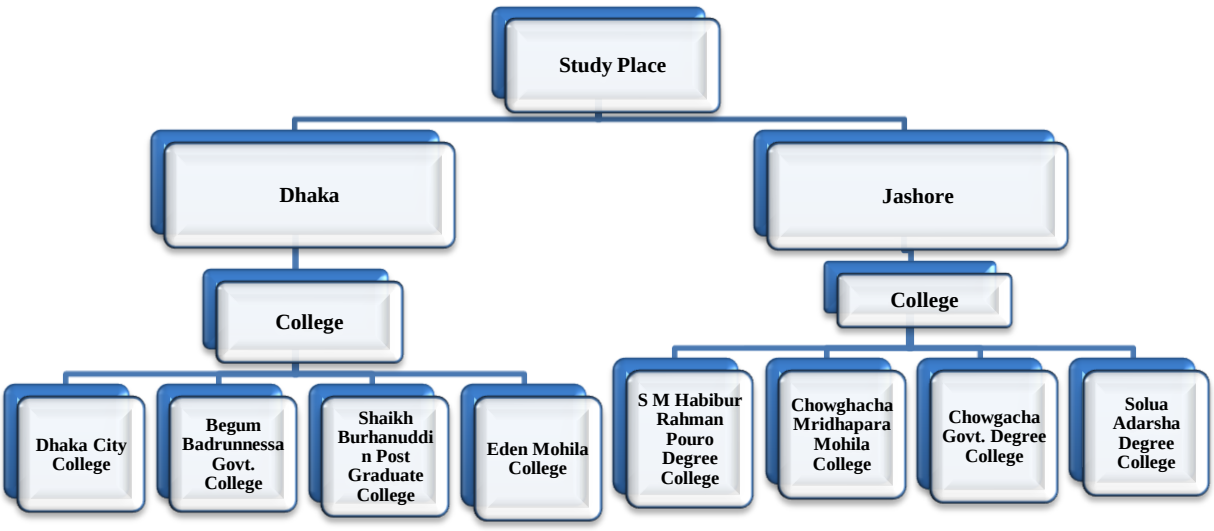
Variable	**Types of Participants**		**Total** *n* (%)	**Residential status**		**Total** *n* (%)
	Non-clinical Respondents *n* (%)	Clinical Respondents *n* (%)		Urban *n* (%)	Rural *n* (%)	
Gender:						
Boy	172(89.6%)	20(10.4%)	192(100%)	96(50%)	96(50%)	192(100%)
Girl	172(89.6%)	20(10.4%)	192(100%)	96(50%)	96(50%)	192(100%)
Age:						
18-21	172(89.6%)	20(10.4%)	192(50%)	96(50%)	96(50%)	192(100%)
22-25	172(89.6%)	20(10.4%)	192(50%)	96(50%)	96(50%)	192(100%)
Mean age	Mean=20.74 SD=2.48					
Education:						
S.S.C	0(0.0)	2(100%)	2(100%)	0	2(100%)	2(100%)
H.S.C	163(94.3%)	9(5.2%)	172(100%)	88(51.2%)	84(48.8%)	172(100%)
B.A/ B.Sc	138(86.8%)	21(13.2%)	159(100%)	78(49.1%)	81(50.9%)	159(100%)
Masters	43(84.3%)	8(15.7%)	51(100%)	26(51.0%)	25(49%)	51(100%)
Religion:						
Islam	321(90.2%)	35(9.8%)	356(100%)	184(51.7%)	172(48.3%)	356(100%)
Hindu	22(81.5%)	5(18.5%)	27(100%)	7(25.9%)	20(74.1%)	27(100%)
Christian	1(100%)	0(0.0)	1(100%)	1(100%)	0(0.0)	1(100%)

Socio-economical Status:						
High	57(83.8%)	11(16.2%)	68(100%)	49(72.1%)	19(27.9%)	68(100%)
Middle	234(90%)	26(10%)	260(100%)	134(51.5%)	126(48.5%)	260(100%)
Low	53(94.6%)	3(5.4%)	56(100%)	9(16.1%)	47(83.9%)	56(100%)

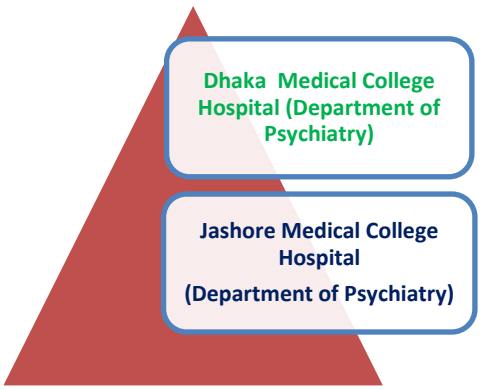
Table-3 showed that equal numbers of respondents were taken in terms of gender (192 boys and 192girls) and age groups (mean age is 20.74±2.48). Most of the respondents were the students of H.S.C, B.A/B.Sc level. Equal numbers of participants were also taken from urban and rural areas. Most of the respondents were Muslim and majority of the respondents belong to middle class.

Study place

- **Non-clinical Study Place:** The non-clinical sample of the present research comprised of 344 respondents (172 boys and 172 girls) from different colleges situated both in urban and rural areas. Colleges from urban areas were Dhaka City College, Begum Badrunnessa Govt. College, Shaikh Burhanuddin Post Graduate College and Eden Mohila College. The non-clinical respondents from rural colleges were from S M Habibur Rahman Pouro Degree College, Chowghacha Mridhapara Mohila College, Chowgacha Govt. Degree College and Solua Adarsha Degree College.



- **Clinical Study Place:** The clinical sample of the present research comprised of 40 respondents (20 boys and 20 girls) from different hospitals. Hospital from urban areas was Dhaka Medical College Hospital (Department of Psychiatry) and Hospital from rural areas was Jashore Medical College Hospital (Department of Psychiatry)**.**



Sampling criteria

Inclusion Criteria-

The criteria that used for the selection of respondents were as follows:

- Young adult girls and boys age of 18 to 25 years.
- Young adult girls and boys who will participate willingly in the study.

- Young adult girls and boys who resides at Chowgacha upazilla under Jashore and Dhaka.

Exclusion Criteria

- Those students who did not give consent to take an interest in the research.
- Students who have any major psychiatric issue/s.
- Clients' inability to provide consent.

Instruments used: Three scales were used in the present study. They were:

1. Hopelessness scale
2. Depression scale and
3. Suicidal ideation scale

Along these scales, a bio-data form was also used for collecting demographic information. The descriptions of the scales are given below:

Hopelessness Scale:

The Beck Hopelessness Scale (BHS) provides a self-report measure of one's negative expectations regarding the future. The Bangla version of Beck hopelessness scale (Chowdhury and Banu, 2010), originally developed by Beck (1993), was used in the present study to measure hopelessness of the respondents. The scale consisted of 20 items.

Reliability:

Test-retest reliability co-efficient of the Bangla version of the scale was r = 0.81 ($p<0.01$), the spilit-half reliability coefficient was r=0.59 ($p<0.01$) and the alpha (Cronbach) co-efficnt was $\alpha = 0.56$ ($p<0.01$). Thus, the Bangla version of the Beck Hopelessness Scale was reliable and had moderate internal consistency to use in identifying the level of hopelessness of the adolescent in Bangladesh.

Validity:

Beck, Weissman, Lester and Trexler (1974) reported the internal consistency reliability of the scale was 0.93 and the alpha coefficient for the sample was 0.86. According to Beck et al. (1974) the scale possessed adequate construct validity.

Scoring:

There are 20-items in the scale that measured none or minimal, mild, moderate and severe levels of hopelessness. None or minimal hopelessness score ranges from 0-3; mild hopelessness score ranges from 4-8; and moderate hopelessness score ranges from 9-14, which indicates that participants may not be in immediate danger but requires frequent regular monitoring. Above 15 indicates severe hopelessness and definite suicidal risk (Beck & Steer, 1988). Nine of the items (1, 3, 5, 6, 8, 10, 13, 15 and 19) are false keyed to control range acquiescent response style. Each item is scored either 0 or 1 and the total BHS score is

a sum of the item responses ranging from 0 to 20. Higher score reflects more intense levels of hopelessness.

Depression Scale:

The Bangla version of Beck depression scales (Uddin and Rahman 2005), originally developed by Beck (1993), and was used for the present study. The depression scale consists of 30 items or statements with printed instruction. All of the items were positively stated.

Reliability:

Both the split-half reliability (Guttman split-half r = .7608) and test-retest reliability (r = .599) of the present depression scale ensured that the scale was a reliable instrument.

Validity:

Estimation of concurrent Validity (by rating scales) shows that, rating of depression by the psychiatrist (r = .377) and self- rating of depression by the patients (r = .558) were positively correlated with the obtained scores on the current depression scale ($p < .01$). Discriminability ($F = 85.386$, $p < .01$) concluded that the depression scale has reasonably high concurrent validity. The depression scale was found to be positively correlation with the depression sub-scale of the Hospital Anxiety and Depression Scale (HADS) (Person correlation, r = .716 at œ = .01). It is a good indicated of construct validity of this depression scale.

Scoring:

The answer options for each item of the scale were according to 5 points rating scale. In depression scale, ‘‘not at all applicable” was scored 1, “not applicable” was scored 2, “uncertain” was scored 3, “a bit applicable” was scored 4 and “totally applicable” was scored

5. Sum of all values indicates total score on the scale. The highest possible score of 30-item of depression scale was 150 and the lowest possible score was 30. Higher score indicates higher depression, and lower score indicates low level of depression. Total score of the respondent reveal his / her levels of depression. It was indicated to categorize the subjects into four levels of severity. Score range for minimal, mild, moderate, and severe were 30-100, 101-114, 115-125 and 125-150 respectively.

Suicidal Ideation Scale

The Bangla version of Beck suicidal ideation scale (Uddin, Faruk & Khanam (2013), originally developed by Beck & Steer (1991), was used to identify of suicidal ideation for the present study. It consists of 19 items and each item consists of three alternative statements graded in intensity from 0 to 2. The total scores, which range from 0 to 38, are obtained by adding the item values.

Reliability

The internal consistency reliability of the Bangla version scale as by measure Cronbach alpha was 0.93.

Validity

Five types of validity for the BSS were determined: Content, Concurrent, Construct Discriminant and Factorial were all found satisfactory (Uddin, Faruk & Khanam, 2013).

Scoring of the suicidal ideation scale

The size of suicidal ideation comprises of 21 but 19 used for the basic thought of suicidal ideational and 2 items used for attempted suicide in past, for these items, scored 0 to 2, which can be utilized to assess a person’s self-destructive intention. The minimum and

maximum score run in 0-38. The high score is interpreted as high self destructive ideation and low score demonstrates low or no self-destructive ideation. Individual scoring up to 10 is distinguished as the low level of suicidal ideation, scoring between 11-27 average levels of suicidal ideation and scores greater than 28 will fall under the category of high suicidal ideation.

Study Design

A mixed method study design, comprising of a cross sectional survey design and qualitative method have been used in the present study.

Procedures

Non-clinical data was collected from 8 (eight) different colleges situated both in urban and rural areas and clinical data was collected from 2 (two) hospitals. Hospital from urban areas was Dhaka Medical College Hospital (Department of Psychiatry) and Hospital from rural areas was Jashore Medical College Hospital (Department of Psychiatry)**.**The data **c**ollection procedure from colleges and hospitals are described below.

Colleges

After receiving the permission of the Principals/concerned authorities, data were collected from the respective colleges. The scales and personal questionnaire were used individually by the researcher following standard procedures. Each of the participants was instructed before starting answering the questionnaire. At the very beginning, a brief description about the purpose of the study was described to each student and consent was obtained thereof. The respondents were advised to read the items of the scales attentively and respond all items quickly. All necessary clarifications regarding the questionnaires were ensured. They were asked to put the tick (√) mark on the appropriate answer of each item.

The respondents were greeted with thanks for their kind co-operation and they were assured that the confidentiality will be maintained strictly.

Hospitals

At the very outset, the forwarding letter issued by Psychiatric Dept. was forwarded to Dhaka Medical College (DMC) for ethical clearance. After receiving the ethical clearance from DMC, a letter was submitted to the director of DMCH for allowing data collection from the Psychiatric department. Then the data was collected from in and out patients of Dhaka Medical College and Jashore Medical College on convenient sampling basis who had been diagnosed mental patient by a psychiatrist. At the very beginning, a brief description about the purpose of the study was described to each client and consent was obtained thereof. The respondents were advised to read the items of the scales attentively and respond all items. All necessary clarifications regarding the questionnaires were ensured. They were asked to put the tick (√) mark on the appropriate answer of each item. The respondents were greeted with thanks for their kind co-operation and they were assured that the confidentiality will be maintained strictly.

In case of the clinical respondents of Jessore Medical College same procedure was followed.

Focus Group Discussions (FGDs)

To find out the causes of hopelessness, depression and suicidal ideation, data was also collected using Focus Group Discussions (FGDs) and thorough interviews of respondents. FGD questionnaire were developed by the researcher to explore the individual and contextually related factors causing suicidal ideation in college students. FGDs were conducted with sixty-four young adult's students who were studying in H.S.C. (Xl-Xll), B.Sc and M.sc. level. Each FGD consisted of eight young adults per group and each group had a

moderator and a record keeper of proceedings to facilitate the discussion and manage the group. These activities allowed the facilitator to participate actively and respond verbally to the topics in the FGD. In addition, the researcher used open-ended questions to encourage young adults to think and share their ideas and experiences on suicidal ideation.

Statistical analysis

Data was presented in different modes like tables, charts, graphs etc. Data analysis was done through the software program namely SPSS (Statistical Package for Social Science version 20).

Ethical Issue

For smooth conduction of the study, the respondents (selective young adults) were informed about the purpose of the study. Before the interview, the respondents were briefed about the objectives of the study and their voluntary participation was solicited and a written consent was taken from the respondents and they were assured that the collected data will be kept confidential. The respondents' written consent was recorded in an appropriate form and preserved in a file. No identification (anonymous) of the respondents was disclosed in the final proposal.

CHAPTER-III
Result

Result

The purpose of the study was to investigate the relation among hopelessness, depression and suicidal ideation in young adults of urban and rural areas.

The specific objectives of the study were-

1. To find out the relation among hopelessness, depression and suicidal ideation.
2. To explore whether hopelessness and depression can predict suicidal ideation among young adults.
3. To assess variation in hopelessness, depression and suicidal according to types of participants, resident status and gender.
4. To explore the difference in hopelessness, depression and suicidal ideation between clinical and non-clinical respondents.
5. To investigate the difference in hopelessness, depression and suicidal ideation among urban and rural young adults.
6. To find out the gender difference in hopelessness, depression and suicidal ideation.
7. To find out the main causes of suicidal ideation perceived by young adults.

In this study, the respondents' hopelessness, depression and suicidal ideation scores were analyzed by using Mean, SD, correlation, regression, 2x2x2 way analysis of variance and content analysis. The results of the study are presenting in the following tables.

Table-4

Correlation co-efficient among hopelessness, depression and suicidal ideation

Variable	**1**	**2**	**3**
Hopelessness	1		
Depression	.60**	1	
Suicidal Ideation	.60**	.57**	1

**p < 0.01

The result shows that there is a statistically significant positive correlation among hopelessness, depression and suicidal ideation. The correlation between hopelessness and depression is 0.60; hopelessness and suicidal ideation is 0.60 and depression and suicidal ideation is .57.

Table-5

Regression analysis of hopelessness and depression on suicidal ideation

Model	Variable	*B*	*SE B*	β	*t*	*p*	*F*	*p*	*R2*	*R2 change*
1	(Constant)	-2.295	.596		-3.849	<.001	220.82	<.001	0.36	0.37
	Hopelessness Score	1.021	.069	0.60	14.860	<.001				
2	(Constant)	-9.77	1.14	0.57	-8.55	<.001	189.09	<.001	0.33	0.32
	Depression Score	0.16	0.012		13.75	<.001				
3	(Constant)	-8.421	1.064		-7.913	<.001	146.48	<.001	0.43	0.06
	H_Sco	.683	.082	.405	8.355	<.001				
	D_so	.093	.014	.329	6.788	<.001				

1. Predictors: (Constant), Hopelessness score
2. Predictors: (Constant), Depression score
3. Predictors: (Constant), Hopelessness score, Depression score

The stepwise multiple regressions were used to find out linear combination of different predictors of suicidal ideation. In the regression analysis, hopelessness and depression emerged as the significant predictors for suicidal ideation (Table 5). The result of multiple stepwise linear regressions was calculated to find out whether hopelessness is the predictor of suicidal ideation. A significant regression equation was found ($R^2 = .036$, $F = 220.82$; $p < 0.001$) and the result reveals that hopelessness is a significant predictor of suicidal ideation ($\beta = .60$; $p < 0.001$). At the same time, simple regression was also calculated

to find out whether depression predicts suicidal ideation. A significant regression equation was found (F= 189.75), with an R^2 of 0.33. Model R, Std. Beta 0.16, 0.57, that is independent measure depression proved as a significant predictor of suicidal ideation. Beside this, findings showed that the linear combination of hopelessness and depression jointly predict significant proportion of variance 43.5% in suicidal ideation. This trend indicates there is a strong relationship of suicidal ideation with hopelessness and depression.

Table-6

Hopelessness Levels of clinical and non-clinical respondents (N =384)

Types of Participants	***Hopelessness Levels***			
	None or Minimal n (%)	***Mild n (%)***	***Moderate n (%)***	***Severe n (%)***
Non-clinical	65(18.9%)	169(49.1%)	80(23.3%)	30(8.7%)
Clinical	0	14(35%)	12(30%)	14(35%)
Total	65(18.9%)	183(47.7%)	92(24%)	44(11.5%)

Table-6 indicates that 18.9% non-clinical respondents were in minimal hopelessness level, 49.1% were in mild, 23.3% were in moderate and 8.7% were in severe hopelessness level. The table also shows that 35% clinical respondents were in mild hopelessness level; 30% were in moderate and 35% were in severe hopelessness level. So, most of the respondents have mild level of hopelessness.

Table-7

Hopelessness Levels according to residential status

Resident Status	Hopelessness Levels			
	None or Minimal n (%)	**Mild n (%)**	**Moderate n (%)**	**Severe n (%)**
Urban	39(20.3%)	97(50.5%)	41(21.4%)	15(7.8%)
Rural	26(13.5%)	86(44.8%)	51(26.6%)	29(15.1%)
Total	65(16.9%)	183(47.7%)	92(24%)	44(11.5%)

Table-7 indicates that 20.3% urban respondents were in minimal hopelessness level, 50.5% were in mild, 21.4% were in moderate and 7.8% were in severe hopelessness level. Whereas the table also shows that 13.5% rural respondents were in minimal, 44.8% were in mild; 26.6% were in moderate and 15.1% were in severe hopelessness level.

Table- 8

Level of hopelessness according to gender

Gender	Hopelessness Levels				
	None or Minimal n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	Total
Boy	24(12.5%)	93(48.4%)	47(24.5%)	28(14.6%)	192(100%)
Girl	41(21.4%)	90(46.9%)	45(23.4%)	16(8.3%)	192(100%)
Total	65(16.9%)	183(47.7%)	92(24.0%)	44(11.5%)	384(100%)

Table-8 indicates that 12.5% boy respondents were in minimal hopelessness level, 48.4% were in mild, 24.5% were in moderate and 14.6% were in severe hopelessness level. Whereas the table also shows that 21.4% girl respondents were in minimal, 46.9% were in mild; 23.4% were in moderate and 8.3% were in severe hopelessness level.

Table-9

2x2x2 analysis of variance of Hopelessness Scores according to Types of Participants, Resident status and Gender

SV	Type III Sum of Squares	*df*	Mean Square	F	P
Types of Participants	534.67	1	534.67	30.26	<.001
Resident Status	53.31	1	53.31	3.01	.08
Gender	50.60	1	50.60	2.86	.09
Types of Participants x Resident Status	0.23	1	.231	.013	.90
Types of Participants x Gender	18.14	1	18.14	1.02	.31
Resident Status x Gender	9.59	1	9.59	.543	.46
Types of Participants x Resident Status x Gender	34.59	1	34.59	1.95	.16
Error	6641.95	376	17.66		
Total	28942.00	384			

Table-9 indicates that there was significant difference in hopelessness according to types of participants (*F=30.26, p<0.001*). Table-9 also reveals that clinical respondents have more hopelessness ($\bar{x}$=10.95) scores than non-clinical participants ($\bar{x}$=7.09). On the other hand, no significant difference in hopelessness was found according to residential status and gender. No two ways interaction between types of Participants and Resident Status, between types of Participants and Gender and between Resident Status and Gender and also no three ways interaction among types of participants, resident status and gender were found to be significant.

Table-10

Mean and SD of Hopelessness score according to Types of participants, Resident Status and Gender

Types of participant	Resident Status	Gender	Mean	Std. Deviation	N
Non clinical		Boy	6.52	3.78	86
	Urban	Girl	6.51	4.31	86
		Total	6.51	4.04	172
		Boy	8.12	4.25	86
	Rural	Girl	7.18	4.46	86
		Total	7.65	4.37	172
	Total	Boy	7.32	4.09	172
		Girl	6.84	4.39	172
		Total	7.08	4.24	344
Clinical		Boy	12.00	4.94	10
	Urban	Girl	8.60	3.53	10
		Total	10.30	4.53	20
		Boy	11.80	4.54	10
	Rural	Girl	11.40	3.23	10
		Total	11.60	3.84	20
		Boy	11.90	4.62	20
	Total	Girl	10.00	3.59	20
		Total	10.95	4.19	40
Total		Boy	7.09	4.23	96
	Urban	Girl	6.72	4.27	96
		Total	6.91	4.24	192
		Boy	8.51	4.40	96
	Rural	Girl	7.62	4.52	96
		Total	8.06	4.47	192
		Boy	7.80	4.36	192
	Total	Girl	7.17	4.41	192
		Total	7.49	4.39	384

As showed in the table 10, the mean hopelessness score of non-clinical boy students ($\bar{x}$=7.32) was greater than non-clinical girl students ($\bar{x}$=6.84). Whereas, the mean hopelessness score of clinical boy students ($\bar{x}$=11.90) was greater than the clinical girl students ($\bar{x}$=10.00). On the other hand, the mean score was higher at rural area ($\bar{x}$=8.06) than that of urban area ($\bar{x}$=6.91).

Table-11

Depression Levels of clinical and non-clinical respondents (N =384)

Type of participant	Depression Levels			
	Minimal ***n* (%)**	**Mild** ***n* (%)**	**Moderate** ***n* (%)**	**Severe** ***n* (%)**
Non-clinical	152(44.2%)	130(37.8%)	33(9.6.%)	29(8.4%)
Clinical	3(7.5%)	20(50%)	4(10%)	13(32.5%)
Total	155(40.4%)	150(39.1%)	37(9.6%)	42(10.9%)

Table-11 indicates that 44.2% non-clinical respondents were in minimal depression level, 37.8% were in mild, 9.6% were in moderate and 8.4% were in severe depression level. The table also shows that 7.5% clinical respondents were in minimal, 50% were mild depression level; 10% were in moderate and 32.5% were in severe depression level.

Table-12

Level of depression according to Residential status

	Depression Levels			
Resident Status	**Minimal** ***n* (%)**	**Mild** ***n* (%)**	**Moderate** ***n* (%)**	**Severe** ***n* (%)**
Urban	95(49.5%)	69(35.9%)	15(7.8%)	13(6.8%)
Rural	60(31.3%)	81(42.2%)	22(11.5%)	29(15.1%)
Total	155(40.4%)	150(39.1%)	37(9.6%)	42(10.9%)

Tabl-12 indicates that 49.5% urban respondents were in minimal depression level, 35.9% were in mild, 7.8% were in moderate and 6.8% were in severe depression level. Whereas the table also shows that 31.3% rural respondents were in minimal, 42.2% were in mild; 11.5% were in moderate and 15.1% were in severe depression level.

Table - 13

Level of depression according to gender

	Depression Levels				
Gender	**Minimal** ***n* (%)**	**Mild** ***n* (%)**	**Moderate** ***n* (%)**	**Severe** ***n* (%)**	**Total** ***n* (%)**
Boy	73(38.0%)	81(42.2%)	15(7.8%)	23(12.0%)	192(100.0%)
Girl	82(42.7%)	69(35.9%)	22(11.5%)	19(9.9%)	192(100.0%)
Total	155(40.4%)	150(39.1)	37(9.6%)	42(10.9%)	384(100.0%)

Table-13 indicates that 38.0% boy respondents were in minimal depression level, 42.2% were in mild, 7.8% were in moderate and 12.0% were in severe depression level. Whereas the table also shows that 42.7% girl respondents were in minimal, 35.9% were in mild; 11.5% were in moderate and 9.9% were in severe depression level.

Table-14

2x2x2 analysis of variance of Depression Scores according to Types of participant, Resident status and Gender

SV	**Type III Sum of Squares**	***df***	**Mean Square**	**F**	**P**
Types of Participant	21574.34	1	21574.34	34.80	<.001
Resident Status	1339.46	1	1339.46	2.16	0.14
Gender	1.16	1	1.16	.002	0.96
Type of Participant x Resident Status	183.66	1	183.66	0.29	0.58
Types of Participants x Gender	41.00	1	41.00	0.06	0.79
Resident Status x Gender	79.13	1	79.13	0.12	0.72
Type of Participant x Resident Status x Gender	1030.99	1	1030.99	1.66	0.19
Error	233059.59	376	619.83		
Total	3572730.00	384			

Table-14 shows a significant difference in depression according to types of Participants (F=34.80, p<.001). Table-13 indicates that depression is more in clinical respondents ($\bar{x}$=114.20) than non-clinical respondents ($\bar{x}$=90.28). But it showed that depression scores do not vary significantly according to resident status and gender. Moreover, no two ways or three ways interaction was found to be significant.

Table-15

Mean and SD of Depression score according to types of Participants, Resident Status and Gender

Type of Respondents	Resident Status	Gender	Mean	Std. Deviation	N
		Boy	84.60	24.69	86
	Urban	Girl	87.59	26.49	86
Non clinical		Total	86.09	25.58	172
		Boy	96.86	25.218	86
	Rural	Girl	92.09	26.60	86
		Total	94.47	25.95	172
		Boy	90.73	25.63	172
	Total	Girl	89.84	26.56	172
		Total	90.28	26.07	344
		Boy	115.70	11.34	10
	Urban	Girl	110.10	15.37	10
Clinical		Total	112.90	13.45	20
		Boy	112.70	14.86	10
	Rural	Girl	120.80	15.02	10
		Total	116.75	15.12	20
		Boy	114.20	12.95	20
	Total	Girl	115.45	15.77	20
		Total	114.82	14.26	40
		Boy	87.84	25.47	96
	Urban	Girl	89.93	26.42	96
Total		Total	88.89	25.90	192
		Boy	98.51	24.77	96
	Rural	Girl	95.08	27.06	96
		Total	96.79	25.93	192
		Boy	93.17	25.62	192
	Total	Girl	92.51	26.80	192
		Total	92.84	26.18	384

As shows in the table 15, the mean depression score of non-clinical boy students ($\bar{x}$=90.73) was greater than non-clinical girl students ($\bar{x}$=89.84). Whereas, the mean depression score of clinical girl students ($\bar{x}$=115.45) was greater than the clinical boy students ($\bar{x}$=114.20). On the other hand, the mean score was higher at rural area ($\bar{x}$=96.79) than that of urban area ($\bar{x}$=88.89).

Table-16

Suicidal ideation Levels according to clinical and non-clinical respondents (N =384)

Type of Participants	Level of Suicidal Ideation		
	Low ***n* (%)**	**Average** ***n* (%)**	**High** ***n* (%)**
Non-clinical	290(84.3%)	39(10.8%)	14(4.1%)
Clinical	21(57.5%)	12(30%)	8(18.5%)
Total	311 (81.7%)	51(13.3%)	22(6.5%)

Table-16 indicates that 84.3% non-clinical respondents have low level of suicidal ideation, 10.8% have an average and 4.1% have high level of suicidal ideation. The table also shows that 57.5% clinical respondents have low level of suicidal ideation, 30% have an average level and 18.5% have high level of suicidal ideation.

Table-17

Level of suicidal ideation according to Residential status

Residential status	Suicidal Ideation		
	Low *n* (%)	Average *n* (%)	High *n* (%)
Urban	156(81.2%)	32(16.7%)	4(1.6%)
Rural	154(80.2%)	19(9.9%)	19(9.9%)
Total	310(80.7%)	51(13.3%)	23(7.5%)

Table-17 indicates that 81.2% urban respondents have low level of suicidal ideation, 16.7% have an average, and 1.6% has high level of suicidal ideation. Whereas the table also shows that 80.2% rural respondents have low, 9.9% have an average and 9.9% have severe level of suicidal ideation.

Table -18

Level of suicidal ideation according to gender

Gender	Suicidal Ideation			
	Low level of suicidal ideation *n* (%)	Average level of suicidal ideation *n* (%)	High level of suicidal ideation *n* (%)	Total n (%)
Boy	153 (79.7%)	22 (11.5%)	17 (8.9%)	192 (100.0%)
Girl	159 (82.8%)	29 (15.1%)	4 (2.1%)	192 (100.0%)
Total	312 (81.2%)	51 (13.3%)	21 (5.5%)	384 (100.0%)

Table-18 indicates that 79.7% boy respondents have low level of suicidal ideation, 11.5% have an average, and 8.9% have high level of suicidal ideation. Whereas the table also shows that 82.8% girl respondents have low, 15.1% have an average and 2.1% have severe level of suicidal ideation.

Table-19

2x2x2 analysis of variance of Suicidal ideation Scores according to types of participants, Resident status and Gender

SV	Type III Sum of Squares	*df*	Mean Square	F	P
Types of Participant	1689.39	1	1689.39	33.89	<.001
Resident Status	256.96	1	256.96	5.15	.02
Gender	287.50	1	287.50	5.76	.01
Types of Participant x Resident Status	132.38	1	132.38	2.65	.104
Types of Participant x Gender	124.96	1	124.96	2.50	.11
Resident Status x Gender	19.59	1	19.598	3.93	.05
Types of Participant x Resident Status x Gender	0.05	1	0.05	.001	.97
Error	18739.01	376	49.83		
Total	32034.00	384			

Table-19 shows that suicidal ideation vary significantly according to types of participants (*F=33.89, p<.001*), resident status (*F=5.15, p<.001*) and gender (*F=5.76, p<.001*). Two way interaction between resident status and gender was also found to be significant *(F=3.93, p<.001)* in suicidal ideation. On the other hand, no two ways interaction between types of participant and resident status and between types of participants and gender were found to be significant. Results also indicated that there was no significant three ways interaction among types of participants, resident status and gender.

Table-20:

Mean and SD of Suicidal ideation score according to Participants Categories, Resident Status and Gender

Types of participants	Resident Status	Gender	Mean	Std. Deviation	N
		Boy	4.34	6.19	86
	Urban	Girl	4.16	6.14	86
Non clinical		Total	4.25	6.15	172
		Boy	5.88	8.49	86
	Rural	Girl	4.14	6.10	86
		Total	5.01	7.42	172
		Boy	5.11	7.45	172
	Total	Girl	4.15	6.10	172
		Total	4.63	6.82	344
		Boy	11.20	9.58	10
	Urban	Girl	7.20	5.88	10
Clinical		Total	9.20	8.01	20
		Boy	16.50	11.91	10
	Rural	Girl	11.10	7.80	10
		Total	13.80	10.19	20
		Boy	13.85	10.87	20
	Total	Girl	9.15	7.020	20
		Total	11.50	9.34	40
		Boy	5.06	6.89	96
	Urban	Girl	4.47	6.16	96
Total		Total	4.77	6.52	192
		Boy	6.99	9.41	96
	Rural	Girl	4.86	6.61	96
		Total	5.92	8.18	192
		Boy	6.02	8.28	192
	Total	Girl	4.67	6.37	192
		Total	5.34	7.41	384

Table-20 reveals that the mean suicidal ideation score of clinical respondents ($\bar{x}$ =11.5) was greater than non-clinical respondents ($\bar{x}$ =4.63). Whereas, the mean suicidal ideation score of urban respondents ($\bar{x}$=4.77) was less than rural respondents ($\bar{x}$=5.92). Result also revealed that boys have more suicidal ideation ($\bar{x}$=6.02) than girl respondents ($\bar{x}$=4.6). Statistically significant two ways interactions between residence status and gender indicated that rural boys have the highest ($\bar{x}$=8.51) and urban girls have the lowest ($\bar{x}$=6.72) suicidal ideation (Table-20).

Table-21

Mean and SD of suicidal ideation scores according to resident status and gender

Resident Status	Gender	
Urban	**Boy**	**Girl**
	7.09 ± 4.23	6.72 ± 4.27
Rural	**Boy**	**Girl**
	8.51± 4.40	7.62 ± 4.52

Table- 21 indicates that rural boy students ($\bar{x}$=8.51) have the highest and urban girl students ($\bar{x}$= 6.72) have the lowest suicidal ideation.

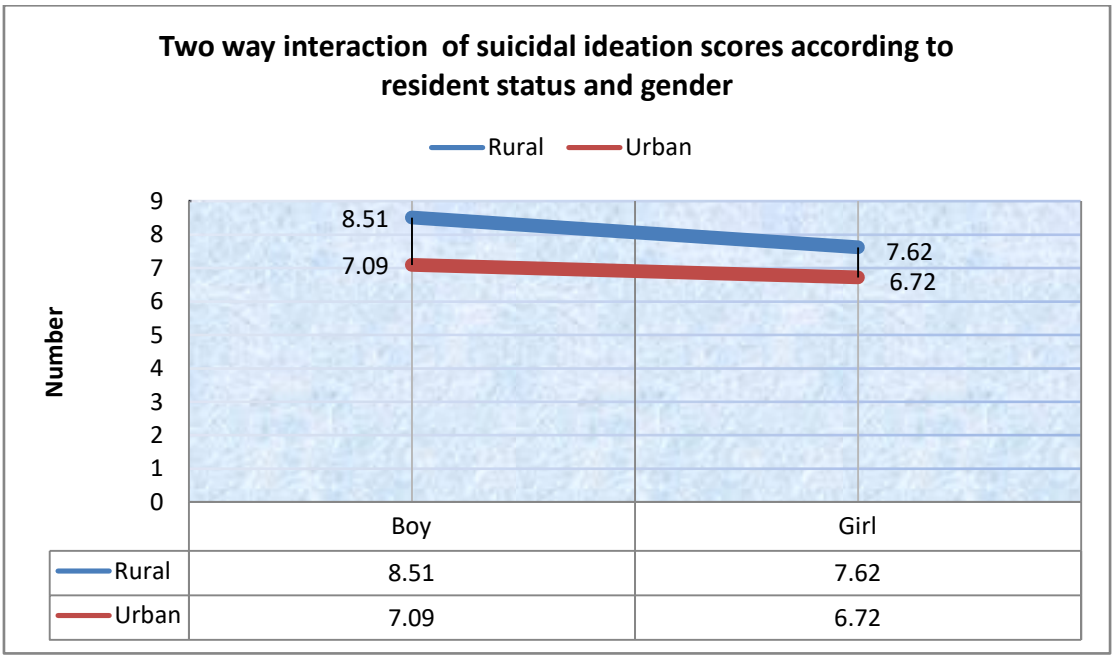


Figure-2: Two ways interaction of suicidal ideation scores according to resident status and gender

To know the causes of suicidal ideation, focus group discussion were arranged. The findings are presented in the following tables along with some case studies.

Table-22:

Percentage of causes of suicidal ideation according to the participants of focus group discussion

	Causes of Suicidal Ideation												
Resident Status/ Gender	**Relationship Break-Up**	**Unexpected Result**	**Family problem**	**Sexual violence**	**Low socioeconomic status and unemployment**	**Unwanted pregnancy**	**Separation**	**Boy and girl discrimination**	**Substance abuse**	**Social isolation**	**Bulling**	**Hopelessness**	**Depression**
Urban	25(78.1%)	25 (78.1%)	26 (81.2%)	14 (43.8%)	19 (59.9%)	11 (34.4%)	12(37.5%)	17 (53.1%)	15 (46.9%)	16 (50%)	12 (37.5)	23 (37.5%)	21 (65.6%)
Rural	27(68.8%)	22 (68.8%)	27 (84.4%)	19 (59.9%)	23 (71.9%)	14 (43.8%)	10(31.2%)	20 (62.5%)	15 (46.9%)	23 (71.9%)	15 (46.9%)	25 (78.1%)	25 (78.1%)
Boys	24(75%)	27 (84.4)	26 (81.2%)	12 (37.5%)	20 (62.5%)	8(25%)	8(25%)	12 (37.5%)	18 (56.2%)	16 (50%)	11 (34.4%)	24 (75%)	22 (68.8%)
Girls	28(87.5%)	20 (62.5%)	27 (84.4%)	21 (65.6%)	22 (68.8%)	17 (53.1%)	14(43.8%)	18 (56.2%)	12(37.5%)	23 (71.9%)	16 (50%)	24 (75%)	24 (75%)

Table-22 shows that 10 causes (relationship break, family problem, sexual violence, low socio-economic status, unwanted pregnancy, boy and discrimination, social isolation, bulling, hopelessness) were being identified as major causes of suicidal ideation by the girl respondents. On the other hand, remaining 3 (Unexpected result, substance abuse, hopelessness) were the major causes of suicidal ideation perceived by the boy respondents.

Some examples of case studies are presented below:

Case-1: As a teenager, our love was so blameless. But we were too young; for this our parents did not accept this relationship. Parents said that both of you were not capable to maintain this relationship. Current time is for studying. Real situations were so difficult. It

took a short time to break up the relation, and it was terribly sad. At that time, we broke up totally, and we felt like we weren't good enough for this world. It creates hopelessness and depression, and we had thoughts of dying by suicide." (It was a statement of a boy respondent).

Case-2: A boy participant was sharing the experience mentioning that if a boy and a girl were studying same year or classmate and fall in love, they can pass a good time for a while in most of the cases. When the girls studied in the 3rd year or 4th year, the family pressurized the girl for marriage. When the girls share this situation to her boyfriend he declined to marry until he become self-dependent/established by having a good job/profession. Then the relation comes to an end. The girl married a third person selected by the family members of the girl. Then the boy faced a terrible situation and at a certain time he does not find meaning of life. He tries to kill himself or suffer from depression.

Case- 3: "L" shared her own experience about one of her close friend. She was 19 years old. Her examination preparation was well but she got poor marks at her exams. Her father was annoyed. He was comparing her with another person. He cursed that she will be married with a rickshaw puller. The girl couldn't bear the stress. Finally, she ended her own life with a gun. (It was a statement of a girl respondent).

Case-4: "X" stated that my parents argued with each other for economic and family affairs in most of the times. Therefore, I do not find peace and tranquility at home after returning from the college. As a result, I feel myself disgraced, misfortune and worthless. Always feel unrest in mind. I feel that there is no meaning of life in this world in most of the time. There is no difference in death and life in this world. When father and mother quarrels

it makes me disgraced. While quarreling they break household items. Father beats mother and if I go to save my mother he pushes away me. I feel helpless. For that reason, I don't like to come back to home and feel that it would be better to die than live. (It was a statement of girl respondent).

Case-5: "M" was a very good student. But her father was a day labor. It was very hard to run the family by his father. It became very tough to finish her education. So, the father took a decision to arrange a marriage for her due to poor economic condition. But "M" became upset after hearing such shocking news of marriage. She was thinking that her dreams have been ruined. It has no meaning to remain alive as her dreams have been shattered. When dreams die then there might have existence of body but the soul expires. (It was a statement of girl respondent).

Case-6: I am **"F".** I am a student and have a part time job in a fashion house. I am very much selective about my dress code. Being a practicing Muslim, I do not wear veil. For this reason, I have to face eve teasing most of the time due to my dress code. I live in a society where people believe that the girls who do not wear veil, is bad girls. My neighbor flat owner is a pious man and a practicing Muslim. His younger daughter and I read in the same Department and same University. They do not like me to pass time with their daughter. The only reason is that I do not wear veil. If the concept of the society about dress code could be changed then the society would be more livable and meaningful. (It was a statement of a girl respondent).

Case-7: R and S both was good friend. They were roaming around together and even studied in the same Department for a long time. They are now Hon's final year student of

Bangle Department. One day **S** proposes love to R. R was overwhelmed upon hearing the proposal and accepted the proposal. After passing four to five months of the relationship, all on a sudden one day they went for roaming around and do the sexual intercourse. After that **S** started to do rough behavior with **R** and stated that if **R** was a good girl she could not have physical relation before marriage**. S** told that he does not want to continue the relationship with such a bad girl. After hearing such words **R** became upset. She was thinking that she lost everything and felt guilty as well as she hates herself. She was thinking about suicide for breaching of trust by the reliable person and the misdeed of his boyfriend. (It was a statement of a girl respondent).

Case-8: My Father and mother both is service holder. They don't have sufficient time to accompany me. They don't have time to give attention to me and show their affection to me. I missed them a lot when I stay at home alone. When they returned home they started to scold me for my daily activities. They always tell me that you will not be able to do anything. You are spoiling everything. For that reason, I feel loneliness and think about suicide. I always feel that I don't have any value in the family. So, I frequently think about suicide. (It was a statement of a boy respondent).

Case - 9: We are two sisters and one brother in our family. Mother take-cares of our brother more compare to ours. Both the parents discuss the future plan of our brother but there is no planning about the two sisters. All sort of demands of brother are being fulfilled without any question. But if we demand something mother insult us. Mother uttered that your education and food expenses are loss project but my son is as like as golden goose. After hearing such type of adverse remarks we became demotivated and lost our hopes. (It was a statement of a girl respondent).

Case-10: I was become a burden to my father since my birth. My father wanted to have a boy child but Almighty Allah disposes. Although my mother was happy after my birth but my father, paternal grand-mother and aunt had lot of complains against me. My complexion was dark. My family members always told that a lot of money will be required for my marriage as I was black. Black girl does not have value in the society. I met with some friends during my student life who did not want to mingle with me due to my dark complexion. I was neglected everywhere from insiders and outsiders. Therefore, I want to return to the Almighty from where I came to this world. Though the black persons are being praised in poem and literature but they are neglected in real world. (It was a statement of a girl respondent).

CHAPTER-IV
Discussion

Discussion

The purpose of the current study was to investigate the relation among hopelessness, depression and suicidal Ideation among young adults. A mixed method study design, comprising a cross sectional survey and qualitative component were used in the present study.

Data was collected from 384 young adults. 8 Colleges were selected following random sampling technique and respondents were selected by using convenient sampling technique. The discussion of the results has been presented below according to the research objectives.

Correlation among hopelessness, depression and suicidal ideation

The first objective of the present study was to find out the relation among hopelessness, depression and suicidal ideation. The finding indicates that a significant correlation exists between hopelessness, depression and suicidal ideation among young adults.

Table- 4 presents the relationship between suicidal ideation and hopelessness. This relation is high and positive (r=.60). Result of the study is consistent with the previous research conducted by Ribeiro et al. (2018). They found a strong association between hopelessness and suicidal ideation, and hopelessness was the strongest predictor for suicidal ideation. In another study, Tan et al. (2015) found that hopelessness is associated with suicidality in medical students. Another study investigated the relationship between hope, hopelessness and suicidal behavior with 206 undergraduate psychology students. Results disclosed that scores on hope and coping were more strongly related to suicidal behavior than hopelessness (Rang & Penton, 1994), but their result is not consistent with the present study finding.

Table- 4 also shows a positive and significant correlation between suicidal ideation and depression (r=.57). This positive and significant relationship between suicidal ideation and depression indicates that depression directly influences the suicidal ideation. This finding is also consistent with some previous studies. For example, the study results of Haile, K. et al. (2018) indicated that the decreased level of serotonin neurotransmitter in the brain of a depressed individual was associated with increased suicidal behavior. Another study revealed that depression is the most proximal correlate of suicidal ideation and suicidal behavior among older adults, regardless of the presence of other factors; the higher the depression, the higher the suicidal ideation (Bonnewyn A, et al., 2009; Corna LM et al., 2010). Jing et al. (2003) pointed out that having previously suffered from depression is the primary risk factoring for suicidal among college students. He et al. (2015) found that university students' self-rating depression scores directly correlate with suicidal ideation.

Regression analysis of hopelessness and depression on suicidal ideation

The result of stepwise regression was calculated to find out whether hopelessness and depression could predict the suicidal ideation. A significant regression equation was found (*F=220.82*), with an R^2 of 0.36, which indicates hopelessness is a statistically significant predictor of suicidal ideation (Table-5). The result of the study is consistent with the previous research conducted by Chochinov et al. (1995). They also found that hopelessness was a significant predictor of suicidal ideation.

Depression is also a significant predictor in suicidal ideation. A significant regression equation was found (*F=189.09*), with an R^2 of 0.33, which indicates depression is a statistically significant predictor of suicidal ideation (Table-5). The result of the current study

is also consistent with the previous research conducted by Cukrowicz et al. (2011). They found a relation between depression and self-destructive ideation with college students. The results of their analysis revealed that the greatest elevation in suicide ideation happens at the highest depressive symptoms. Significant suicidal ideation was also experienced by college students with mild and moderate depressive symptoms. Wang (2013) also found that depression was a statistically significant predictor of suicidal behaviour. Another study revealed that young adults who are depressed are more likely to have suicidal ideation, as are young adults in a state of hopelessness (Stewart S. M et al., 2005).

Hopelessness and types of participants

Finding of the Table- 9 indicates that there is a significant difference in hopelessness between two types of participants (*F=30.26, p<0.001*). Result revealed that clinical respondents are more hopeless ($\bar{x}$=10.95) than that of non-clinical ($\bar{x}$=7.09) respondents. A significant number of studies have been done in this area, some of them are cited below in support of the present finding.

Result of the study is consistent with a previous research of Sokero, P. (2006). Finnish study also found significantly higher hopelessness score in patients with depression as compared to patients with other mental disorders (Sokero P., 2006). Hopelessness as it occurs in depressed patients may be viewed as having characteristics pertaining to both state and trait.

During depression, hopelessness escalates and then subsides over the course of illness (Beck et al., 1990; Beck &Wesihaar, 1990; Beck, 2005; Williams et al., 2005a). The research findings of Bonner and Rich (1988b) and Goldney et al. (1991) suggest that non-clinical

samples, social/emotional alienation and deficient reasons for living (Bonner & Rich, 1988b) are associated with depression and hopelessness (Goldney et al.1991).

Hopelessness and Residential status:

Result of Table- 9 indicates that there is no statistically significant difference in hopelessness between urban and rural participants. This study finding is consistent with the finding of Haatainen K.et al. (2004). Their study showed that place of residence had no significant association with hopelessness. But this finding is not consistent with the finding of Teresa D.et al (2010). They hypothesized that the residents of reservations will experience less hopelessness than respondents living in non-reservation areas. They expected that residents of urban areas would feel the least hopeless. They stated that urban life would provide more social and economic opportunities and institutional supports and that these would result in feelings of reduced hopelessness (Teresa D. et al, 2010). May be, at present, more social and institutional supports are not enough to face the challenges of rural life. For this reason, this no difference in hopelessness in urban and rural students has been found.

Hopelessness and Gender

Table- 9 indicates that there is no significant difference in hopelessness between boy and girl respondents. Contradictory results have been found in this regard. For example, Ibrahim et al. (2017) found that this tendency is higher in males compared with females. On the other hand, Cui et al. (2011) found that girls significantly report more about suicidal ideation than boys. These contradictory findings indicate that may be both boys and girls are similarly concern or indifferent about hopelessness. May be for this reason, no difference between boys and girls in hopelessness has been found. Another reason for this no difference

may be that parents are given equal weightage to their boy and girl children. So, both boys and girls have similar attitude toward hopelessness.

Result of the Table- 9 shows that no two way interaction between types of participants and resident status, between types of participants and gender and between resident status and gender was statistically significant. No three ways interaction among types of participants, resident status and gender in hopelessness was found to be significant.

Depression and types of respondent

Table- 14 shows a significant difference in depression according to types of participants *(F=34.80, p<0.1*). Result revealed (Table-15) that clinical participants have more depression ($\bar{x}$=114.20) than that of non-clinical participants ($\bar{x}$=90.28). Result of the study is consistent with some previous research done by Ohayon et al. (2014). They stated that the rates of depression in young adults are increasing. Reviews of 36 different universities counseling centers indicated an overall increase in anxiety, eating disorders, fear, alcohol abuse, substance abuse, anger, and hostility among college students (Potter et al., 2004). There is a strong correlation between the college students experience and the increased rates of suicidal ideation and depression: these relationships are most likely due to stressful life events, but can also be influenced or caused by an individual being predisposed to development of depression (Kendler, Karkowski & Prescott, 1999).

Depression according to resident status and gender

Table- 14 indicates that depression does not vary significantly according to resident status and gender. That means that urban and rural boy and girl students do not differ significantly based on depression. One of the reasons may be that respondents are supported

by student advisor, university psychological and medical services etc. Besides Psychological counseling services for students are being promoted via the Internet (i.e. social networking sites, such as Face book). Additionally, students may be benefitted from online support groups. But this study finding is not consistent with the previous findings of Kandel, D.B et al., 1982; Nolen Hoelssema, S et al., 1994; and Roberts, R et al., 1990). All of them found that female reports more depression than that of male. But in the present study, it has been found that males and females do not differ significantly in depression. One of the reasons for this no difference may be that their emotionality is not restrictive. They are free to express their emotions as Jacobson et al. (2011) found that restrictive emotionality is associated with depressive symptoms.

Result of the Table-14 showed that no two way interaction between types of participants and resident status, between types of participants and gender and between resident status and gender was statistically significant. No three ways interaction among types of participants, resident status and gender in depression was found significant.

Suicidal ideation and types of participants

Table-19 shows that there is a significant difference in suicidal ideation according to types of participants *(F=33.89, p<.001)*. Result reveals (Table-20) that clinical respondents have more suicidal ideation ($\bar{x}$=11.50) than that of non-clinical ($\bar{x}$=4.63) respondents. Result of the present study is consistent with some previous research carried out by Schotte and Clum (1982). They found that in non-clinical samples of suicidal ideators, however, this is not necessarily the case. It has been argued that the relationship between depression, hopelessness and suicidal ideation in non-clinical samples is dependent on the level of suicidal ideation. That is, the higher the level of suicidal ideation, the more the relationship

between depression and hopelessness. It is possible that feelings of depression have a greater impact on the development of low levels of suicidal ideation but that feelings of hopelessness have greater impact on higher levels of suicidal ideation. If this is the case then it would be expected that the relationships between suicidal ideation, depression and hopelessness would change to resemble that found in clinical samples as the level of suicidal ideation increased (Schotte and Clum, 1982).

Another research findings of Bonner and Rich (1988b) and Goldney et al. (1991) suggested that in non-clinical samples, social/emotional alienation and deficient reasons for living (Bonner and Rich, 1988b) and depression and hopelessness (Goldney et al. 1991) have some association with further suicidal ideation. The findings from clinical samples (Beck et al., 1985, 1989; Petrie et al., 1988) indicated that hopelessness is reliably associated with further suicidal behavior. This provides some support for the findings of Goldney et al., (1991) that in non-clinical samples hopelessness is associated with further suicidal ideation.

Suicidal ideation and Resident status

The result shows that suicidal ideation vary significantly according to resident status ($F=5.15$, $p<.001$. (Table-19). This study finding is consistent with the finding of Whyte, M.K. (2010). He also found that students with a rural background exhibited a higher prevalence of suicidal ideation than those with urban background. This may possibly be ascribed to a higher rate of psychological distress among students from rural households and to their social disadvantages. Earlier studies revealed that rural residency was associated with depression not only in adolescents, but also in individuals aged 18 and older in rural China (Hesketh, T. et al., 2002; Liang, Y. et al., 2012; Wong, F.K. et al., 2009).

Suicidal ideation and Gender

Table- 19 shows that suicidal ideation vary significantly according to gender (*F=5.76, p<.01*).This study finding is consistent with the finding of Mustaffa, S et al. (2014). Their study also indicated that the level of suicidal ideation among male students is higher compared to female students which are in agreement with this study. Another study revealed that the males might be more vulnerable to suicidal ideation, probably due to conduct problems as these seemed to increase the risk of suicidal thoughts, as found in other research works (Strandheim A et al., 2014).

Two ways interaction in suicidal ideation according to resident status and gender:

Two ways interactions between resident status and gender have found to be significant *(F=3.93, p<0.1)* in suicidal ideation (Table-19). Result revealed that the rural boy students ($\bar{x}$=8.51) have the highest and urban girl students ($\bar{x}$=6.72) have the lowest suicidal ideation. This study finding is not consistent with the finding of Phillips et al. (2002a). Their study revealed that the pattern of youth suicides in China is very different from that in the West: female rates are 60% higher than male rates and rural rates are three-fold urban rates.

Table-19 shows no significant two ways interaction between types of participants and resident status in suicidal ideation. This study finding is not consistent with the finding of (Jiacheng Liu et al., 2022). They found that the prevalence of Suicidal ideation was 43.7 % (449/1027) in the urban group and 37.7 % (147/390) in the rural group. The prevalence of suicidal ideation was statistically significantly different between the urban and rural groups (χ^2 = 4.21, *P* = 0.04). For patients in urban areas, there were significant differences between the group with suicidal ideation and without suicidal ideation. This inconsistency needs further exploration.

Two way interaction in suicidal ideation between types of participants and gender:

Table-19 shows that there is no significant two way interaction between types of respondent and gender in suicidal ideation. This study finding is consistent with the study result of J. Johnson, P.A. et al. (2010). They conducted a study on "Resilience to suicidal ideation in psychosis: Positive self-appraisals buffer the impact of hopelessness". A total of 90 participants with schizophrenia-spectrum disorders were recruited into the study. The participants were administered with Beck Hopelessness Questionnaire, Beck Scale for Suicidal Ideation and Resilience Appraisals Scale. Twenty-two participants reported no previous suicide attempt whereas 17 reported one previous attempt and 38 reported two or more previous attempts. Age, gender and duration of illness were not found to be related to suicidal ideation. Positive self- appraisals were found to have a moderate association between hopelessness and suicidal ideation.

Three ways interaction in suicidal ideation among types of respondents, resident status and gender:

Result also indicates that no three ways interaction among types of respondents, resident status and gender was found to be significant in suicidal ideation. This study finding is also consistent with some earlier results (Bonner and Rich, 1988b and Goldney et al., 1991). The study showed that when concerned with attempted suicides, no differences were observed between rural and urban municipalities in this study for either gender. Instead, higher rates were found when comparing semi-rural with urban areas for the whole period among young women and at specific times among young men. Notwithstanding the scarcity of research on non-fatal suicidal behavior in youths across geographical areas and despite varying understandings of the definition of rural settings, the results align partly with studies

showing non-existent rural–urban gaps in youth suicide attempts or a some-what lower rate among rural compared to urban youths (Goldman-Mellor S et al., 2018; Johnson AO et al.,2003; Jonsson F et al., 2019).

The main causes of suicidal ideation perceived by young adults in urban and rural areas:

This study provides a rich description of significant causes of suicidal ideation from young adult's perspectives. It is in line with Stephen et al., (2006) & Crosby (2011). Among the myriads of factors that increase the risk of suicidal ideation among young adults are external factors such as relationship problems, academic problems, and family problems.

From focus group discussion, it is revealed that teenage romance is a common source of stress leading to young adult's suicide, particularly when it results in the breakdown of the relationships, which is consistent with Orri et al. (2014).

The findings revealed that unexpected results are hardly addressed significantly, and it is a critical source of suicidal ideation among young people. This study finding is consistent with an earlier study by Amare (Amara, 2018) reported that students who were disappointed in their academic results were more likely to have suicidal ideation than their peers.

This FGD revealed that another important cause of suicide is "Bullying" which is consistent with the findings of Mohammad K.H. S. et al., (2017). They found a significant association between bully victimization and suicidal ideation. This is an alarming signal for

present world, especially in western countries. Similar studies were done by Holt et al.(2007)who, found the similar result.

Low socioeconomic condition is a common problem in urban and rural areas in Bangladesh which may cause suicide. Similar results were founded by Vijayakumar L et al., 2005; Qin, Agerbo & Mortensen, 2003. They found that economic condition as a major risk factor for suicide in both developed and developing countries. A greater rate of suicide was observed in the young people of Bangladesh who belong to low income or poor economic status.

Analysis of the study also shows that social isolation is the another cause which increased level of risk factors that influence suicidal ideation among young adults, which is consistent with the study findings of Afia A. et al. (2021).

This study found another important cause of suicide is gender discrimination, which is consistent with Arafat et al. (2021). The findings of the study also showed that families engage girls in household responsibilities more including raising younger siblings. On the other hand, families invest on boys' education because social norms suggest that boys will take care of the parents in their old age. The study connects financial deprivation and gendered social norms to girls' dropout of high school. Parents tend to compromise with girl's education first if they have to impose financial sanction in domesticity.

The poor relationship between parents and their child, lack of parent's support and academic pressures also act as a risk factor for suicidal ideation. These findings corroborate that of Donath et al. (2014) who stated that parent-children conflict affects the likelihood of entertaining suicidal ideation.

This study indicated that students who had weak family ties were said to have poor resilience and become easily overwhelmed by challenges of life which makes them be quick to think about taking their lives as the best option. This was also asserted by Zhai et al. (2015), who stated that parents with negative relationships disrupted the cohesiveness of the family, which could result in suicidal ideation.

Conclusion

Suicide is a common tendency among the hopeless and depressed young adults. After the meticulous efforts, the present study has reached to its target which underscored the fact that the hopelessness, depression and suicidal ideation have increased the propensity to suicide among the young adults both in urban and rural areas.

It is evident from the study that rural young adults have more tendencies for suicidal ideation compare to urban young adults. Rural young adults are more exposed to hopelessness and depression which ultimately leads to suicidal ideation. In most of the cases, the common causes are: relationship break-up, discrimination between boys and girls, low socio-economical problem, under privileged girls and sexual violence. Young adults with high level of depression and low self-esteem level start feeling hopeless, helpless and full of despair. They do not find themselves as the active agent to solve such problems and suicide may seem to be just the permit to solve their problems. Whereas, urban young adults are more exposed to hopelessness and depression which ultimately leads to suicidal ideation due to mostly high expectation of parents, desire of excellent academic results, family problem and also separation. They are also engaging themselves with risky behaviors like smoking, drinking alcohol, substance abuse, risky sexual behavior, physical attack etc. with an expectation that they can overcome hopelessness and depression. After such disturbing period of sufferings, the victim reaches to the highest level of the hopelessness. They may develop symptoms of depression later on. Instead of sharing perceived problems with their dear ones, they tend to find the solution with thoughts of endangering their lives through ideas of suicide.

Counseling should be started at secondary stage in various colleges and universities in urban and rural areas. Except this, to overcome depression and suicidal ideation among young adults, workshops, seminars, counseling, etc. on hopelessness, depression, problem solving and stress management, etc. should be conducted on regular basis. When student faced critical situation and could not manage situation, they should consult with the student advisor/student counselor. They should organize mental health campaign to be presented by psychiatric, psychologist and student counselor to motivate the hopelessness, depression and suicidal ideation's respondents.

Mental health professionals should give more emphasis on practical and supervisory roles to prevent suicide and thereby saving lives of thousands of young adults of our country.

Recommendations:

1. Parents should be aware that their behavior and relationship are affecting their children.
2. As a large number of students have suicidal ideation, the college and university authority can adopt proper mental health services like counseling. On the other hand, college and university authority can arrange programs and seminars so that students become inspired to go to the counselor or for mental health services.
3. Parents should be more concerned about their relationship with their children, as poor family relationship leads to suicidal ideation.
4. Teachers should promote positive interpersonal relationships among students. Proper guidance, advisory services, counseling services and peer counseling should be introduced in Colleges and Universities.
5. The family can save their children from going to the wrong track in their lives by making them understand the difference between good and bad. This maturity among students can be attained over a period of time with proper guidance and training. College authorities should teach the ways of dealing with hopelessness, depression, anger management, stress management, suicidal ideation, loneliness and what to do at the time of difficulties.
6. Boys and girls should be look after under family surveillance.
7. Family quarrel/disturbance should be tried to stop.
8. Community based social stakeholders' meetings should be organized by local leaders to create awareness among the people that suicide is a great sin.
9. Freedom of exchange of opinion/ideas among the young adults should be viewed as positive gesture.
10. Motivational educational program should be under taken.

Limitations of the study:

1. This survey was conducted only on respondents of Dhaka and Chowgacha under Jashore district's respondents. The same survey may provide different result on different district of Bangladesh.
2. The study was conducted based on 8 colleges of urban and rural areas. Efforts should be given to broaden the size of the sample including more colleges. Larger samples would help to generalize the results.
3. Present research is a descriptive one. Besides exploring the descriptive foundations, further research should be directed toward applying some behavioral intervention programs like cognitive restructuring, counseling etc. by keeping the findings of the present research as baseline.
4. The present study conducted only the students belonging to the age group 18 to 25 year. Hence, the results derived from this study cannot be true for all other age groups.
5. The participants were not selected through random sampling within surveillance.
6. Another limitation is that suicide attempts were not assessed in this study. For understanding the prevalence rate of suicidal attempts it is also necessary to conduct further study.

Implication of this Study

This current study has contributed to identify commonly happened social disorder in Bangladesh in the context of psychosocial factors leading to suicide. It can be helpful for the teacher, parents, family members, therapist, educator, caregiver, and social workers and suicide prevention program.

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Appendices

Annexure-1

05 April, 2023

To
The Dean
Faculty of Biological Science
University of Dhaka
Dhaka-1000, Bangladesh

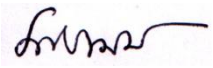
Sub: Application for ethical clearance certificate.

Dear Sir,

As the principal Investigator of the PhD research titled, "Hopelessness, depression and suicidal ideation among young adults in urbanand rural areas", I, undersigned would like to submit the duly filled-up application form to have an ethical clearance certificate in support of pursuing my long cherished PhD.

Your kind cooperation and positive response is highly appreciated.

Sincerely yours,



Dr. Mahfuza Khanam
Professor
Department of Psychology
University of Dhaka
Dhaka-1000, Bangladesh

ডিন অফিস
জীববিজ্ঞান অনুষদ
ঢাকা বিশ্ববিদ্যালয়, ঢাকা-১০০০, বাংলাদেশ

Tel : 58613243
PABX : 9661900-59/4355, 7545
Fax : 880-2-865583
E-mail : deanbio@univdhaka.edu
mimdadul07@yahoo.com

Ref. No. 91/Biol. Scs. December 12.12.2019

Ethical Review Committee
Professor Dr. Mahfuza Khanam
Department of Psychology
University of Dhaka

Sub: Ethical Clearance.

Dear Dr. Mahfuza Khanam,

With reference to your application on the above subject, this is to inform you that your research proposal entitled "Hopelessness, depression and suicidal ideation among young adults in urban and rural areas" has been reviewed and approved by the Ethical Review Committee of the Faculty of Biological Sciences, University of Dhaka.

I wish for the success of your research project.

Professor Dr. Md. Imdadul Hoque
Dean, Faculty of Biological Scineces
University of Dhaka

Annexure-2

Date: January 26, 2022
To
The Chairman
Ethical Review Committee
Dhaka Medical College
Dhaka.

Subject: **Application for the ethical approval of the research.**

Through: Head of the Department of Psychiatry, Dhaka Medical College and Hospital.

Dear Sir,

Please refer to my earlier letter dated November 15, 2021 (copy enclosed) and your subsequent valuable comments/suggestions on the research proposal. With due respect and humble submission, I would like to state that I have made necessary correction in my research proposal according to your comments/suggestions. Moreover, I would like to express my heartfelt thanks for your valuable contribution in development of my research proposal. Now, I am seeking ethical approval from your esteemed committee/organization.

I, therefore, pray and hope that you would be kind enough to grant me the approval and oblige thereby.

Sincerely,

Jebin Nahar
PhD (Researcher)
Department of Psychology
University of Dhaka
Dhaka.

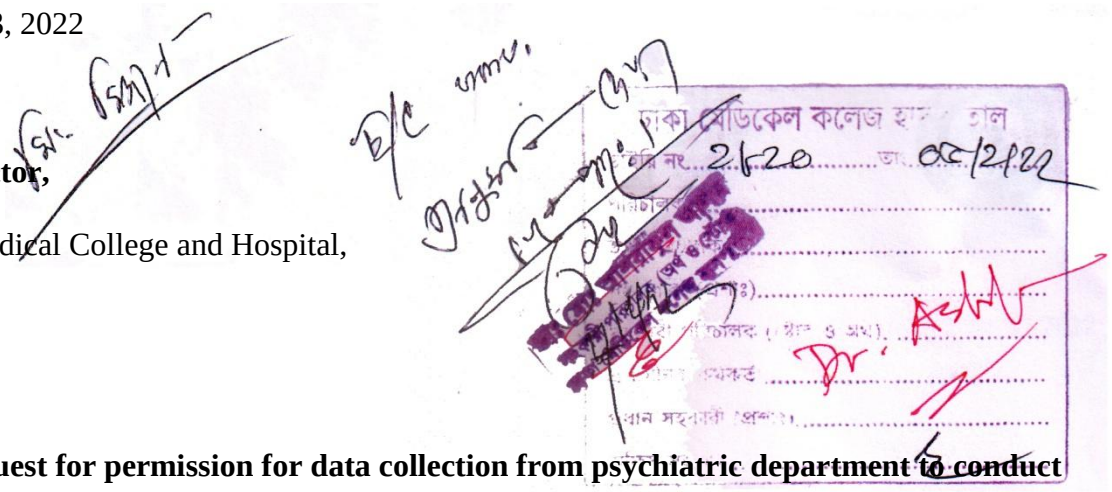
February 3, 2022

To

The Director,

Dhaka Medical College and Hospital,

Dhaka.



Sub: Request for permission for data collection from psychiatric department to conduct research work in order to obtain Ph.D.

Dear Sir,

I, Jebin Nahar, am perusing Ph.D. on Hopelessness, depression and suicidal ideation among ideation among young adults in urban and rural under Department of Psychology, University of Dhaka. In this connection, I would like to select some respective patients from Psychiatric Department of your hospital as my respondents for analyzing hopelessness, depression and suicidal ideation among young adults for academic purpose. Recently, I have received ethical clearance certificate from Ethical Review Committee of Dhaka Medical College in this regard. I am assuring you that I shall protect the personal identity of the patients by assigning each patient a random code number.

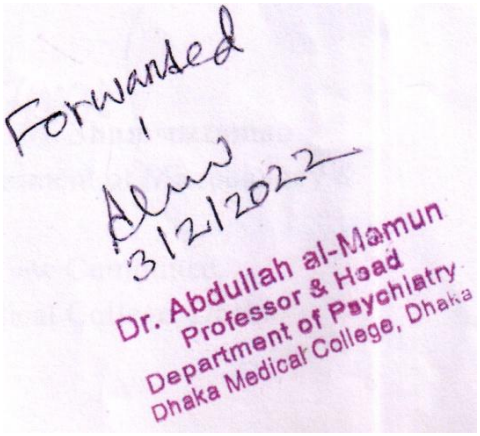
I, therefore, request you to kindly grant me the permission to collect data from your Department of Psychiatry. Your kind co-operation will make this study a success.

Looking forward to your kind co-operation and positive response in this regard.

Sincerely,

Jebin

Jebin Nahar
PhD (Researcher)
Department of Psychology
University of Dhaka.



ঢাকা মেডিকেল কলেজ
DHAKA MEDICAL COLLEGE
Dhaka, Bangladesh

Ref: Memo No. ERC-DMC/ECC/2022/24 Date: 01/02/2022

Ethical Clearance Certificate

The Ethical Committee of Dhaka Medical College Approved the Following Protocol.

Title of the Research Work	:	Hopelessness, depression and suicidal Ideation among young adults in urban and rural areas
Principal Investigator	:	**Jebin Nahar** PhD Student Department of Psychology University of Dhaka .
Supervisor	:	**Dr. Mahfuza Khanam** Professor Department of Psychology University of Dhaka .
Place of Study	:	**Department of Psychiatry** Dhaka Medical College Hospital, Dhaka.
Duration	:	**July, 2019 to June, 2022**

Prof. Dr. S. M. Shamsuzzaman
Head, Department of Microbiology &
Chairman
Ethical Review Committee,
Dhaka Medical College, Dhaka.

Dhaka Medical College, Dhaka-1000, Bangladesh. Phone: 880-2-55165088, Fax : 880-2-55165006
E-mail : principal@dmc.gov.bd, dmc_principal@yahoo.com, web: http://www.dmc.gov.bd

Annexure-3

July 26, 2022
To
Dr.Aminur Rahman
Assistant Professor
Jashore Medical College Hospital
Department of Psychiatry
Jashore.

Through: Chairman, Department of Psychology, University of Dhaka.

Sub: Request for permission for data collection from psychiatric department to conduct research work in order to obtain Ph.D.

Dear Sir,

I, Jebin Nahar, am perusing Ph.D. on Hopelessness, depression and suicidal ideation among young adults in urban and rural under Department of Psychology, University of Dhaka. In this connection, I would like to select some respective patients from Psychiatric Department of your hospital as my respondents for analyzing hopelessness, depression and suicidal ideation among young adults for academic purpose. Recently, I have obtainedethical clearance certificate from Ethical Review Committeesof University of Dhaka, Dhaka Medical College in this regard.I am assuring you that I shall protect the personal identity of the patients by assigning each patient a random code number.

I, therefore, request you to kindly grant me the permission to collect data from your Department of Psychiatry. Your kind co-operation will make this study a success.

Looking forward to your kind co-operation and positive response in this regard.

Sincerely,

Jebin

Jebin Nahar
PhD (Researcher)
Department of Psychology
University of Dhaka.

Recommended
26.9.22
Professor
Department of Psychology
University of Dhaka

26.7.22
Md. Kamal Uddin
(PhD, Kyushu University, Japan)
Professor and Chairman
Dept.of Psychology,University of Dhaka

Permitted
30/07/22
DR. MD. AMINUR RAHMAN
MBBS, M.Phil (Psychiatry)
Asst. Professor, Dept. of Psychiatry
Jessore Medical College, Jessore.

Annexure-4

অংশগ্রহনকারীর সম্মতিপত্র

আমি মনোবিজ্ঞান বিভাগের গবেষক **জেবিন নাহারের** গবেষনায় স্বেচ্ছায় অংশগ্রহণ করতে সম্মত আছি। এই অংশগ্রহণ করার মাধ্যমে আমার কোন প্রকার শারীরিক, মানসিক, অর্থনৈতিক ও সামাজিক ক্ষতি সাধন হবে না। আমার পুরো তথ্য গোপন রাখা হবে এবং তথ্যগুলো শুধুমাত্র গবেষনার কাজে ব্যবহৃত হবে। এই শর্ত সাপেক্ষে আমি তার গবেষনায় অংশগ্রহণ করতে রাজি আছি।

অংশগ্রহনকারী স্বাক্ষরঃ

তারিখ ঃ

গবেষকের স্বাক্ষরঃ

তারিখ ঃ

Consent of the Participant

I am willingly participating in the Research Program of **Jebin Nahar,** a researcher of Psychology. This participation will not be harmful for me by any sort of physical, mental, economical, or even social aspects. All of my information shall be kept confidential and shall be used only for this research work accordingly.

I do herby agree to work with her by abiding by the terms & conditions as applicable.

Participant's Signature: **Researcher's Signature:**

Date: Date:

Annexure-5

ব্যক্তিগত তথ্য ঃ

উপযুক্ত স্থানে টিক (✔) দিন। **তারিখ ঃ**

1.	আইডি নং	
2.	লিঙ্গ ঃ	১. ছেলে ২. মেয়ে
3.	বয়স ঃ	
4.	আপনি যে জেলায় / এলাকায় বসবাস করেন তার নাম	
6.	শিক্ষাগত যোগ্যতা ঃ	১. S.S.C ২. H.S.C ৩. B.A/B.sc ৪. MA/M.Sc
8.	ধর্ম	১. ইসলাম ২. হিন্দু ৩. খ্রিস্টান ৪. বৌদ্ধ

		৫. অন্যান্য
9.	পরিবারের ধরন	১. যৌথ পরিবার ২. একক পরিবার
10.	পরিবারের মোট মাসিক আয়	
11.	আর্থ-সামাজিক অবস্থা	১. উচ্চবিত্ত ২. মধ্যবিত্ত ৩. নিম্নবিত্ত
12.	পরিবারে সদস্যদের সাথে সম্পর্ক কেমন	১. খুবভাল ২. ভাল ৩. মোটামুটি ৪. ভালনা
13.	মানসিক সমস্যা ইতিহাস আছে কিনা?	১.হ্যাঁ ২. না
14.	মানসিক সমস্যা জন্য কোন মানসিক স্বাস্থ্য সেবা নেয়ার ইতিহাস আছে কিনা?	১.হ্যাঁ ২. না
15.	বর্তমান সমস্যার জন্য কোন ডাক্তার / মনোবিজ্ঞানী/ মনোচিকিৎসকের কাছে গিয়েছেন কিনা?	১.হ্যাঁ ২. না

Demographic information:

Date: **Time:**

1	Name of the Id		
2.	Sex	1. [ ] Boy	2. [ ] Girl
3.	Age		
5	Level of education	1. [ ] No Formal Education 2. [ ] SSC 3. [ ] HSC	4. [ ] B.A/B.Sc 5.[ ] M.A/M.Sc
6	Religion	1. [ ]Muslim 2. [ ] Hindu	3. [ ] Christian 4. [ ]Buaahist
8.	Average monthly household income (actual)		
9	In which area do you live?		
10	Types of family	1. Nucleus family	2. Extended Family

11	Socioeconomically status	1. High 2. Middle 3. Low	
12	How are your relationship with family	1. Very good 2. Good	3. Not bed 4. Not good
13	History of mental disorder	1. Yes	2. No
14.	History of mental health service taking	1. Yes	2. No
15.	Have you ever visited Doctor, Psychiatrist, Psychologist	1. Yes	2. No

Annexure-6

Hopelessness Scale (Beck)

এই প্রশ্নপত্রে ২০টি উক্তি/বাক্য আছে। আপনি প্রতিটি বাক্য সতর্কতার সাথে পড়ুন। বাক্যগুলির যেটি আপনার মনের অবস্থাকে (আজকের দিন থেকে শুরু করে গত এক সপ্তাহে) সঠিকভাবে তুলে ধরে তবে "সত্য" এর উপর টিক (√) চিহ্ন দিন। ঠিক একই ভাবে যে বাক্যটি আপনার মনের অবস্থার সাথে মিলছে না তবে "মিথ্যা" এর উপর টিক (√) চিহ্ন দিন। সবশেষে প্রতিটি বাক্য ঠিকমতো পড়া হয়েছে কিনা তা দেখে নিন।

১. আমি আশা এবং উৎসাহ নিয়ে ভবিষ্যতের অপেক্ষায় আছি।	সত্য মিথ্যা
২. আমি সব আশা ছেড়ে দিয়েছি কারণ নিজের ভাল কোন কিছু করার জন্য আমার আর কিছুই করার নেই।	সত্য মিথ্যা
৩. যখন খারাপ সময়ের ভিতর দিয়ে যাই, তখন আমি বুঝতে পারি যে সময় সব সময় খারাপ যাবে না	সত্য মিথ্যা
৪. দশ বছর পর আমার জীবন কেমন হবে তা আমি কল্পনাও করতে পারি না।	সত্য মিথ্যা
৫. আমি যেসব কাজ খুব বেশী করতে চাই, তা শেষ করার মত যথেষ্ট সময় আমার আছে।	সত্য মিথ্যা
৬. যেসব বিষয়/কাজ নিয়ে আমি উদ্বিগ্ন থাকি আমি আশা করি যে ভবিষ্যতে আমি সে সব বিষয়ে সফল হব।	সত্য মিথ্যা
৭. আমার মনে হয় আমার ভবিষ্যত অন্ধকারাচ্ছন্ন।	সত্য মিথ্যা
৮. আমি সাধারণভাবে একজন ভাগ্যবান এবং জীবনের ভাল জিনিসগুলোর অধিকাংশই একজন সাধারণ মানুষ অপেক্ষা বেশী পাওয়ার আশা করি।	সত্য মিথ্যা
৯. আমি বিশ্রাম নেয়ার কোন সুযোগই পাইনা আর ভবিষ্যতে যে পাব তা বিশ্বাস করার মত কোন কারণও নেই।	সত্য মিথ্যা
১০. অতীত অভিজ্ঞতা গুলো আমাকে ভবিষ্যতের জন্য সুন্দরভাবে তৈরী করে দিয়েছে।	সত্য মিথ্যা

১১. আমি আমার সামনে আনন্দের পরিবর্তে শুধু নিরানন্দ দেখি।	সত্য মিথ্যা
১২. যা আমি পেতে চাই তা পাওয়ার কোন আশা আমার নাই।	সত্য মিথ্যা
১৩. আমি আশা করি ভবিষ্যতে আমি বর্তমান অবস্থার চেয়ে বেশী সুখে থাকবো।	সত্য মিথ্যা
১৪. আমি যে ভাবে চাই, কোন কিছুই সেভাবে হয় না।	সত্য মিথ্যা
১৫. ভবিষ্যত সম্পর্কে আমি বেশ আস্থাশীল।	সত্য মিথ্যা
১৬. যা আমি চাই তা কখনোই পাইনা, তাই নিজের জন্য চাওয়াটা বোকামী।	সত্য মিথ্যা
১৭. ভবিষ্যতে আমার প্রকৃতই সুখি/তৃপ্ত হবার (অর্থাৎ আমি প্রকৃত পক্ষে সন্তুষ্ট থাকব) সম্ভাবনা খুবই কম।	সত্য মিথ্যা
১৮. ভবিষ্যত আমার কাছে অস্পষ্ট এবং অনিশ্চিত।	সত্য মিথ্যা
১৯. আমি খারাপ সময়ের চাইতে ভাল সময়ের জন্য বেশী অপেক্ষা করবো।	সত্য মিথ্যা
২০. কোন কিছু পাওয়ার জন্য চেষ্টা করার কোন মানে হয় না, কারণ সম্ভবতঃ সেটা পাওয়া যাবে না।	সত্য মিথ্যা
Total :	

0 - 3 = None or minimal

4 - 8 =Mild

9 - 14 =Moderate. May not be in immediate danger but requires frequent regular monitoring. Is the life situation stable.

15 + = Severe. Definite suicidal risk.

Beck Hopelessness Scale

This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the past week including today, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to the statement. Please be sure to read each statement carefully.

No	Statements		
1	I look forward to the future with hope and enthusiasm	TRUE	FALSE
2	I might as well give up because there is nothing I can do about making things better for myself	TRUE	FALSE
3	When things are going badly, I am helped by knowing that they cannot stay that way forever	TRUE	FALSE
4	I can't imagine what my life would be in 10 years	TRUE	FALSE
5	I have enough time to accomplish the things I want to do	TRUE	FALSE
6	In the future, I expect to succeed in what concerns me most	TRUE	FALSE
7	My future seems dark to me	TRUE	FALSE
8	I happen to be particularly lucky, and I expect to get more Of the good things in life than the average person	TRUE	FALSE

9	I just can't get the breaks, and there's no reason I will in future	TRUE	FALSE
10	My past experiences have prepared me well for the future	TRUE	FALSE
11	All I can see ahead of me is unpleasantness, rather than pleasantness	TRUE	FALSE
12	I don't expect to get what I really want	TRUE	FALSE
13	When I look ahead in the future, I expect to be happier than I am now	TRUE	FALSE
14	Things just don't work out the way I want them to	TRUE	FALSE
15	I have great faith in the future	TRUE	FALSE
16	I never get what I want, so its foolish to want anything	TRUE	FALSE
17	Its very unlikely that I will get any real satisfaction in the future	TRUE	FALSE
18	The future seems vague and uncertain to me	TRUE	FALSE
19	I can look forward to more good times than bad times	TRUE	FALSE
20	There's no use in really trying to get anything I want, because I probably won't get it	TRUE	FALSE

0 - 3 = None or minimal

4 - 8 =Mild

9 - 14 = Moderate. May not be in immediate danger but requires frequent regular monitoring .Is the life situation stable.

15 + =Severe. Definite suicidal risk.

Annexure-7

বিষন্নতা পরিমাপক

নিচের বিবৃতিগুলো পড়ে গত এক সপ্তাহের মধ্যে এই বিবৃতি গুলো আপনার ক্ষেত্রে কতটা প্রযোজ্য তা বিবৃতির পার্শ্বের সম্ভাব্য পাঁচটি উত্তরের যেটি প্রযোজ্য সেটির ঘরে টিক(√) চিহ্ন দিয়ে নির্দেশ করুন। আপনাকে সম্ভাব্য এই পাঁচটি উত্তর থেকে যে কোন একটিকে বেছে নিতে হবে এবং সবগুলো প্রশ্নের উত্তর দিতে হবে। অনুগ্রহ করে লক্ষ্য করুন সবগুলো বিবৃতির উত্তর দিয়েছেন কিনা।

বিবৃতিসমূহ	একেবারেই প্রযোজ্য নয়	প্রযোজ্য নয়	মাঝামাঝি	কিছুটা প্রযোজ্য	পুরোপুরি প্রযোজ্য
১. আমার অশান্তি লাগে।					
২. ইদানিং আমি মন মরা থাকি।					
৩. আমার ভবিষ্যত অন্ধকার।					
৪. ভবিষ্যতে আমার অবস্থা দিনদিন আরো খারাপ হবে।					
৫. আমার সব শেষ হয়ে গেছে।					
৬. আমি মনে করি যে, জীবনটা বর্তমানে খুব বেশী কষ্টকর।					
৭. বর্তমানে আমি অনুভব করি যে মানুষ হিসাবে আমি সম্পূর্ণ ব্যর্থ					
৮. আমি কোথাও আনন্দ-ফুর্তি পাইনা।					
৯. নিজেকে খুব ছোট মনে হয়।					
১০. সবকিছুতে আমার আত্নবিশ্বাস কমে গেছে।					
১১. আমার মনে হয় মানুষ আমাকে করুণা করে।					
১২. জীবনটা অর্থহীন।					
১৩. প্রায়ই আমার কান্না পায়।					
১৪. আমি প্রায়ই বিরক্ত বোধ করি।					

১৫. আমি কোন কিছুতেই আগ্রহ পাইনা।					
১৬. আমি ইদানিং চিন্তা করতে ও সিদ্ধান্ত নিতে পারিনা।					
১৭. আমি আজকাল অনেক কিছুতেই মনোযোগ দিতে পারিনা।					
১৮. আমি আগের মতো মনে রাখতে পারি না।					
১৯. আমি দূর্বল বোধ করি এবং অল্পতেই ক্লান্ত হয়ে পড়ি।					
২০. আমি এখন কম ঘুমাই।					
২১. আমি এখন বেশী ঘুমাই।					
২২. আমার মেজাজ খিঁটখিঁটে হয়ে গেছে।					
২৩. আমার ক্ষুধা কমে গেছে।					
২৪. আমার ক্ষুধা বেড়ে গেছে।					
২৫. আমার ওজন কমে গেছে (ইচ্ছাকৃতভাবে ও জন্ম নিয়ন্ত্রণের চেষ্টা করার ফলেনয়)।					
২৬. আমার মনে হয় যে আমার কাজকর্মের গতি কমে গেছে।					
২৭. হাসির কোন ঘটনা ঘটলেও আমি আর হাসতে পারি না।					
২৮. যৌন বিষয়ে আমার আগ্রহ কমে গেছে।					
২৯. সামাজিক কাজকর্মে আগের মতো অংশগ্রহণ করতে পারি না।					
৩০. শিক্ষাবা পেশাগত কাজকর্ম আগের মতো করতে পারিনা।					
Total:					

***94+** = Depressed; **30-100** = Minimal; **101-114** = Mild; **115-123** = Moderate; **124-150** = Severe*

Developed by: Zahir Uddin and Dr. MahMudur Rahman, Department of Clinical

Psychology, D.U.

Depression Scale :

S.L	Items	Not at all applicable	Not applicable	Moderately applicable	Somewhat applicable	Fully applicable
1	I feel lack of peace in my mind					
2	Now a days I experience low mood					
3	My future is dark					
4	My condition will be worse in future					
5	I am finished					
6	Currently I think that my life is very painful					
7	Currently I feel that i am a complete failure					
8	I find no					

	pleasure any where					
9	I feel myself very inferior					
10	My self-esteem has reduced in every respect					
11	I think that i am an object of pity to the people					
12	Life is meaningless					
13	I often feel like crying					
14	Often i feel irritated					
15	I feel no interest in anything					
16	Now a days i cannot think and cannot take decisions					

17	Now a days cannot concentrate in many things					
18	I cannot remember as before					
19	I feel week and become exhausted easily					
20	Currently i sleep less					
21	Currently i sleep more					
22	My temper has turned irrtable					
23	My appentive has reduced					
24	My appentive has increased					
25	My weight has reduced (Not due to					

	intentional attempt to control weight					
26	I think speed of my work has reduced					
27	I can not laugh even when there is a funny event					
28	My desire in sex has reduced					
29	I can not participate in social activities as i used to					
30	I can not do academic or professional activities as i used to.					

Annexure-8

Beck Scale for Suicidal Ideation (BSS)

অনুগ্রহ করে সতর্কতার সাথে প্রত্যেকটি গ্রুপের উক্তিগুলো পড়ুন। যে উক্তিটি আপনার গত এক সপ্তাহের (আজকের দিনসহ) অনুভূতিকে সবচেয়ে ভালোভাবে বর্ণনা করে, প্রতি গ্রুপ থেকে শুধু সেই উক্তিটি বৃত্তাকার চিহ্ন দ্বারা শনাক্ত করুন।		
১	০	আমার বাঁচার মোটামুটি প্রবল ইচ্ছে আছে।
	১	আমার বাঁচার সামান্য ইচ্ছে আছে।
	২	আমার বাঁচার কোন ইচ্ছে নেই।
২	০	আমার মরার কোন ইচ্ছে নেই।
	১	আমার মরার সামান্য ইচ্ছে আছে।
	২	আমার মরার মোটামুটি প্রবল ইচ্ছে আছে।
৩	০	আমার বেঁচে থাকার কারণগুলো মরে যাবার কারণগুলোর চেয়ে অধিকতর জোরালো।
	১	আমার বেঁচে থাকার কারণগুলো এবং মরে যাবার কারণগুলো প্রায়সমান জোরালো।
	২	আমার মরে যাবার কারণগুলো বেঁচে থাকার কারণগুলোর চেয়ে অধিকতর জোরালো।
৪	০	আমার আত্মহত্যা করার কোন ইচ্ছে নেই।
	১	আমার আত্মহত্যা করার সামান্য ইচ্ছে আছে।

	২	আমার আত্মহত্যা করার মোটামুটি প্রবল ইচ্ছে আছে।
৫	০	জীবননাশক পরিস্থিতিতে পড়লে আমি জীবন বাঁচানোর চেষ্টা করব।
	১	জীবননাশক পরিস্থিতিতে পড়লে বাঁচা মরা আমি ভাগ্যের উপর ছেড়ে দিব।
	২	জীবননাশক পরিস্থিতিতে পড়লে আমি মৃত্যুকে এড়ানোর চেষ্টা করব না।
যদি আপনি ৪ ও ৫ নং উভয় গ্রুপ থেকে ক নং বাক্য পছন্দ করে থাকেন তাহলে সরাসরি ২০ নং বাক্যে চলে যান। আর যদি ৪নং ও ৫নং থেকে খ অথবা গ নং বাক্য পছন্দ করে থাকেন তবে ৬নং থেকে শুরু করুন এবং এগিয়ে যান।		
৬	০	আমার আত্মহত্যার চিন্তা ক্ষণস্থায়ী।
	১	আমার আত্মহত্যার চিন্তা কিছুটা স্থায়ী।
	২	আমার আত্মহত্যার চিন্তা দীর্ঘস্থায়ী।
৭	০	কদাচিৎ অথবা অকস্মাৎ আমি আত্মহত্যার চিন্তা করি।
	১	আমি প্রায়ই আত্মহত্যার চিন্তা করি।
	২	আমি অবিরত আত্মহত্যার চিন্তা করি।
৮	০	আত্মহত্যার ধারণাটি আমার নিকট গ্রহণীয় নয়।
	১	আত্মহত্যার ধারণাটি আমার নিকট গ্রহণীয়ও নয় বর্জনীয়ও নয়।

	২	আত্মহত্যার ধারণাটি আমার নিকট গ্রহণীয়।
৯	০	আমি আত্মহত্যা করা থেকে নিজেকে সরিয়ে রাখতে পারব।
	১	আমি আত্মহত্যা করা থেকে নিজেকে সরিয়ে রাখতে পারব কিনা এ ব্যাপারে আমি সন্দিহান।
	২	আমি আত্মহত্যা না করে পারবনা।
১০	০	আমার পরিবার, বন্ধুবান্ধব, ধর্ম এবং আত্মহত্যার ব্যর্থ প্রচেষ্টা প্রসূত সম্ভাব্য ক্ষত বা পীড়া ইত্যাদির বিবেচনায় আমি আত্মহত্যা করব না।
	১	আমার পরিবার, বন্ধু-বান্ধব, ধর্ম এবং আত্মহত্যার ব্যর্থ প্রচেষ্টা প্রসূত সম্ভাব্য ক্ষত বা পীড়া ইত্যাদির বিবেচনায় আমি আত্মহত্যার ব্যাপারে কিছুটা উদ্বিগ্ন।
	২	আমার পরিবার, বন্ধু-বান্ধব, ধর্ম এবং আত্মহত্যার ব্যর্থ প্রচেষ্টা প্রসূত সম্ভাব্য ক্ষত বা পীড়া ইত্যাদির বিবেচনায় আমি আত্মহত্যার ব্যাপারে উদ্বিগ্ন নই।
১১	০	আমার আত্মহত্যা করতে চাওয়ার মূল কারণগুলো অন্যকে প্রভাবিত করা যেমন, কারো উপর প্রতিশোধ নেয়া, কাউকে অধিকতর সুখি করা, আমার প্রতি অন্যদের মনোযোগ আকর্ষণ করা ইত্যাদি।
	১	আমার আত্মহত্যা করতে চাওয়ার কারণ শুধু অন্যকে প্রভাবিত করা নয়; আমার সমস্যাগুলোর সমাধান করাও বটে।
	২	আমার আত্মহত্যা করতে চাওয়ার কারণ মূলত আমার সমস্যাগুলো থেকে মুক্তি পাওয়া।

১২	০	কীভাবে আমি আত্মহত্যা করব সে ব্যাপারে আমার সুনির্দিষ্ট কোন পরিকল্প নেই।
	১	কীভাবে আমি আত্মহত্যা করব সে ব্যাপারে মনোযোগের সাথে ভেবেছি কিন্তু এখনও বিস্তারিত কাজ করিনি।
	২	কীভাবে আমি আত্মহত্যা করব সে ব্যাপারে আমার নির্দিষ্ট একটি পরিকল্পনা আছে।
১৩	০	আমার আত্মহত্যা করার সুযোগ নেই বা আত্মহত্যার পদ্ধতি নাগালে নেই।
	১	আমি যে পদ্ধতিতে আত্মহত্যা করব তা সময় সাপেক্ষ এবং বস্তুত সে পদ্ধতি আমার ব্যবহারের সুযোগ নেই।
	২	আমি যে পদ্ধতিতে আত্মহত্যা করব সে পদ্ধতি আমার নাগালে আছে কিংবা থাকবে এবং তা ব্যবহারের সুযোগ আছে কিংবা থাকবে।
১৪	০	আমার আত্মহত্যা করার সাহস কিংবা দক্ষতা নেই।
	১	আমার আত্মহত্যা করার সাহস কিংবা দক্ষতার ব্যাপারে আমি সন্দিহান।
	২	আমার আত্মহত্যা করার সাহস এবং দক্ষতা আছে।
১৫	০	আমি আত্মহত্যার চেষ্টা করব এটা প্রত্যাশা করি না।
	১	আমি আত্মহত্যার চেষ্টা করব কিনা এ ব্যাপারে আমি সন্দিহান।

	২	আমি যে আত্মহত্যার চেষ্টা করব সে ব্যাপারে আমি নিশ্চিত।
১৬	০	আমি আত্মহত্যা করার কোন প্রস্তুতি নেইনি।
	১	আমি আত্মহত্যা করার কিছু প্রস্তুতি নিয়েছি।
	২	আমি আত্মহত্যা করার প্রস্তুতি প্রায় অথবা সম্পূর্ণ শেষ করেছি।
১৭	০	আমি আত্মহত্যা পূর্ব চিরকুট এখনও লিখিনি।
	১	আমি আত্মহত্যাপূর্ব চিরকুট লিখার কথা ভেবেছি অথবা লিখা শুরু করেছি কিন্তু এখনও শেষ করিনি।
	২	আমি আত্মহত্যাপূর্ব চিরকুট লিখে ফেলেছি।
১৮	০	আত্মহত্যা করার পর কি ঘটবে সে ব্যাপারে আমি কোন ব্যবস্থা নেইনি।
	১	আত্মহত্যা করার পর কি ঘটবে সে ব্যাপারে আমি কিছু ব্যবস্থা নেয়ার কথা ভেবেছি।
	২	আত্মহত্যা করার পর কিঘটবে সে ব্যাপারে আমি নির্দিষ্ট কিছু ব্যবস্থা নিয়েছি।
১৯	০	আমি আমার আত্মহত্যা করার ইচ্ছা লোকজনের কাছে লুকোইনি।
	১	আমি আমার আত্মহত্যার ইচ্ছার কথা লোকজনকে বলব কিনা সে ব্যাপারে ইতস্তত বোধ করছি।
	২	আমি আমার আত্মহত্যা করার ইচ্ছা লোকজনের কাছ থেকে লুকিয়ে রেখেছি।

২০	০	আমি কখনও আত্মহত্যার চেষ্টা করিনি।
	১	আমি একবার আত্মহত্যার চেষ্টা করেছি।
	২	আমি দুই বা ততোধিকবার আত্মহত্যার চেষ্টা করেছি।
যদি আপনি পূর্বে আত্মহত্যার প্রচেষ্টা করে থাকেন তবে পরবর্তী বাক্যগুলো থেকে ১টি বাক্য পছন্দ করুন।		
২১	০	শেষবার আত্মহত্যা- প্রচেষ্টার সময় আমার মৃত্যুর ইচ্ছে কম ছিল।
	১	শেষবার আত্মহত্যা- প্রচেষ্টার সময় আমার মৃত্যুর ইচ্ছে মাঝারি ধরণের ছিল।
	২	শেষবার আত্মহত্যা- প্রচেষ্টার সময় আমার মৃত্যুর ইচ্ছে প্রবল ছিল।

Beck Suicide Ideation Scale

Please carefully read each group of statements below. Circle the ONE statement in each group that best describes how you have been feeling for the past week, including today. Be sure to read all of the statements in each group before making a choice.

Part 1.

1.	0	I have a moderate to strong wish to live.
	1	I have a weak wish to live.
	2	I have no wish to live.
2	0	I have no wish to die.
	1	I have a weak wish to die.
	2	I have a moderate to strong wish to die
3	0	My reasons for living outweigh my reasons for dying.
	1	My reasons for living or dying are about equal.
	2	My reasons for dying outweigh my reasons for living
4	0	I have no desire to kill myself.
	1	I have a weak desire to kill myself.
	2	I have a moderate to strong desire to kill myself.
5	0	I would try to save my life if I found myself in a life
	1	I would take a chance on life or death if I found myself in a life

	2	I would not take the steps necessary to avoid death if I found myself in a life
If you have circled the option ZERO (0) in all of the above statements, then you can stop answering the questionnaire, however if you have circled 1 or 2 in any of the above statements please proceed to Part 2 of this questionnaire.		
Part-2		
6	0	I have brief periods of thinking about killing myself which pass quickly.
	1	I have periods of thinking about killing myself which last for moderate amounts of time.
	2	I have long periods of thinking about killing myself.
7	0	I rarely or only occasionally think about killing myself.
	1	I have frequent thoughts about killing myself
	2	I continuously think about killing myself.
8	0	I do not accept the idea of killing myself.
	1	I neither accept nor reject the idea of killing myself.
	2	I accept the idea of killing myself
9	0	I can keep myself from committing suicide.
	1	I am unsure that I can keep myself from committing suicide.
	2	I cannot keep myself from committing suicide.

10	0	I would not kill myself because of my family
	1	I am somewhat concerned about killing myself because of my family
	2	I am not or only a little concerned about killing myself because of my family
11	0	My reasons for wanting to commit suicide are primarily aimed at influencing other people, such as getting even with people, making people happier, making people pay attention to me, etc.
	1	My reasons for wanting to commit suicide are not only aimed at influencing other people, but also represent a way of solving my problems.
	2	My reasons for wanting to commit suicide are primarily based upon escaping from my problems.
12	0	I have no specific plan about how to kill myself.
	1	I have considered ways of killing myself, but I have not worked out the details.
	2	I have a specific plan for killing myself.
13	0	I do not have access to a method or an opportunity to kill myself.
	1	The method that I would use for committing suicide takes time, and I really do not have a good opportunity to use this method.
	2	I have access or anticipate having access to the method that I would

		choose for killing myself and also have or shall have the opportunity to use it.
14	0	I do not have the courage or the ability to commit suicide.
	1	I am unsure that I have the courage or the ability to commit suicide.
	2	I have the courage and the ability to commit suicide.
15	0	I do not expect to make a suicide attempt.
	1	I am unsure that I shall make a suicide attempt.
	2	I am sure that I shall make a suicide attempt.
16	0	I have made no preparations for committing suicide.
	1	I have made some preparations for committing suicide.
	2	I have almost finished or completed my preparations for committing suicide.
17	0	I have not written a suicide note.
	1	I have thought about writing a suicide note or have started to write one, but have not completed it.
	2	I have completed a suicide note.
18	0	I have made no arrangements for what will happen after I have committed suicide.
	1	I have thought about making some arrangements for what will happen

		after I have committed suicide.
	2	I have made definite arrangements for what will happen after I have committed suicide.
19	0	I have not hidden my desire to kill myself from people.
	1	I have held back telling people about wanting to kill myself.
	2	I have attempted to hide, conceal, or lie about wanting to commit suicide

Scoring of the Tool

The size of suicidal ideation comprises of 21 but 19 used for the basic thought of suicidal ideational and 2 items used for attempted suicide in past, for these items, scored 0 to 2, which can be utilized to assess a person's self-destructive intention. The minimum and maximum score run in 0-38. The high score is interpreted as high self destructive ideation and low score demonstrates low or no self-destructive ideation. Individual scoring up to 10 is distinguished as the low level of suicidal ideation, scoring between 11-27 average levels of suicidal ideation and scores greater than 28 will fall under the category of high suicidal ideation.

Annexure-9

Focus Group Discussion Questionnaire

There are two main questions in FGD:

1. In your opinion what are the causes responsible for suicidal ideation?

2. Please sharec your experience, if any, about the issues which are responsible for suicidal ideation?

ফোকাস গ্রুপ আলোচনার প্রশ্নমালা:

ফোকাস গ্রুপ আলোচনাতে দুটি প্রধান প্রশ্ন রয়েছে। তাহলো:

১. আপনার মতে, আত্নহত্যার চিন্তার জন্য দায়ী কারণগুলো কি?

২. আত্নহত্যার চিন্তার জন্য দায়ী বিষয়গুলি সর্ম্পকে আপনার অভিজ্ঞতা শেয়ার করুন, যদি থাকে?

Annexure-10

পিএইচ.ডি./ডি.বি.এ./এম.ফিল.

(থিসিসে **Plagiarism** নেই মর্মে প্রত্যয়নপত্র)

গবেষকের নাম (ক) বাংলায় জেবিন নাহার

(খ) ইংরেজীতে JEBIN NAHAR

বিভাগ/ইনস্টিটিউট মনোবিজ্ঞান

থিসিসের শিরোনাম Hopelessness, depression and suicidal ideation among young adults in urban and rural areas

তত্ত্বাবধায়কের নাম ঃ ড° মাহফুজা খানম, অধ্যাপক

যুগ্ম-তত্ত্বাবধায়কের নাম ঃ (১).....

(২).....

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Hopelessness, depression and suicidal ideation among young adults in urban and rural Areas

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University of Dhaka

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