EXPLORING EARLY WARNING SIGNS OF SUICIDE IN BANGLADESH

Thesis submitted in partial fulfillment of the requirements for the Degree of M.Phil. in Clinical Psychology awarded by the University of Dhaka

Submitted by

Rubina Jahan Rumi

M.Phil (Part-II)

Registration No: 305/2013-2014

Department of Clinical Psychology

University of Dhaka

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DEDICATION

I dedicate my dissertation work to my Mother Rahima Begum, a strong soul who taught me to believe in hard work and that so much could be done with little.

I also dedicate this dissertation to my dearest elder sister Imroz Jahan for being my guardian and inspiration. The person I became today is because of her unconditional love, support and encouragement.

APPROVAL OF THE THESIS

This is to certify that the study “EXPLORING EARLY WARNING SIGNS OF SUICIDE IN BANGLADESH” submitted by **RUBINA JAHAN RUMI** to fulfill the requirements for the degree of M. Phil in Clinical Psychology is an original study. The research was carried out by her under my guidance and supervision. I have read the thesis and believe this to be an important work in the field of clinical psychology. The findings can be utilized in saving life and improving mental health condition.

Date:

. . . .

(Dr. Muhammad Kamruzzaman Mozumder)

Associate Professor

Dept. of Clinical Psychology

University of Dhaka

ABSTRACT

Although sufficient work on general warning signs of suicide has been conducted worldwide, the numbers of studies that focus on behavior immediate to suicide are very limited. Additionally, as culture is known to shape human behavior in numerous ways, is necessary to understand the pre-suicidal behavior of Bangladeshi cases if any warning sign based intervention is to be developed for this country. The aim of the present study was to explore pre-suicidal behavior in order to identify early warning signs of suicide. A qualitative research design using phenomenological approach was adopted in this study. Purposive sampling technique was employed to select eight participants using predefined inclusion and exclusion criteria. Data were collected from para-suicide cases and family members of cases who have completed or attempted suicide. In-depth interview was used to collect data which were audio recorded for ensuring accuracy. Data analysis process involved verbatim transcription of the interviews, open and axial coding. The findings provided detailed insight and understanding of suicide warning signs along with overall suicide process. The findings clearly reflect the notion that suicide is preventable. Suicidal individuals provide pre suicide warning signs at different time frame and on different modalities such as behavioral, cognitive and emotional. Moreover, it was found that suicidal individuals often directly express their suicidal thoughts to the family members and friends. Their expression of suicidal warning signs ranged from proximal to distal in terms of time frame. Another important findings revealed in this study was that people around the suicidal individual were able to perceive their suicidal risk. However, instead of providing help these people ignored the risk based on subjective judgment. The probable reason behind this ignorance might be the lack of knowledge about warning signs and stigma around suicide. In either case present study can contribute into this through

enhanced knowledge from detailed understanding gained in this study. Findings of the present study suggest a well defined set of warning signs in the context of Bangladesh. These warning signs can be utilized in designing national suicide prevention guidelines for Bangladeshi population.

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CHAPTER 1

INTRODUCTION

INTRODUCTION

Suicide is a serious public health concern worldwide. This problem is especially acute in countries where necessary resources and services for early intervention, prevention and support for people in need are limited (Chehil & Kutcher, 2012). Similar to many other countries, suicide is a growing and serious public health and social concern in Bangladesh. It can be assumed that suicides can often be prevented if the potential suicidal cases can be identified at an early stage (Nordentoft, 2007). Suicidal thoughts may be assumed to impact distinctively on the person's behavior and activities. Identifying these behavioral differentials between non-suicidal and suicidal (ideation, planning or action) stage can be an important aspect of developing an early warning system for intervention. The current study will attempt to explore early warning signs of suicidal behavior and will contribute in generating preventive measures to curb suicidal attempts.

According to World Health Organization (1998) suicide is the act of killing oneself, it must be deliberately initiated and performed by the person concerned in the full knowledge, or expectation, of its fatal outcome. This definition implies that suicide is a conscious act of any human being where the person intends to end his/her life with a planned lethal method.

Definition of attempted suicide or para suicide includes those situations in which a suicidal act has led to a non-fatal outcome (World Health Organization, 1998). In other words, attempted suicide is purposeful self-inflicted acts that has produce non-fatal outcome and is associated with implicit or explicit intention to die (Gould, Greenberg, Velting, & Shaffer, 2003).

Over the decades, warning signs have been used as a way to prevent broad spectrum of health problems and related disorders. For example, among many health

issues warning signs for heart attack, stroke and diabetes are commonly known (Carter, 2004). Similar approaches to prevent and treat ailment at earlier stage based on early warning signs have been utilized to mental health sectors (Nordentoft, 2007). American Psychological Association stressed on the necessity to understand warning signs for youth violence in order to prevent this (Peterson & Newman, 2000). These strategies are applicable to many other mental health problems as well. The most important utility of warning sign is the early detection of risk in particular field so that preventive steps could be taken.

Warning signs play an important role in the early detection of suicide (Rudd, 2008). There is no consensus on the definition of warning signs and risk factors in suicide. Warning signs of suicide is commonly perceived as the proximal indicators of suicidal behavior. These includes near-term risks i.e., acute risks where time period implies hours to few days. On the other hand there are risk factors which may not immediately precedes suicide attempts but bear a distal relationship with it. In such case of distal longer term risk, the gap between the risk exposure and suicide attempt may be in months to years.

Rudd et al. (2006) reported that warning sign is the earliest detectable sign that indicate most current and immediate suicide risk starting from hours to days. Van Orden et al. (2006) reported that through warning signs individuals underlying conditions get behaviorally manifested in different ways. Warning signs are directly observable and they reflect the current state of a person and thus point to the presence of suicidal crisis (Van Orden et al., 2006).

Warning signs are manifested in an individual’s behavior, thoughts, and in mood level. Hendin, Maltsberger, and Szanto (2007) reported three broad categories of warning

signs: (a) suicidal thoughts and direct behavior, (b) behaviors indirectly related to suicide, (c) affective states or intense feelings/emotions. These categories are explained below:

a) **Suicidal thoughts and direct behaviors:** Suicidal thoughts are generally reflected through verbal statements e.g. I want to kill myself, I wish I was dead, I wish I would never wake up. Statements about hopelessness, helplessness, and feeling out of control or worthlessness may indicate the presence of suicidal thoughts as well. Additionally, some individuals may demonstrate suicidal behavior such as planning for suicide, proactively collecting means (pesticides, gun, and knife) and setting time to commit suicide.

b) **Behaviors indirectly related to suicide:** These are passive actions such as withdrawal from family and friends, reckless behavior, lack of self-care etc. This behavior also includes preoccupation with suicide and/or death e.g. creative works expressing thoughts of death, giving away possessions, setting one's affairs in order. Other behavior falling into this category maybe suddenly taking unnecessary risks e.g. not taking prescribed medications, ignoring physical limitations, putting life in dangerous situations, increased use of alcohol or drugs.

c) **Affective states:** When we face a situation, the thought process generates pleasant or unpleasant feelings. These affect our emotions or the affective state. The affective state in a person with suicidal risk may include e.g. agitation, anger, irritability, sadness, sudden mood swing etc.

In a study Hendin et al. (2007) also stated warning signs as proximal factor rather than a risk factor which he referred as distant construct that simply predicts or may be related to suicide. This concept indicates a basic difference between warning signs and

risk factors of suicide. Risk factors include many factors that influence a person whether he/she is likely to be vulnerable to be suicidal at any point of time in life (Mandrusiak et al., 2006). It is also considered as vulnerable factor that can increase the likelihood of suicide. Extensive evidence has been found that risk factors can predict lifetime risk of suicide but it cannot notify the immediate danger. Acute risk includes those risk that are present in a time span ranging from weeks to months and long term risk covers a time span of a year or more (Rudd et al., 2006). This time frame of risk identification is a significant issue that gives a clear idea that warning sign and risk factors are completely different aspect regarding suicide threat prediction. Through above discussion it seems that early detected warning signs can play significant role preventing suicide as it implies imminent risk of an individual rather than risk factors which encompass the longer term risk.

1.1 Global View of Suicide

Suicide is a significant concern worldwide. Suicide represents 1.4% of the Global Burden of Disease (Chehil & Kutcher, 2012). According to a report from WHO, suicide has worldwide death toll of around 800000 people per yearly, taking an average of one life in every 40 seconds (World Health Organization, 2014). The same report also suggested that the rate of para suicide is10-20 times higher compared to suicide. World Health Organization (2014) reported that Asian countries account for approximately 60% of the world's suicides.

1.2 The Context of Suicide in Bangladesh

There is a paucity of literatures on suicide in Bangladesh context, and there is no comprehensive article on suicide in Bangladesh context. Still suicide is a neglected and

under attended public health problem in Bangladesh. Few review research and reports had conducted over time through which an overall impression of scenario of suicide in Bangladesh could be drawn.

1.2.1 Suicide Rates. It is very difficult to provide a reliable estimate of the actual suicide rates due to the absence of national mortality surveillance system in Bangladesh. A handful of studies conducted on community samples have reported wide variation in suicide rates across Bangladesh.

One study from 2009-2010 covering a subsection of Chuadanga, a district in the western region of Bangladesh (Feroz et al., 2012), second, a longitudinal study from 1982-2002 conducted in a semi-urban area of Jessore district in the southwest (ICDDR, 2003) and a third longitudinal study from 1990-1999, conducted on 70 village under service converge the local non-government organization Bangladesh Rural Advancement Committee (Hadi, 2005). These studies showed quite high suicide rates 128.8 per 100000 in the 2009-2010 study in Chuadanga district, and a mean of 39.6 per 100000 in the longitudinal study (1982-2002) in Jessore District, with an annual range of rates from 10.7 to 119.5.

Another cross sectional study was conducted during 2003 (January-December) by Mashreky, Rahman, and Rahman (2013) to explore epidemiology of suicide in Bangladesh, reported that the yearly suicide rate was 7.3 (95% CI 5.6-9.5) per 100000.

According to a report published in the national daily newspaper *The Daily Star*, from 73389 people committed suicide in Bangladesh during 2002 to 2009. While *Bangladesh Manabadhikar Bastabayan Sangstha*, a human rights group of Bangladesh shows that from January 2011 to August 2011, 258 people committed suicide.

Unlike India, Nepal or Sri Lanka, Bangladesh does not report national suicide rate to WHO. For this given difficulties (Mark Jordans, 2013) interpolated suicide rates in Bangladesh from three published studies in their report published on Suicide in South Asia. They reported the non-pooled mean rate of suicide in Bangladesh as 58.3 (SD=63.22). While for India, it was 28.8 (SD=32.17), for Sri Lanka 25.7 (SD=4.80), for Nepal 8.6 (SD=8.87) and for Pakistan, it was 3.6 (SD=5.06).

Worldwide rate of committing suicide is higher among men compared to women (Mark Jordans, 2013). However, the reported rate in Bangladesh indicates higher suicide rate among female compared to male. Feroz et al. (2012) found male to female ratio was around 1:4. In another case study conducted on high rate of suicide in Shailakupa and Harinkundu Upazilla of Jhinaidah district of Bangladesh shows that female suicide rates are highest 67.3% than male 32.7% (Development, 2010). Arafat (2014) reported female and male ratio to be 3:2 in Bangladesh. In Bangladesh, women of reproductive age seem to be at highest risk among others. In a study, 65.5% of the individuals' committing suicides were from the age group of 20-39 years.

1.2.2 Methods of Suicide. The most common methods of suicide are; poisoning, hanging, heavy doses of sleeping pills, jumping from height, jumping in deep water, causing serious injury on vital part of the body and shooting by fire arms. A study from Foundation for Research and Development, (2010) reported self-poisoning as the most common method of suicide in Bangladesh. The percentage of poisoning is 75% whereas 13% by jumping in front of speedy vehicle and 11.53% by hanging (Foundation for Research and Development, 2010). This finding has been supported by other research conducted regionally. Jordans et al. (2014) conducted a study where they explored the suicide facts in South Asia found poisoning and hanging as the two most common means

of suicide in Bangladesh. Police reports also suggested poisoning as the most commonly used ways of committing suicide. Another study reported means of suicide to be related with age group, as they found, hanging to be the predominant means for young people in the age group of 11-20 years (Rahim & Das, 2009).

1.2.3 Causes of Suicide. Suicide can occur for many different causes. This will vary widely from country to country. A set of underlying factors usually serve as the root causes that work in the background and contribute to suicide. These may include low coping skills, low problem solving capacity, and problems in emotional regulation. Attributable causes are the final precipitating factors which lead to suicide. In Bangladesh, the common issues precipitating suicide are loss, relationship problem, poverty, unemployment, failures, marital or family problems, physical and mental sufferings, and unbearable feeling or pain. In a case study it was found that highest number suicide occurs due to failure of love (21%), followed by financial hardship (13.35%),and (10%) acute discord in relationship between couples (Prime University, 2010). Another study shows, around 57% had discord in family, 23% at least one family member died by suicide, 17% were suffering from chronic diseases (Feroz et al., 2012).

Yusuf, Akhter, Chowdhury, and Rochat (2007) reported among the different causes of suicide, personal problem were 23.9%, economic hardship 18.6% and history of suicidal attempt by any relative and previous attempt to suicide found to be highly significant factors to suicide.

According to statistics provided by Jatiya Mahila Ainjibi Samity, (2006-2010) 40 girls committed suicide because of stalking. They also reported that 4,747 women and girls killed themselves from 2001-2010 due to physical and mental violence in the family.

1.3 Theories of Suicide

Overtime many theorist and researcher worked on suicide and developed different theoretical model on suicide. To understand overall suicide process it is important to have a look on those existing theories and knowledge. Few important and well known theories of suicide have been presented below to have a overall understanding on this particular area.

1.3.1 Durkheim's sociological theory of suicide. Durkheim's main statement was that suicide is not an individual act. He stated that suicide was a social fact that was tied to social structures because it was something that happened by social causes (Pope, 1976) . In order to test his theory he studied suicide rates across time and place (throughout Europe, spanning many years). After completing his preliminary research and analyses, he came to the conclusion that, despite major differences in suicide rates between individual societies, rates within a society remained stable over time. Durkheim elaborated three different types of suicide that are found in all societies (Van Poppel & Day, 1996). These include:

- Egoistic suicide- which results from lack of integration of the individual into society. This means that a person is not included in many things that happen in society, they feel unattached, helpless and useless. Due to these feelings of inadequacy, the person takes his or her own life (Breault & Barkey, 1982).
- Altruistic suicide- it results from the individual's taking his own life because of higher commandments. This means that the individual feels that something larger than himself is causing him to take his own life, such as religious Martyrs or suicide bombers (Stack, 2004).

- Anomic suicide- which results from lack of regulation of the individual by society. This means that the society is going through some sort of change, where the rules of the society are not as clear as they were. The individual feels confused and does not know how to handle the major changes occurring around him/her, and thus commits suicide (Pope, 1976).

1.3.2 Joiner's interpersonal-psychological theory of suicide. In the interpersonal-psychological theory of suicidal behavior, Joiner Jr, et. al., (2009) proposed that an individual will die by suicide if he or she has both the desire for suicide and capability to act on that desire. According to the theory, suicidal desire results from two interpersonal states: perceived burdensomeness and thwarted belongingness (Ribeiro & Joiner, 2009). However, these two is associated with another factor namely the acquired capability for suicide. Suicidal desire develops from repeated exposure and habituation to painful and provocative events (Van Orden et al., 2010).

1.3.3 Aaron T Beck's hopelessness theory of suicide. Aaron Beck emphasized the role of hopelessness in the process of suicide. In one study Beck and colleagues found those with high hopelessness were 11 times more likely to die by suicide than those with lower scores (Beck, Kovacs, & Weissman, 1975). Beck also argued that previous suicidal experience sensitizes suicide-related thoughts and behaviors so that they become more accessible and active. It allows for subsequent episodes to be more easily triggered and more severe (Minkoff, Bergman, Beck, & Beck, 1973). Beck's assumption shares similarities with Joiner's model which proposes an escalating course of suicidal behavior over time through habituation.

1.3.4 Roy Baumeister's escape theory of suicide. Roy Baumeister analyzed suicide in terms of motivations to escape from aversive self-awareness. Awareness of the self's inadequacies generates negative affect, and thus individual desires to escape from self-awareness and the associated affect (Baumeister, 1990). Roy Baumeister described a series of steps leading up to serious suicidal behavior: first, individual experiences a negative and severe discrepancy between expectations and actual events. Second, an aversive state of high self-awareness develops, which produces negative affect. Third, person attempts to escape from negative affect as well as from the aversive self-awareness by retreating into a numb state of cognitive deconstruction.

1.3.5 David Rudd's fluid vulnerability model of suicide. David Rudd proposed fluid vulnerability model of suicide which includes some major points (Rudd, 2006). Which are: suicidal episodes are time-limited, risk factors that both trigger a suicidal episode and determine the duration and severity of an episode are fluid, imminent risk cannot endure beyond periods of heightened arousal and baseline risk varies from person to person.

1.4 Implications of Warning Signs

In terms of suicide prevention warning sign can play role in primary, secondary and tertiary level of intervention. *Primary level* includes working with people who have not shown the signs yet or have limited signs. *Secondary level* considers community mental health that are helpful in preventing suicide. And *tertiary level* engages more critical point where person are already in acute risk and in need of professional help. The

present study is designed to explore early warning signs of suicide which will able to cover this wide spectrum area of suicide prevention.

1.4.1 Public awareness. Awareness about early warning signs of suicide the general public can be a valuable option in fighting increasing suicide rate. When people are aware about these signs they can identify and provide support or refer when they came across a person with suicide risk. Van Orden et al. (2006) reported that the general public is not readily aware of suicide warning signs. Therefore, a well-defined set of warning signs would be a great help in order to develop a public health campaign featuring suicide warning signs. Gould et al. (2003) mentioned that the basic rationale behind exploring warning signs is that it promotes public awareness. Not only has that it also greatly contributed in early detection and intervention.

Rudd (2008) emphasized in his study that if lay people get to know the standard set of warning signs of suicide it can serve the primary goal of saving lives by improving recognition of those at risk and facilitating referral for professional care. Thus warning signs generally are intended for public consumption demanding appeal from both public health and clinical perspective.

A study by Van Orden et al. (2006) found that participants who read warning signs of suicide reported greater abilities to recognize if someone is suicidal. Their result suggested that a list of warning signs may be effective in increasing the public's ability to recognize suicidal crises without creating or magnifying stigmatization of suicidal people. Therefore, a list of suicide warning sign will be a valuable resource for suicide hotline, a large number of lay volunteers, emergency staff, first responders e.g., police, nurses and mental health professionals.

1.4.2 Family and friends. It would also be immensely valuable for close friends and family members, so that they can take preventive measures to protect the people who are suicidal. Friends and families are the first responders. If they understand the early warning signs they can actively protect the loved ones. One estimate suggests that 75% of individual who die by suicide are not in touch with mental health professionals at the time of their death (Owens, Booth, Briscoe, Lawrence, & Lloyd, 2003). That means either the person were not able to detect the own risk of suicide or the person was aware of the risk but could not able to seek help (Hjelmeland & Knizek, 2004). In either cases family, friends or other individuals in the social network would be benefited by the warning signs to recognize the risk in vulnerable person that could lead them more specific idea how to help a suicidal individual (Hjelmeland & Knizek, 2004).

Not only for the suicidal person, for every life lost to suicide there are more people left on tragedy; parents, children, siblings, and friends. The suffering does not end with the death of one specific person, this people fall in risk of suicide. In order to protect their mental wellness people in the community again in need of knowing the warning signs of suicide.

1.4.3 Self awareness. If a person is aware of his/her own psychological state and is informed about early warning signs of suicide, it is the best way of tackling suicide. In a study comparing self-report survey and clinician completed measures of suicidality, assessment showed that the patients self-rating was more predictive of future suicidality than clinicians (Joiner Jr, Walker, Rudd, & Jobes, 1999). There is research evidence suggesting that suicidal people do not intend to die, they see suicide as a means to end their pain. People considering suicide have some insight which varies with the level of acuteness of the suicidal ideation. Therefore, if the individual can be made aware about the

early warning signs, they may be able to take necessary steps at the earliest stage when they have significant insight, to prevent continuing further to the suicidal steps. These findings show hope that a person can address their own suicide risk if they are aware of a precise and rigorous guideline of early warning signs. Those warning signs will primarily help the person to seek psychological intervention and thus decrease their risk in longer term. Not only that this self-awareness is a great resource but also can contribute to community mental health.

1.4.4 Clinical application. Early warning signs can be very helpful for professionals treating suicidal individuals. World Health Organization (2006) reported in their study that about 25% of counselors have had a client who have committed suicide. Through these findings it is easy to assume that there are many more attempted cases that counselors are come across in their professional journey. In such situations, a counselor has to identify risk factors associated with suicidal behavior which are most critical to clinical decision-making. Rudd et al. (2006) reported that research based suicide warning signs would be of great value for the clinicians who must make the decisions about the safety of their patients in the coming hours to days. Studies showed that cognitive behavior therapy was effective in preventing suicide attempts for adults who recently attempted suicide (Brown et al., 2005). Another study also support this findings where it was found that suicide can be successfully prevented through psychotherapy (Marasinghe, Edirippulige, Kavanagh, Smith, & Jiffry, 2012).

Suicides among elderly individuals can also be reduced if the mental health professionals are aware about suicide signs and symptoms. WHO (2013) reports approximately 70% of elderly persons who commits suicide were found to share their suicidal ideation with family and significant other before their fatal act. This also

emphasizes the role of family members, friends and mental health professionals who can significantly contribute to crisis management in such cases.

Suicide is highly related with different mental health disorders. It is estimated that 90% of committed suicide cases had a mental disorder where 60% were depressed at the time of suicide (World Health Organization, 2006). Depression other forms of mood disorders have been linked to suicidal behavior (Angst, Angst, & Stassen, 1999). In schizophrenia, 10-15% patients commit suicide (Amador, Friedman, Kasapis, & Yale, 1996). Therefore, mental health professionals should be alert about potential risk of suicide.

Being aware of warning signs for suicide risk and by applying an appropriate suicide risk assessment, the health service provider can assist in early detection, assessment and management or referral of patient. Thus, they can assist an individual in crisis to save his/her life.

1.5 Literature Review

Most of the research relating to the suicide issues has been conducted around suicide statistics, methods, causes, risk factors prevention and intervention. Globally only a handful of research has been done on suicide warning signs and most of these studies were limited in scope. Studying suicide warning signs never seem to have much attention in the scientific research community.

McClure (2012) studied the relevance of suicide warning signs in a general outpatient psychiatric population. They found more than half of their study participants reported suicidal ideation or behavior in the last week while about three fourths of respondents reported a history of suicidal ideation and suicide attempt. The prevalence

varied between 90% for insomnia/hypersomnia and 19% for self harm or reckless behavior. Suicidal behavior was highly prevalent among cases with affective states of anxiety, agitation, anger, rage, feeling trapped, and hopelessness (McClure, 2012).

Van Orden et al. (2006) conducted a study to test the effectiveness of a list of suicide warning signs for public. Participants read two sets of warning signs where only experimental group read the suicide warning signs. Other group read health based warning signs like diabetes and heart attack. Result indicated that participants who read the suicidal warning signs reported greater abilities to recognize suicidal risk in individual. One very important note is that instead of empirical research based list of warning signs they used a consensus based listing of suicide warning signs targeted at general public done by AAS (American Association of Suicidology) to develop a list of suicide warning signs targeted at public. The set of warning signs used in this study contains few categories which notify generalized and broad spectrum of suicide. Another conceptual study addressed the issue of suicide warning signs attempting to differentiate the construct from risk factors. As discussed above, the same consensus set of warning sign identified by the working group of American Association of Suicidology (AAS) has been used in this study (Rudd et al., 2006).

Hendin et al. (2007) reported three broad categories of warning signs namely suicidal thoughts and direct behavior, behaviors indirectly related to suicide and affective states or intense feelings/emotions. And they concluded that the presence of intense affective states was one of the three factors that usually occur before a death by suicide.

Hall, Platt, and Hall (1999) reported in their study that intense affective states were present in a severe form up to 3 months prior to a suicide attempt or death by suicide. Another study conducted with psychological autopsies of 40 inmates who died from

suicide and the findings showed that 70% displayed agitation or anxiety prior to their death (Way, Miraglia, Sawyer, Beer, & Eddy, 2005).

Rudd (2008) further published a review study which emphasized importance of incorporating suicide warning signs in clinical practice. As in clinical practice a practitioner has to differentiate between warning signs and risk factors to articulate the link among warning signs of suicide, hopelessness and intent to die.

1.6 Limitations of Previous Studies

Researchers conducted different types of research on the topic of suicide which has been mentioned in above section. Some major gaps have been found after analyzing previous studies related to overall suicide issue. The following sections discussed the limitations of the previous studies.

1.6.1 Gap in understanding warning signs. Many studies have been conducted on suicide issues all over the world. Most of these studies were conducted in western countries, and most of them were actually about risk factors instead of warning signs of suicide. Very little empirical research has found on warning signs. Risk factors are events or issues in the life of a person that increases the risk of suicide in that person. It is like vulnerability in the person that predisposes sucidal behavior. On the other hand, warning signs are the most imminent signs before the suicidal event. Intervention using warning signs may be helpful in managing people with a high risk level.

1. 6.2 No research on warning signs of suicide in Bangladesh. In Bangladesh a handful of research has been conducted over time on suicide issues (Ali et al., 2014; Feroz et al., 2012; Reza et al., 2013). Similar to global research interest, these studies are limited

in terms of a) topic e.g. prevalence, gender discrimination of suicide, and b) populations e.g. more limited in community survey. Till to date no research has been conducted on suicide warning signs in Bangladesh. There is no indigenous set of suicide warning signs that can raise awareness among general public and assist clinicians in our country. Lack of local research is one of the major problems in our health system. If suicide warning signs could be identified and listed in our country, early detection and referral to suitable service could be ensure and a number of valuable life could be save

1.6.3 Limited into confirmatory research design. Researcher and clinicians are more guided to design research in quantitative method including experimental and survey designs. It is well established that any area that lacks knowledge in a particular issue demands detailed exploratory investigation targeting to generate new knowledge to fill the gap. As already mentioned here that worldwide there is a lack of research on warning signs of suicide. This phenomena needs to be explored in a more empirical way. Qualitative research already grab the attention of such kind and it is time that researcher expand their vision beyond some traditional models.

It has been found that most of the scholarly research done on suicide warning signs used AAS's consensus set of suicide warning signs. There has been no scientific or clinical scrutiny. The result has been a confusing mix of information (Rudd, 2008). Rudd (2008) mentioned that such kind of consensus raises public confusion. The gap in scientifically validated list of warning signs has been also been reported in other studies. Mandrusiak et al. (2006) found 3000 identifiable suicide warning signs on an internet survey and concluded that most of the warning signs listed were irrelevant, inaccurate and misguiding. Therefore scientific and empirical research is needed to assist practitioners in

applying warning signs in clinical practice and in raising ability to recognizing suicide risk by general public.

1.7 Rationale for the Present Study

Although sufficient work on general warning signs of suicide has been conducted worldwide, the numbers of studies that focus on behavior immediate to suicide are very limited in the world context and nonexistent in Bangladesh. Therefore, present study aimed to fill some major gap in this are:

- Worldwide very little empirical research has done on warning signs. This research will create empirical research based warning signs. This study had an interview based approach where interviews were done with suicidal individual and also with significant key informant. Researcher attempted to capture the lived experience of suicide very closely from both parties. A research using this specific design has not been attempted before. It is expected to fill the knowledge gap around the suicide.
- In any case, as culture is known to shape human behavior in numerous ways, it is necessary to understand the pre-suicidal behavior of Bangladeshi cases if any warning sign based intervention is to be developed for our country.
- This will enable clinicians and caregivers of suicidal clients to understand most at risk situation and to provide or refer for immediate support accordingly.
- This study will create further indigenous knowledge on suicide prevention intervention for Bangladesh.

1.8 Objectives of the Present Study

The aim of the present study was to identify the early warning signs of suicide. To meet this broad objective the researchers broke down the main objective into specific objectives, which are as follows:

1. To explore patterns of behavior demonstrated by the suicidal cases prior to committing suicide.
2. To retrospectively explore their pre-attempt cognitive state.
3. To retrospectively explore their pre-attempt emotional state.
4. To formulate recommendations based on the findings for the prevention of suicide in Bangladesh.

CHAPTER 2

METHOD

METHOD

2.1 Study Design: Phenomenology

The aim of the present study was to explore pre-suicidal behavior of suicidal cases to identify the early warning signs of suicide in Bangladesh. The purpose was to know how a person feels, thinks and behave immediately before suicide in a very detailed manner. To get this desired information, present research was done following phenomenological approach of qualitative research design. There are several reasons of making this specific selection among many other research designs.

Firstly, literature review indicates that empirical studies on this particular area of suicide is limited in world context and nonexistent in our country. This lack of knowledge regarding suicide warning signs required in depth exploratory study on the topic before confirmatory quantitative studies can be done. Qualitative methods are well known for their capacity to explore individuals' experiences in a through manner to enable deeper understanding of the construct.

Secondly, suicidal behavior might significantly vary across cultures. Existing knowledge from foreign context may have limited utility in Bangladeshi cultural context. The ability of qualitative research approach to general indigenous knowledge may be of great value in this case. As it helps get an inner experience of participants, to understand how meanings are formed in a cultural context, and to discover rather than to test relation between different constructs.

Thirdly, the research conducted worldwide on suicide warning signs seemed to be methodologically limited (see Section 1.6.2 in Chapter 1). They used top-down theorizing

i.e., generating list of warning sign from experts' idea instead of exploring data from suicidal cases. Adoption of qualitative phenomenological approach in the present research will ensure inclusion of participant's perspective.

Fourthly, among different qualitative approaches (e.g., ethnography, case study, phenomenology, and grounded) phenomenological approach seemed especially suitable for the present research because of its emphasize on subjectivity and discovery of the essences of experience and systematic method to derive knowledge (Husserl, 1965). Suicide is sensitive issue and the pattern of behavior associated with is supposed to be very personalized. Phenomenological approach is well suited to make meaning out such personalized individual experiences and to provide a comprehensive description of the construct under study.

2.2 Participants

Data were collected from three groups of participants. It was presumed to get representative and appropriate data regarding suicide from these three different groups of participants. They are:

Group-1: Cases who attempted suicide

Group-2: Caregivers of cases who attempted suicide and

Group-3: Caregivers of cases who committed suicide

2.2.1 Attempted case. Attempted case or para suicide includes those situations in which a suicide attempt has led to a non-fatal outcome. These people, who attempted suicide but survived.

2.2.2 Key-informant. Key informants were the people closely connected with the suicidal individuals and may include family members, close relatives, friends, colleagues or any other person having significant knowledge on the behavior and mental state of the person who committed/attempted suicide. In qualitative study, key informant helps to enrich data from a different perspective and help in understanding the contextual factors as well (Mertens, 2014). Key informants were vital source of data for this study.

2.2.3 Inclusion and exclusion criteria. Inclusion and exclusion criteria are a set of predefined definitions that is used to identify and select participants. Such criterion has important implications for the scientific rigor of a study as well as for assurance of ethical principles. The inclusion and exclusion criteria for the each of the participant groups in this study are presented in Table 2.1.

Table 2.1 Inclusion and exclusion criteria used to select participants

Groups	Inclusion Criteria	Exclusion Criteria
Group 1: **Cases who attempted suicide**	1. An individual who have attempted suicide 2. Have passed 15 days after attempt	1. Impulsive attempt 2. Attention seeking 3. Self-reported memory dysfunction 4. Any other physical/psychological state which can hamper participants' ability to report the event (KII)

Groups	Inclusion Criteria	Exclusion Criteria
Group-2: Caregivers of cases who attempted suicide	1. Close observant of an individual who attempted suicide 2. 15 days have passed after attempt was made by the case	1. Impulsive attempt 2. Attention seeking 3. Under 18 years (KII) 4. Self-reported memory dysfunction (KII) 5. Any other physical/psychological state which can hamper participants' ability to report the event (KII)
Group-3: Caregivers of cases who committed suicide	1. Close observant of an individual who have committed suicide (as confirmed by post-mortem report) 2. 40 days have passed after suicide incident	1. Attention seeking 2. Impulsive suicide cases 3. Complex suicide circumstances for which the KII may become vulnerable to be interviewed 4. Under 18 years (KII) 5. Self-reported memory dysfunction (KII) 6. Any other physical/psychological state which can hamper participant's ability to report the event (KII)

1.2.4 Participant characteristics.

Eight participants have been interviewed in this study. Among them there were four attempted cases and four key informants including one key informant of suicide committed case. Four female and one male suicidal case could be reached. The age of the respondents ranged from 20 years to 49 years. The respondents were predominantly from Dhaka city while one of them was from outside of Dhaka. Data has been collected within 3 months of suicidal event.

2.3 Sampling

Qualitative research aims to provide an in-depth understanding of the world as seen through the eyes of the people being studied (Wilmot, 2005). For this purpose present study mainly followed purposive sampling procedure. In qualitative research, purposive sampling is used to select a limited number of informants strategically so that their in-depth information will give optimal insight into an issue about which little is known (Varkevisser, Pathmanathan, & Brownlee, 1993).

Several steps were employed to identify attempted and committed suicide cases suitable for this phenomenological study. Few organizations for example, DMCH, Nasirullah Psychotherapy Unit (NPU), Kaan Pete roi and local Police Station were contacted to find links of appropriate participants.

However, to offer a fuller conceptualization of the participant selection procedure used in this study, it is necessary to reflect on two important concepts: maximum variation sampling and saturation.

Maximum variation sampling. Maximum variation sampling is largely purposive in nature. In qualitative study the main objective of a maximum variation sampling technique is to select a sample for heterogeneity. Maximum variation sample aims to include a wide variation of participants to gain a fuller understanding of the topic under study (AncaVitcu, Vitcu, & Marcu, 2007). When using maximum variation sampling method, the researcher selects a small number of units or cases that maximize the diversity relevant to the research question.

Saturation. According to Morse (1995) saturation is defined as "data adequacy" and operationalized as collecting data until no new information can be obtained. Saturation involves eliciting all forms or types of occurrences and valuing variation over quantity. However, when all the domain has been fully sampled and all data have been collected, replication of data occurs (Morse, 1995). This replication signals saturation and at this point researcher decides that data collection is complete. Saturation ensures completeness of the collected data as required for understanding phenomena.

2.4 Methods of Data Collection

There are different kinds of data collection methods in qualitative study (e.g., observation, in depth interview, focus group discussion, pile sorting, and narrative dairy). Among all these methods researcher selected in depth interview (IDI) and key informant interview (KII) as the primary data collection method in this study. IDI seemed to be better suited with the objectives of this study. Apart from IDI, additional methods e.g., observation has been used for data collection.

2.4.1 In-depth interview (IDI). In-depth interview (IDI) is a 'one to one 'and 'face to face' conversation session with the participants. IDI provides opportunity to explore experiences and understanding of participants where researcher can get a detailed picture of a certain issue. In this study a topic guide has been used to conduct IDIs with the participants. This topic guide was developed and used to get focused on the issue and keep track of present research topic.

2.4.2 Key-informant interview (KII). In this study key in formant interview is especially significant for the type of current data. In cases of committed suicide, KIIs are the only source of getting data regarding pre-suicidal behavior pattern, cognitions and emotions. Moreover, the perceptions of key informants toward the phenomena were another significant area of exploration in this study.

2.4.3 Observation. Although observation is a very effective study tool within the domain of qualitative research, the present research did not use any systematic observation method. It was done throughout the IDI sessions where researcher kept notes of observed phenomena of that moment.

2.5 Instruments

A few paper-based instruments were used in addition to collection of interview data. These included demographic questionnaire, screening questionnaire, topic guide, consent form, and explanatory statements.

2.5.1 Demographic questionnaire. A brief questionnaire was used to collect necessary socio-demographic information of the participants such as gender, age, religion, educational status, occupational status and relation with the case (see Appendix A).

2.5.2 Screening questionnaire. Screening questionnaire was used to confirm that the prospective participant fulfill the inclusion and exclusion criteria (see Appendix B). Separate criteria were used for the three groups of participants.

2.5.3 Topic guide. A topic guide was used to as a general guideline to direct the researcher during conduction IDIs and KIIs. In this study a topic guide was developed following rigorous procedures through several drafts. The topic guide contained the major exploration aspects on different areas including general behavior pattern, pre-suicidal activity, thoughts and feelings (see Appendix C). Exploration using topic guide involved both open and close ended questions along with probes where needed. The probes were mostly guided by five part model where behavior, thoughts, feelings, physical reactions were explored with every experiences. Same topic guide was used for interviewing both suicidal cases and key informants with slightly variation on some issues.

2.5.4 Explanatory statements. Participants of this current study were provided with an explanatory statements document that described the details on the nature and procedure of the research and aspects related to participation in this research (see Appendix F). The explanatory paper contained information on the following,

- What does the research involve?
- Why were you chosen for this research?
- Consenting to participate in the project and withdrawing from the research

- Possible benefits and risks to participants
- Confidentiality
- Storage of data
- Use of data for future research
- Dissemination of result

2.5.5 Consent form. Research includes some important ethical considerations from researcher's part. Among them getting consent and providing explanatory statement report is particularly significant. Voluntary informed consent is the prerequisite of a participant's participation in research. Informed consent and consenting process is about the protection and respect for research participants (Shahnazarian, Hagemann, Aburto, & Rose, 2013). The goal of the informed consent process is to provide sufficient information so that a participant can make an informed decision about whether or not to enroll in the study to continue participation (Shahnazarian et al., 2013). To ensure these issue participants were provided consent form mentioning details regarding their participation under this study (see Appendix E).

2.5.6 Voice recorder. A digital voice recorder was used to record the interviews. Data were transcribed into text format by manually typing the text into a word file after electronic transfer of the audio files to the computer.

2.6 Data Collection Procedures

2.6.1 Data collection. Data collection for this research was conducted in different hospitals and communities inside and outside of Dhaka city. Researcher has to go to participant's residents to interview them. To avoid the putative risks regarding home visits at different places researcher recruited a research assistant to accompany with her during data collection in this study. The researcher was the sole interviewer in this study.

Researcher adopted several processes to reach suitable participants for this study. At fist researcher targeted Dhaka Medical College and Hospital (DMCH) as suicidal cases first addressed at such hospitals. In Bangladesh, DMCH considered to be one of the best medical for handling such emergency cases. Most of the suicidal cases are referred to this hospital. Because of the availability of suicidal (both attempted and committed) cases researcher used the patient directory of forensic and emergency department of DMCH and contacted with the potential participants. At first researcher contact them through phone and invited them to come to the hospital for individual interview. Therefore, they were also given the choice to stay at their resident. In these cases researcher along with a co-researcher went to their home for data collection. Before proceeding to the interview the participants were given the explanatory statement paper where the detail of present study was described e.g., title of research, objectives, time requirement, benefits and possible risks and contacts of the researcher. The participants were also oriented verbally by the researcher. After getting the verbal consent of the participants, researcher filled the screening questions to include or exclude from participation of the interview. Those who were found to be suitable for the interview then were given the written consent paper for agreement. Researcher also filled out the demographic information shit with each of the participants. After finishing procedural works researcher finally moved to the IDI session

with the participants. Each interview took 60-80 minutes. Interview ended when the researcher felt saturated on data provided by the participants.

While collecting data for the researcher it was found that most of the cases come out of Dhaka city. As soon as they ended the medical procedure they were leaving Dhaka. In all those cases researcher faced a great difficulty to reach the participants. Two reasons contributed to this difficulty getting participants these were: first, people were not interested to talk about suicide and second, most of the cases were from different districts of Bangladesh. It was not possible for the researcher to go different areas for interviewing.

For above reasons, researcher followed multiple sources to reach participants. These include Nasirullah Psychotherapy Unit (NPU) and Kaan Pete Roi (KPR; an emotional support and suicide prevention helpline). Through KPR researcher went to Khulna, a remote district of Bangladesh. Researcher also contacted local Police stations for this reason. The overall data collection procedure is presented in the flowchart (see Figure 2.2).

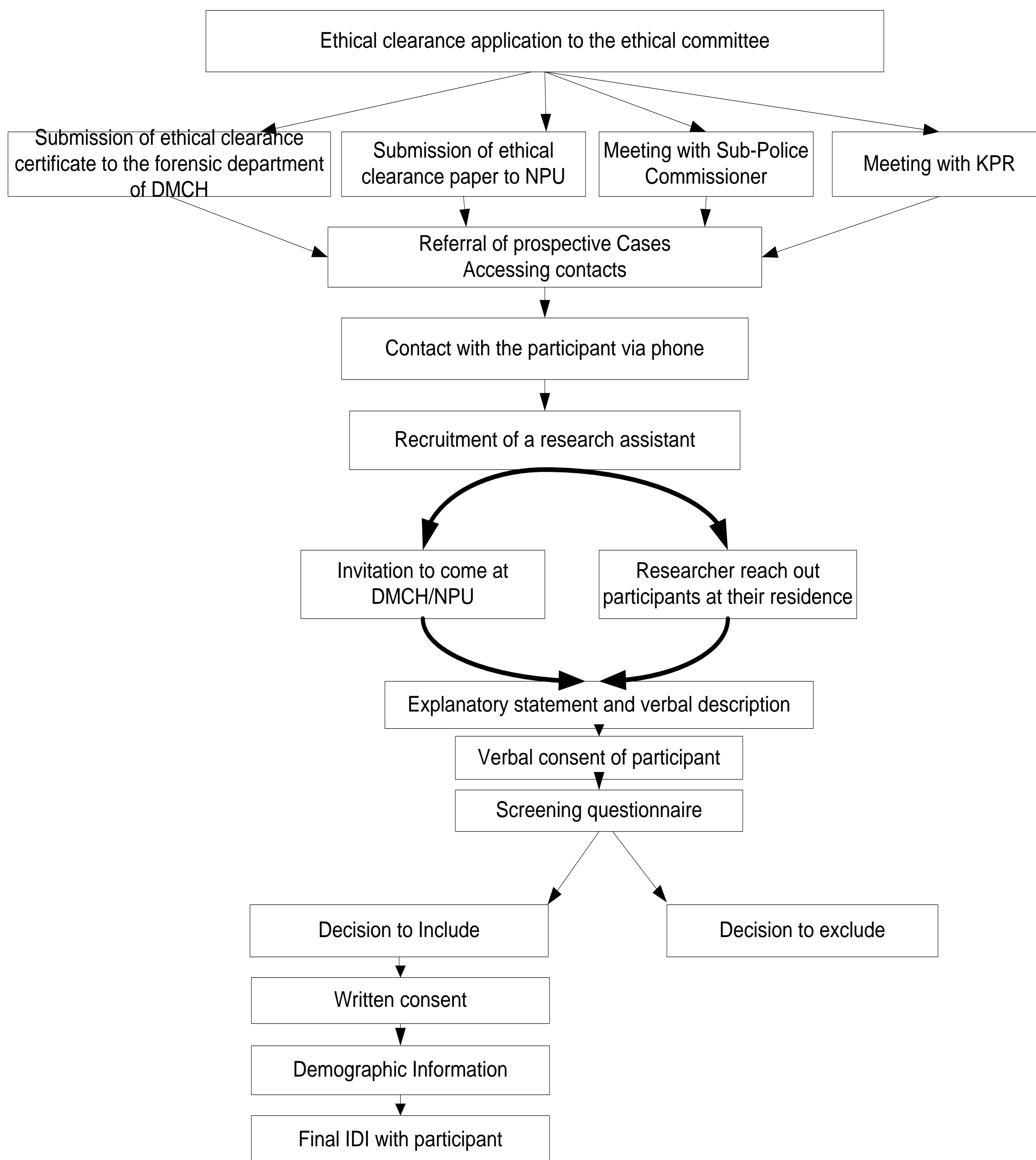

Figure 2.1 Flow chart of data collection procedure.

2.6.2 Data analysis procedures. Data analysis has done using qualitative data analysis software NVIVO-10. Steps involved in data analysis are presented in the following sections.

2.6.2.1 Data transcription. After the whole interview process all audio recorded interviews were transferred into a computer. Researcher herself transcribed most of the interviews and the remaining were transcribed by a research assistant with psychology background having training and previous experience doing qualitative data transcription. The contents of each interview were reviewed multiple times during the preparation of the transcripts. As promised to the participants, all audios were deleted after transcription.

2.6.2.2 Data Analysis. As with all qualitative data, phenomenological data analysis involves such processes as coding (open, axial, and selective), categorizing and making sense of the essential meanings of the phenomenon. As the researcher works with the rich descriptive data, then common themes or essences begin to emerge. This stage of analysis basically involves total immersion for as long as it is needed in order to ensure both a pure and a thorough description of the phenomenon (Kleiman, 2004).

*Open coding***.** During open coding, the data that have been collected are divided into segments and then they are scrutinized for commonalities that could reflect categories or themes. Once the data have been categorized, they are examined for properties that characterize each category. The researcher examined and identifies the meaning of the data by: asking questions; making comparisons and looking for similarities and differences between the comments.

In this way, similar comments [or incidents and events, i.e. phenomena] are grouped together to form categories. So basically, open coding is a process of reducing the data to a small set of themes that appear to describe the phenomenon that is under investigation.

Axial coding. Axial coding involves putting data back together in new ways by making connections between categories. This is done by exploring the conditions, the context and interaction of strategies, and the consequences. Which influence the phenomena and/or social processes that are being studied.

Steps of analysis. The structure of phenomena is the major finding of any descriptive phenomenological inquiry. This structure is based upon the essential meanings that are present in the descriptions of the participants and is determined both by analysis (as detailed below), and also by insights. Kleiman (2004) described the analysis processes in qualitative research are explained below:

- Read the interview transcript in its entirety in order to get a global sense of the whole.
- Read the interview transcript a second time - this time more slowly - in order to divide the data into meaningful sections or units.
- Integrated those sections/units that identified as having a similar focus or content and make sense of them.
- Subject integrated meaningful sections/units to a process that is known as free imaginative variation.
- Elaborated findings - this includes descriptions of the essential meanings that were discovered through the process of free imaginative variation.
- Revisited the raw data descriptions again in order to justify interpretations of both the essential meanings and the general structure.
- After completing the data analysis, researcher followed this with a critical analysis of the study. This critical analysis included verification that:

a) Concrete, detailed descriptions have been obtained from the participants
b) The phenomenological reduction has been maintained throughout the analysis
c) Essential meanings have been discovered
d) A structure has been articulated
e) The raw data has verified the results

2.7 Ethical Consideration

Ethical principles are concerned with protecting the rights, dignity and welfare of research participants (Barker, Pistrang, & Elliot, 1994). Certain issues were prominent for this study to maintain standard ethics are given below:

2.7.1 Research ethics review. Before interviewing, researcher gained the research ethics approval. The research review is developed to protect the privacy of participants and provide consent to perform research according to established steps in the protocol (Stuckey, 2014). Present study was reviewed and approved by the ethical committee of the Department of Clinical Psychology, University of Dhaka bearing the Project Number: MP150601 (see Appendix H).

2.7.2 Informed consent. Researcher provided detailed information regarding the present study including nature and purpose of the study, potential risk and benefits of participation, and an offered by the researcher answering participants query at any time. The participants were also provided an explanatory statement paper where the details of the study were described. So that participant could make a free and informed decision

about whether or not to enter the study. Finally an informed consent form was given to each participant to read and sign after the study was fully described to them.

2.7.3 Right to withdraw. Researcher ensured that participants may withdraw their participation at any time during interview session. It was mentioned on the consent paper and researcher also described verbally to each participants.

2.7.4 Voluntary participation. Participants were provided clear information that they were not given any financial assistance or compensation for participating in this research. Whether or not to participate in this study was completely on their voluntary choice.

2.7.5 Wellbeing of the participants. As this research was sensitive it was presumed that participants might re-experience the event while talking about the suicidal issues in details during interview session. This could be traumatic for some participants and there was a possibility that it will create short-term or long-term psychological problem among them. Therefore the possibility of experiencing distress was clearly written in the explanatory statement and described to the respondents before asking for their participation. To deal with the anticipated risks involved in this research the participants were provided a referral directory which provided the name and address of the places where they can seek for help. Researcher talked with Nasirullah Psychotherapy Unit (NPU) and managed special referral system; therefore NPU had agreed to provide emergency psychological help for the participants. Participants got the opportunity to get free of cost emergency psychotherapy sessions in NPU. Therefore cconsideration of participants ‘wellbeing was given utmost priority during data collection.

2.7.6 Privacy and confidentiality. As this research is sensitive privacy and confidentiality of participants were given high priority. The identity of the participant was kept confidential. To ensure this researcher used a code number for each interview. And contact shit of the participant was also kept separated from other procedural papers. Researcher was aware of the privacy issues and participants were given freedom to not share issues if they feel uncomfortable.

2.7.7 Researcher's safety. The present research required several home visit to the participants residence. It was assumed that home visits might not be safe for the researcher. To ensure the physical safety researcher recruited a co-researcher who travelled different places with the researcher.

CHAPTER 3

FINDINGS

FINDINGS

The data of the present study were analyzed following the content analysis procedure described in detailed at Section 2.6.2.2 in Chapter 2. Qualitative data analysis software NVIVO-10 was used to aid the process of data analysis. As described in methodology section, this data analysis involved processes such as coding (open and axial), categorizing and making sense of the essential meanings of the phenomenon. At the end of iterative analysis, the findings have been organized into four broader sections which revealed suicide warning signs and its associated phenomena and process. These were named as manifestation aspects, predispositional aspects, suicide context, and intervention aspects. Each of these four sections contained several categories and sub-categories which emerged from the data and illustrated the warning signs of suicide. A Flowchart of overall categorization has been presented in Figure 3.1.

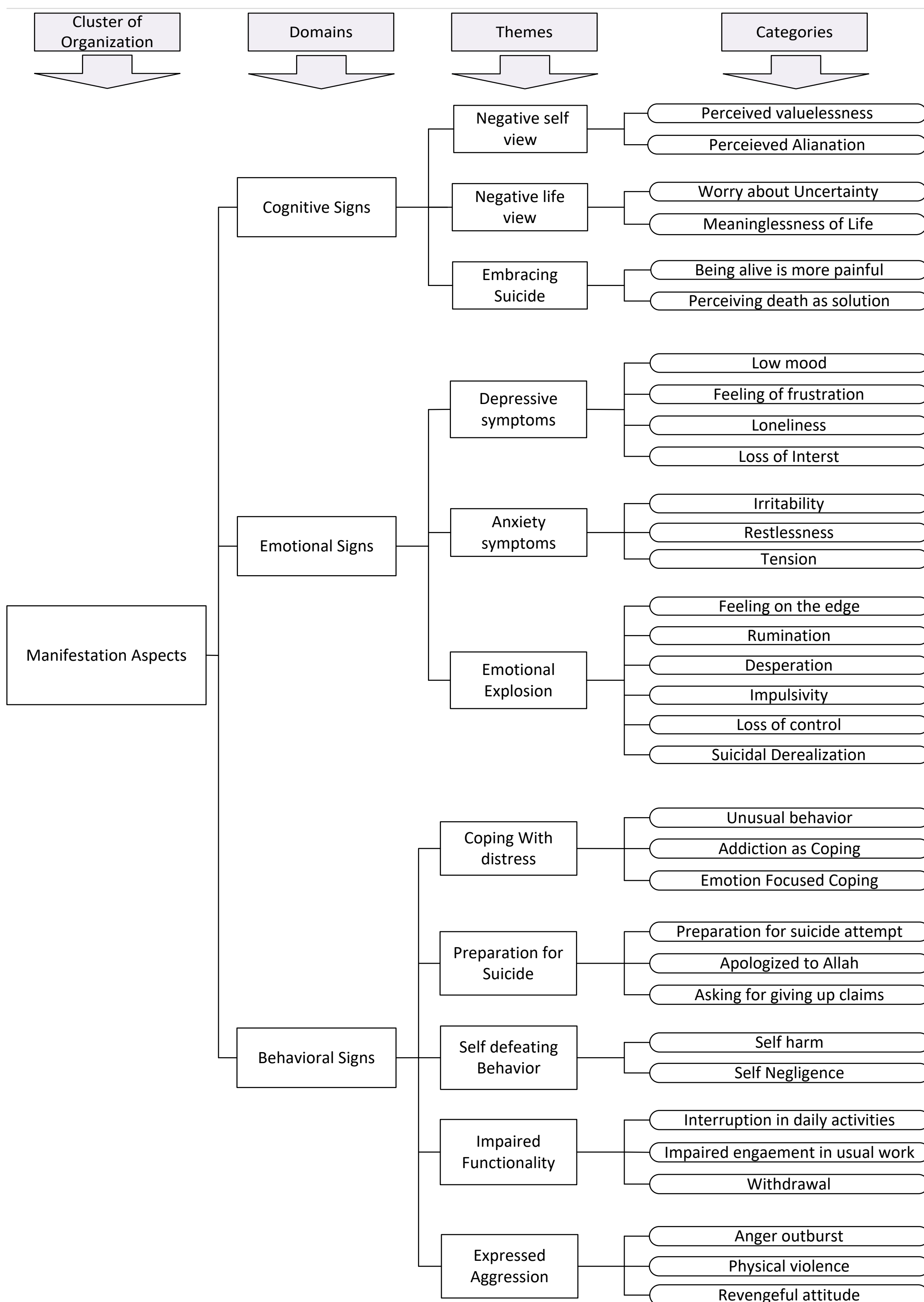

Figure 3.1 Flowchart of overall categorization

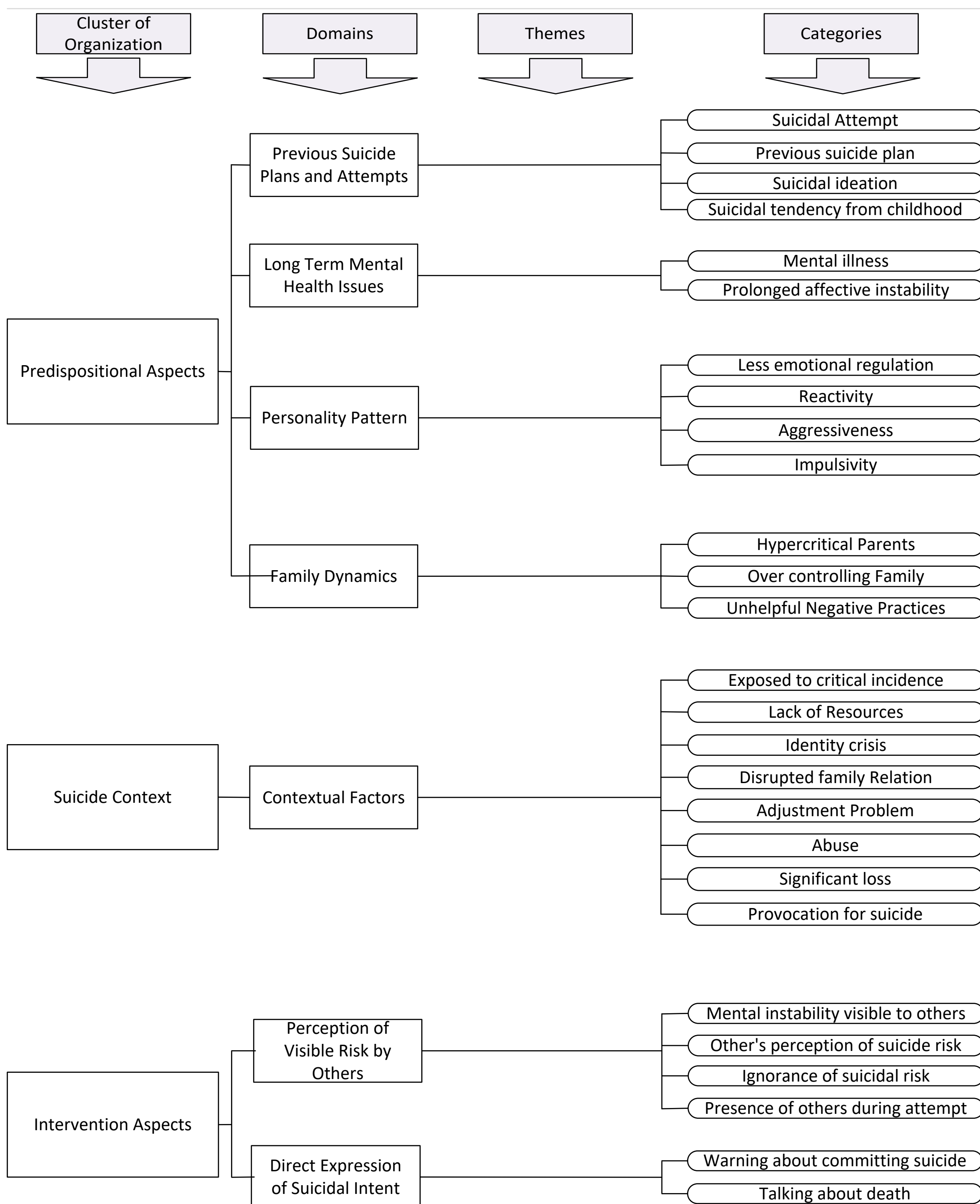

Figure 3.1 Flowchart of overall categorization (continued)

3.1 Manifestation Aspects

Individual's inner instability is reflected in their behavior overtly. Additionally, covert manifestation of this instability is reflected in thoughts and feelings. A set of suicide warning sign has been presented under this category dividing them into cognitive warning signs, emotional warning signs and behavioral warning signs.

3.1.1 Cognitive signs. Individuals were found to think differently before suicide. They reported to have negative changes in their thought process. It was mostly covert and less observable by others. Under these categories three important sub-categories namely, negative self view, negative life view and embracing idea of suicide were found (see Figure 3.2).

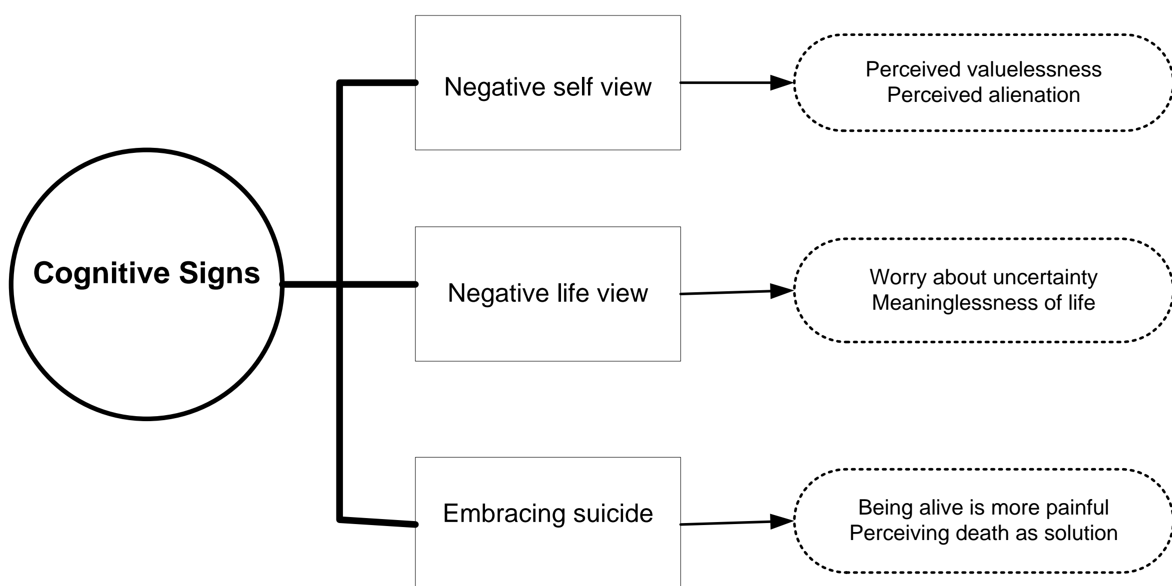

Figure 3.2 Overall presentations of cognitive warning signs

3.1.1.1 Negative self views. Under this title individual's negative view about self-during the crisis has been categorized. The general idea of negative self-view was proposed by Aaron Beck in 1976 in his "Negative Triad Model", where an individual generates negative thoughts about self in an automatic, spontaneous and seemingly

uncontrollable way. The present study revealed several types of negative self-thoughts among suicidal individuals which are presented in the following sections.

Perceived valuelessness. Feeling worthless or valueless is commonly felt by people in trauma or crisis. This acute negative feeling of self leads many individuals to suicidal decisions. In this study findings shows individuals went through this experience prominently during their crisis. Therefore, this can be counted as one of the warning signs of suicide.

> *"If he does not value it, why would others bother? And at this age with my two daughters and my family, will anyone ever take responsibility of it [me and my children]? No one will." [Attempted case]*

Perceived alienation. Before suicide attempt suicidal individuals alienated themselves from social connections. They were less engaging, less interactive to others. They perceived them as being isolated from regular social and interpersonal relationships. Their strong sense of such alienation worked as a strong motivation behind their decision of suicide.

> *"I have no one. Rather my existence is problematic for all. I do not see anyone who will understand me. Everyone is busy in their life. Does it matters if I am alive or dead?" [Attempted case]*

3.1.1.2 Negative life views. Negative life view is another component mentioned by Aaron Beck in 1976 in his "Negative Triad Model". Like negative self view, here an

individual's negative thoughts centers about his/her life. All suicidal cases of this study reported some kind of negative life views in crisis.

Worry about uncertainty. Uncertainty about future and life is also found in suicidal individuals of the present study. One of the suicidal individual quoted that she felt helpless as she did not know how to survive. She got mentally weak as she was not financially independent. Her whole concept of future was trapped by the feeling of uncertainty.

> *"What will I do if I leave him? Where will I go? May be my brothers will take care of me for a day or two. The girl is of marital age. I am an adult woman. Where will we go? What will we do? What will we eat? This was always haunting me inside. What will I do?" [Attempted case]*

Meaninglessness of life. Finding life as having no meaning is another very common cognitive sign found in individuals. Most of them reported that life seemed meaningless during crisis period. They perceived meaninglessness in terms of failing to achieve their desired goal (money, partner, education etc).

> *"My dreams were shattered, this internal pain was so severe that I myself shall end my life. When I failed to get him [as lover], the deepest wish of my life left unfulfilled - what else is left in this life?" [Attempted case]*

3.1.1.3 Embracing suicide. Most of the individuals weighed death over life as they were perceiving life as meaningless and burdensome. They thought death will bring them

peace. However, they finally reached at a decision where they embraced death and such selective perception precipitated them to commit suicide.

Being alive is more painful. They found their life more painful than living. In time their life got trapped into the circumstances where their perception about life was highly stressful.

> *"Living is more painful at this moment, I am not happy in this state, there is an extreme amount of pain inside." [Attempted case]*

Perceiving death as solution. As mentioned above they took suicide as a solution of their problem and cure of their pain. Some of them thought death will bring peace. Some of them found themselves as the problem in the family so they thought committing suicide would help in relieving others.

> *"Why should I carry this pain another 20 hours, 20 years? Let me solve it now, this is what I thought." [Attempted case]*

3.1.2 Emotional signs. In above section cognitive warning signs have been elaborated which described as more covert form of signs. Unlike thought process, emotional signs of suicide are more observable. Participants both suicidal individuals and key informants reported that their negative thinking reflected in their mood. Thus emotional ups and downs were easily detectable in different circumstances. In this category three sub-categories were found (see Figure 3.3).

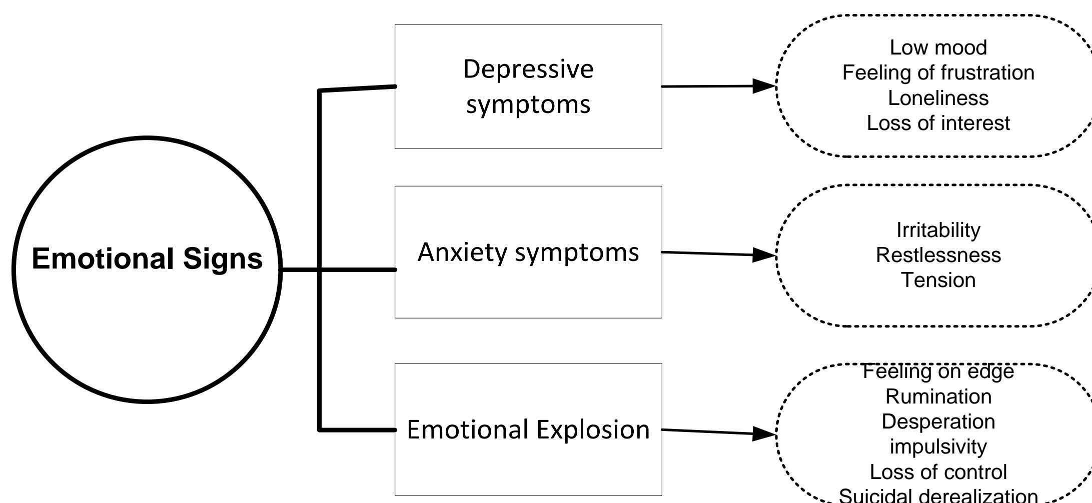

Figure 3.3 Overall presentations of emotional warning signs

3.1.2.1 Depressive symptoms. Almost all suicidal individuals have been found to show depressive signs before suicidal incident. Under this category four sub-categories have been elaborated.

Low mood. One of the main depressive signs among the suicidal individuals was low mood. Most of the time of a day, they used to feel very low and that was reflected in their face and behavior. Key informants also confirmed this in their interview.

> *"Used to have a gloomy face. At work - seemed to work right but kept the gloomy face on. Expression of anger, irritability and pain was there - "I am talking but my husband is not listening, he is not giving me permission to leave."" [KI-husband of attempted case]*

Feeling of frustration. Suicidal individuals were frustrated about their life regarding relationship, financial crisis, lack of independence, academic issues and marriage etc. They were unable to achieve their desired goal which made them depressed and frustrated. Coping with such long term frustration brought a great deal of anxiety,

depression and anger. This long term frustration of not being able to meet the expected goal created a vast amount of helplessness among the individuals. At this point, they lost hope in life. Few suicidal individuals reported that they felt suffocated during extreme pain. They could not breathe and relax. They used to feel being trapped by the difficult situation.

> *"What is the meaning of feeding me and keeping me alive? It is better if I die. I showed a lot of anger, cried a lot but they were not inclined to change, they will keep me like this [not meeting my needs]." [Attempted case]*

> *"These things, I used to feel out of breath, sometimes it felt like I have no room to breathe, it was like not being able to breathe at all." [Attempted case]*

Loneliness. As the suicidal individual used to get socially avoidant during pain most of the time they spent time alone. They avoided social interaction and situation. Their social isolation was one of the main factors that decreased their sharing behavior and healthy problem solving attitude. They used to submerge into their own thoughts and pain. Therefore, this caused their feeling of loneliness even higher.

> *"Loneliness, not having anybody [beside me] and this acute pain overwhelmed my brain and my awareness, thinking and processing. This thing [suicidal idea] came from that."[Attempted case]*

Loss of interest. One of the common experiences during crisis found among suicidal individuals was loss of interest in life. Feeling low and lethargic hence not willing to live the life were reported by them. Most of them were found to mention the pain over life. Pain was heavier to them at that moment and they felt like not living on this planet is

a good option. Moreover, key informants in this study also reported suicidal individual's loss of motivation in activities and social withdrawal. They felt threat to face social interaction. Being socially interactive to family and friends was a burden for them. Moreover they felt agony to perform daily activities and maintain their routine work.

> *"From the beginning it was too much pain in my life! I no more felt like living." [Attempted case]*

3.1.2.2 Anxiety symptoms. Individuals were reported to have anxiety oriented signs during their critical situation before suicide.

Irritability. Individuals felt trapped by the situation that causes them to feel helpless. They noticed that their mood became highly irritable as they found themselves to be helpless. This irritability caused their intolerance to people and situations. Their level of irritation brought observable changes in mood and behavior. As a result, close family members could notice their irritation. Suicidal individuals reported that because of their irritability they could not tolerate other people. Sometimes their temperament also got high.

> *"Meaning there is pain and then again my mental state becomes very irritable." [Attempted case]*

Restlessness. Restlessness is another emotion found in suicidal individuals. They reported their inner conflict and lack of peace. Their concentration level also significantly diminished because of high level of restlessness feeling.

> *"Restless feeling. Only restless feeling."[Attempted case]*

Tension. Tension was a common emotional reaction during crisis moment. Each person was going through a unique kind of life circumstances. Therefore, beyond their individual crisis, most of them found to have experienced a significant level of tension. The particular situations were for example; financial crisis, relationship dilemma, career uncertainty, academic etc. As they were not able to change the situation or get the thing they desired their level of tension went higher.

> *"Meaning they would not let me study, that is why, will not be able to study so will not have a career, had a lot of tension regarding this thing."[Attempted case]*

3.1.2.3 Emotional explosion. Six sub-categories comprise this category namely feeling on the edge, rumination, desperation, impulsivity, loss of control and suicidal idealization.

Feeling on the edge. Individuals reported that they have reached a point of life where they felt the edge. Their endless struggles for a long time made them desperate to find some peace. One of them mentioned, she has been suffering more than anyone from birth.

> *"I have been tolerating many things since my childhood. No one tolerates things like these. No one tolerates so much like me." [Attempted case]*

> *"I have my back pressed against the wall." [Attempted case]*

Rumination. Each individual cases explored in the present study went through unique type of critical incidence and they had to cope with it. However, many of them were found to self-bargain against the distress they were going through. These self-bargaining thoughts found to manifest in the form of rumination. In rumination of same

thoughts strike in individual's brain repeatedly thus creates a narrowed focus. Where a person feels stuck and only focuses on negative thoughts. Therefore, individual develops negative biases towards life.

> *"Thought about these always occupied me, that I cannot do anything, that I cannot get out of it, staying in the room all the time, can't do job or studies, nothing. . . . . my head was filled with these thoughts all the time." [Attempted case]*

Desperation. Suicidal individuals were seemed to be desperate to solve problems at the time of crisis. They act in do-or-die manner to end their pain and sufferings. Their family members observed them to behave in an unusual way. Their belief system had been changed due to the intensity of their critical situation. They became fearless about the consequences of their desperation and considered suicide.

> *"To bring dad out of that [extramarital affair], [she] went to numerous traditional healers (kobiraj) although she did not have faith in traditional healers (kobiraj). Whatever others suggested, whoever they suggested, she ran to those places and persons." [KI-daughter of attempted case]*

> *"At the time the thought was not like that [rational], the thought was to kill myself and I felt a lot of courage to do so." [Attempted case]*

Impulsive urge. Individuals reported uncontrollable thoughts of suicide. Whenever they encountered intense problem situation or felt depressed with pain they got impulsive thoughts that used to keep pushing them to commit suicide. In such circumstances, they could not control these thoughts.

> *"[I felt] I will hang myself right now. I will take something now."[Attempted case]*

Loss of control. Most of the suicidal individuals reported that they had experienced loss of control. By this they meant, they were unable to control their emotional outbursts. Sometimes they were not able to control their impulses to act. Their suicidal attempt was one of the reasons of losing control over themselves.

> *"No actually I couldn't control myself, at the end when I myself attempted suicide, all the pain inside that I had and then an unknown painful frustration created a trance, that's when I lost control of myself." [Attempted case]*

Suicidal derealization. As mentioned in the earlier section individual's loss of control lead them experiencing derealization immediately before the suicidal attempt. They felt that they were possessed by something. Something they cannot control and explain. Some of them named it as a state of trance. Others reported this as an abnormal state where they were in between reality and possession. In the time of crisis few individuals were so submerged into pain they could not feel the life. They got emotionally blunt. The experience was so different for them that they thought as if they were not the part of this life and world. Hence, they belong to the different place.

3.1.3 Behavioral signs. Warning signs of suicide were found to be mostly manifested by individual's behavior. Behaviors are more explicit and observable than individual's thoughts or feelings. Suicidal individuals of the present study seemed to behave according how they feel and think. So, behavioral signs were seemed to be easily detectable by surrounding family members and relatives of suicidal person. In this category five important sub categories have been clustered (see Figure 3.4).

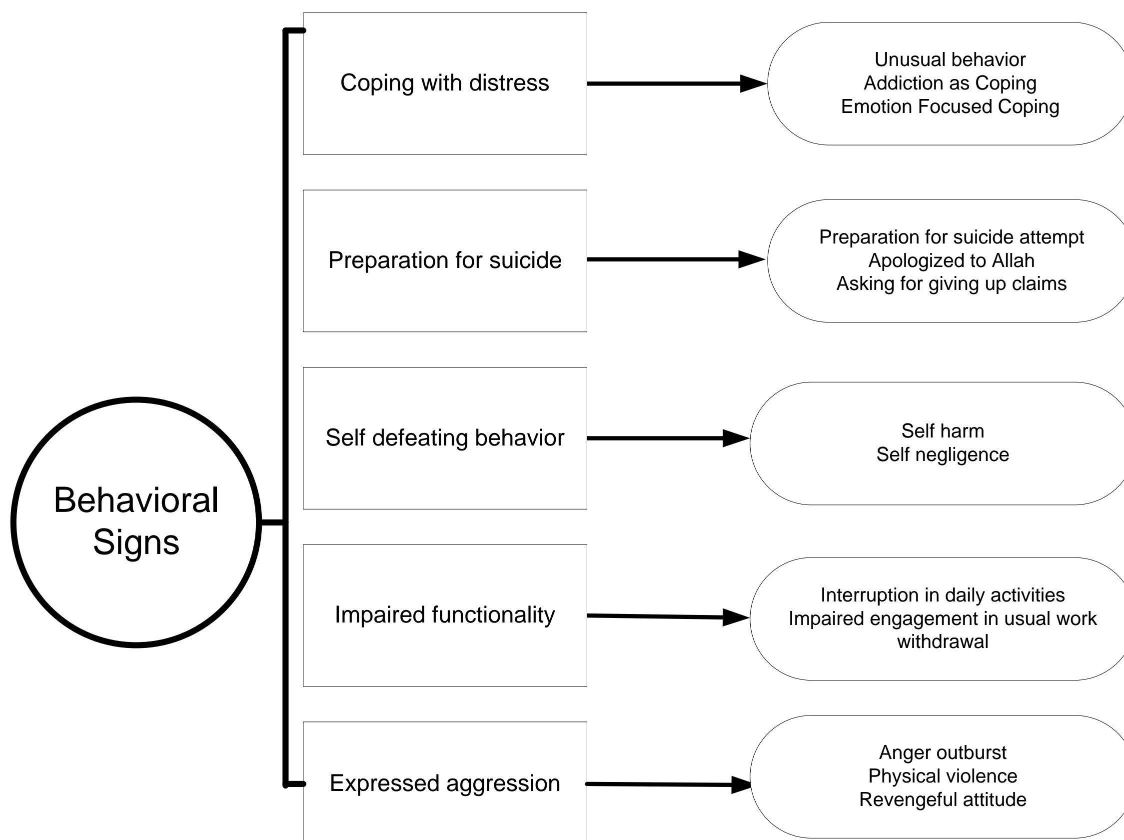

Figure 3.4 Overall presentations of behavioral warning signs

3.1.3.1 Coping with distress. Coping mechanisms are ways in which external or internal stress is managed, adapted to or acted upon. Coping can be positive or negative. In this research, suicidal individuals tried to cope with their distress through different coping type behavior.

Unusual behavior. Individuals were seemed to exhibit some noticeable unusual behaviors immediately before suicide attempt. Key informants reported that they were behaving very differently than usual times. They became extremely sensitive to things and reacting frequently even for silly reasons. Few individuals became physically violent very often at that time. While some individuals showed opposite behavior such as they became extremely quite. Locked themselves in room and stopped interaction with others for a long time.

"She could not sleep alone; I used to sleep with her. She said, "I feel scared". But that girl slept alone that night. She went to her mashi and said, "There are so many pictures of other people in your mobile but not a single picture of mine. Capture my picture in yor mobile". Mashi said, "There is no electricity". She said, "It will be good if you use flashlight". That evening she took a picture in her mashi's phone." [KI, mother of committed case]

Addiction as coping. Few individuals were taking different kind of substance to manage their stress. It was one of the prominent behavioral changes found before suicide attempt. Alcohol, cannabis, sleeping pills and cigarettes are the few among many other substances. They reported that they used to take substance to reduce their pain and stress.

"I got hurt and I took drug to tolerate the pain. Drugs, allowed me to dive into a trance like state. Then I felt slightly well. Then I took drugs again." [Attempted case]

"Those [cigarettes] are limitless. It could be seen that after a short span of time my ashtray used to get filled." [Attempted case]

3.1.3.2 Emotion focused coping. Suicidal individuals adopted emotion-focused coping strategies to reduce and manage the intensity of the negative and distressing emotions in their life. They aimed to reduce the pain that a stressful situation has caused rather than solving the problematic situation itself.

Individuals were found to internalize their problem. Through internalization they pushed their problem or pain deep inside. Crying was one of the common behaviors that

were found in almost all individuals. Immediately before suicidal attempt their crying behavior significantly increased. Most often they were found to be crying alone, at other time they cried in front of close family members or friends.

> *"I used to lock my room and cry alone when no one was there. Sometimes the girls were there watching TV in the other room and I cried a lot in prayers (namaj)." [Attempted case]*

Suppression of emotion was another significant way of coping mechanism found among suicidal individuals. For different kind of life situations, they went through severe mental pressure. Suicidal individual used to suppress pain instead of sharing it. The purpose of such kind was to act normal hiding the emotion from society and relatives.

> *"No, I did not let anyone understand. The people I socialized with, no one could understand that there is so much pain in me." [Attempted case]*

Praying (namaj) was found to be a coping behavior performed during extreme anxiety and in problem situations. Because talking about pain with others was difficult, praying was an easy escape from pain. One person reported that he was listening to sad songs during severe distress. Sad songs helped him to reduce the burden of pain. Music helped him to accumulate his thought into place and stay calm inside.

> *"She Prayed (namaj) and cried to Almighty."[KI-daughter of attempted case]*

3.1.3.2 Preparation for suicide. Suicidal individuals reported that the journey of taking the decision of committing suicide was very painful and burdensome for them. Struggling with the stress or pain was not easy and suicidal decision did not happen

overnight. Once they came to the point that he/she is going to commit suicide it became even more painful. In the long run they had to cope with this decision of suicide as well. Some behaviors of them showed their preparation prior to commit suicide. Preparation for suicide happened in two level; first, mental preparation of suicide and second, means related preparation.

Preparation for suicide attempt. Just before the suicide attempt suicidal individuals were found to engage in some preparatory activities. These preparations directly related to the act of suicide. For example, writing suicide notes, making the environment ready for attempt, forcing others to leave the room etc.

> *"After crying a lot she asked me to leave the room. I said why would I leave the room? I won't. She said, yes leave the room. I have business here." [KI-daughter of attempted case]*

Apologized to Allah. Before attempting suicide individuals were found to pray and ask forgiveness from Almighty for such action. It indicates a spiritual sign that manifest victim's search for inner peace. They could not get peace in this world and thus they are seeking it after death. It also indicates their struggle of accepting the fact that this action will cause their death and they will no more be a part of this world.

> *"After saying prayers (namaj), I asked Allah to please forgive me for taking my own life. I was praying to Allah though Munazat, cried, finished praying (namaj), folded the prayer mat and kept it in its place and right there, did the act [hanged myself]." [Attempted case]*

Asking for giving up claims. Another coping behavior under this category was to asking for giving up claims from closed ones. However, it is one of the important warning signs that directly indicate this person might think of death. Asking forgiveness or setting things right was very prominent actions taken by the suicidal individuals.

> *"As far as I've heard, she went to khala's (Aunt) house the day before [suicide attempt]. She told Khala (Aunt) that if anything happen this time she will commit suicide. And asked her to waive all debts and claims in such case. I heard something like that." [KI-daughter of attempted case]*

3.1.3.3 Self defeating behavior. An important type of behavioral manifestation found among suicidal individuals were self defeating behavior. They were also seemed very indifferent to self-care. This category represents two sub categories namely self ham and self negligence.

Self harm. Suicidal individuals were found to have self-harm history during their mental sufferings in different points of time. They vented out their inner conflict and pain through hurting themselves. Cutting hands, hurting heads or not having food daily are some actions that directly indicate their losing interest in life.

> *"Out of severe mental pain I have cut my wrist with a blade six months earlier." [Attempted case]*

Self negligence. Self-negligence means intentionally neglecting to attend to basic needs and lack of self-care in terms of personal health, hygiene and living conditions. Self-negligent behavior has been found in suicidal individuals of the present study.

> *"After this I did not eat for seven or eight days, did not even drink water." [Attempted case]*

3.1.3.4 Impaired functionality. Present study revealed that individuals were having trouble performing their regular activities before suicide attempt. This category includes three important sub categories namely interruption in daily activities, impaired engagement in usual work and withdrawal.

Interruption in daily activities. Interruption in daily activities was one of the significant behaviors. Individuals reported that their daily routine became haphazard before their attempt. Their normal daily routine such as eating, sleeping, bathing pattern was changed. Either they would miss these activities or delay them. They could not perform timely and properly like they used to do it before.

> *"At that time, everything was a mess, sleeping, showering, and cooking; she didn't feel like doing anything." [KI-daughter of attempted case]*

Impaired engagement in usual work. Losing interest in usual work has been found to be common among suicidal individuals. They lost interest in work once they used to do regularly. They no longer felt happy in such engagements. They became lethargic and lack of motivation to perform usual work. This behavior showed a significant change that indicates apparent change in them before and after crisis.

Withdrawal. Suicidal individuals were found to have shown social avoidance. They withdraw themselves from daily life social interaction. Suicidal individuals were found to submerge into their own pain in time of crisis. Their learned helplessness led

them to give up fighting with pain. They tend to communicate less with others; they became quite. They could not share their problem with others because they were worried that it would bring nothing but judgments and humiliation.

> *"[after the incident, my mother] Called my father home from the office. After that I stopped eating, stayed in the room, closed the door and stayed there all the time, did not get out or speak." [Attempted case]*

3.1.3.5 Expressed aggression. One of the significant behavioral expressions of the suicidal individuals was aggressiveness. This category includes anger outburst, physical violence and revengeful attitude towards other.

Anger outburst. Before the suicidal incident individual's common behavior reaction was anger outburst. They reported getting angry more frequently even with insignificant incidents during pre suicidal state compared to their normal functioning state. Individuals reported severe disturbance of normal daily interaction pattern caused by their angry outburst. According to the key informants, suicidal person seemed to react harshly to others even for normal responses. They became less tolerant of people and situations because of high stress and mental pressure. Their angry attitude was also significantly noticeable by others.

> *"I used to behave very rudely with my children. I used to scream and get mad at them when they asked me anything."[Attempted case]*

Physical violence. In the time of crisis, most of the suicidal individuals were found to be physically violent. They expressed their suppressed pain through violence. Sometimes their inner conflict behaviorally manifested through severe physical aggression

towards individuals or material objects. Physical violence includes beating others, throwing materials etc. The following quotation reflect such violence.

> *"I said, do not cook for me. Yes - then she was cooking shrimp, I kicked the pan, spilling the lobsters, then came back to the room." [Attempted case]*

Revengeful attitude. As individuals were dealing with long term pain and problem situations they were found to develop revengeful attitude toward close ones. They thought other people who are doing injustice to them should be punished. If they commit suicide the survivor would have to deal with the consequences and that might be a punishment for them. In other way, individuals who considered themselves as the problem thought committing suicide would free others thus would end the problem.

> *"I will free him [from this burden] by committing suicide. She often spoke like this." [KI-daughter of attempted case]*

3.2 Predisposition Aspects

Content analysis of the transcript revealed several aspects that can be clearly linked with predisposition aspects of suicide. Few significant predisposition aspects has been found in the present study namely previous suicide plans and attempts, long term mental health issues, personality pattern and family dynamics. The presence of such factors in an individual's life and their simultaneous interactions during crisis were found to significantly predispose their decision of committing suicide.

3.2.1 Previous suicide plans and attempts. Individuals reported that they were previously attempted suicide and have been planning for long before. Some of them reported to have suicidal ideation as well. The overall picture of previous suicide plans and

attempts has been presented in following flowchart (see Figure 3.5).

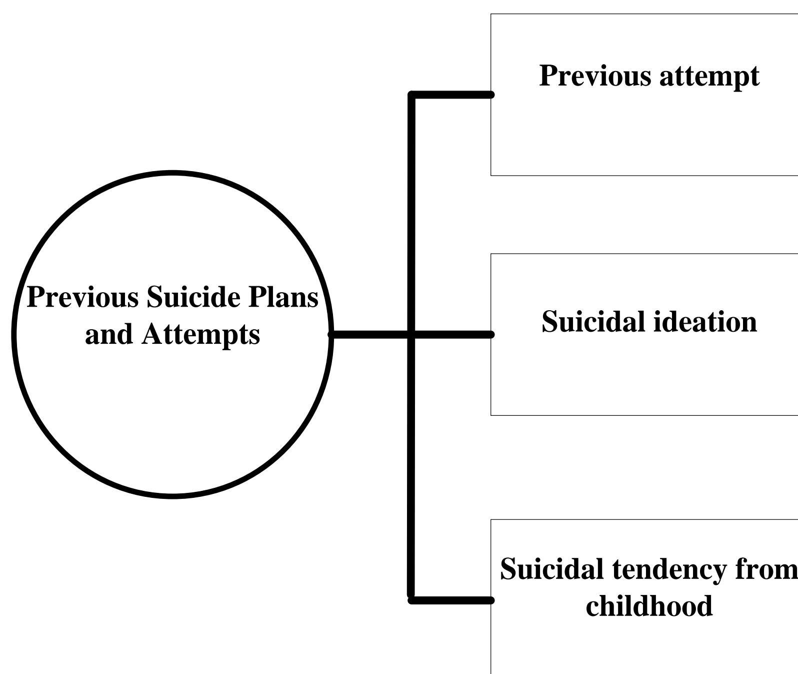

Figure 3.5 Overall pictures of previous suicide plans and attempts

3.2.1.1 Previous attempt. Four individuals reported the history of their previous suicide attempt. Among them one person attempted twice while others have a history of single previous attempt. Apart from this four, one person reported that he planned to commit suicide before. He has planned to commit suicide by hanging with a fan.

3.2.1.2 Suicidal ideation. Most of the individuals mentioned that they had suicidal ideation for long time before attempt. They repetitively had the thought of suicide as they were coping with extreme mental pain.

> *"I'm thinking about these [suicidal ideas], [since] my husband stopped giving me money three months before attempting suicide." [Attempted case]*

3.2.1.3 Suicidal tendency from childhood. Two individuals reported their history of being suicidal from childhood. One key informant mentioned that her daughter was showing such suicidal tendency from early childhood. If anything went wrong she became suicidal. Another person reported that she had suicidal thoughts from early childhood and her first attempt was in very early life.

> *"The matter is, my suicidal attempt is not just for now it started from my early childhood." [Attempted case]*

3.2.2 Long term mental health issues. Present study revealed suicidal individuals were suffering from mental illness and prolonged psychological instability. These long term mental health issues made them vulnerable to consider suicide. They reported that they were tired of coping with such issues for long time (see Figure 3.6).

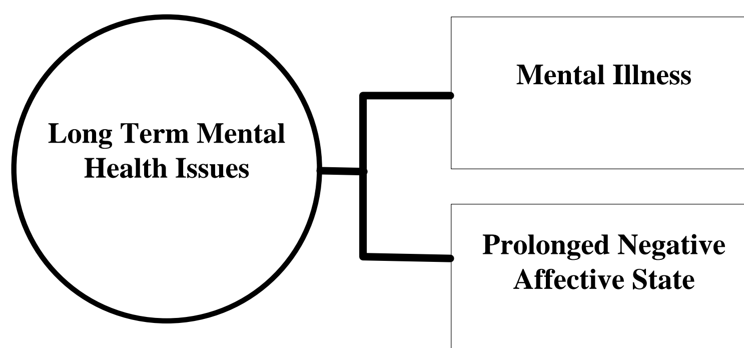

Figure 3.6 Categories on long term mental health issues

3.2.2.1 Mental illness. One key informant reported that her daughter have been diagnosed with having a mental illness. Another suicidal individual mentioned of suffering from depression for long time but it was not diagnosed clinically.

> *"Mental illness was written on the prescription. [Although] We did brain CT scan, they found nothing, it was a psychological illness." [KI-mother of suicide committed case]*

3.2.2.2 Prolonged negative affective state. Present study showed that all suicidal individuals were experiencing prolonged psychological instability. It was significantly hampered their daily life activities and relationships. Emotional instability decreased their ability to cope with stressful situations. This mental burden caused their physical imbalance as well.

> *"No, I mean, I'm always worried. I had anxiety all the time. My BP is high and whenever I become tensed my BP increases." [Attempted case]*

3.2.3 Personality pattern. In this earlier section some important predisposing factors have been elaborated. In suicide process, individual's personality trait was found to be one of the most contributing factors in this study. Some factors were commonly found among suicidal individuals such as impulsivity, reactivity, and aggressiveness which reflected their lower capacity of emotional regulation (see Figure 3.7). When they encountered any critical life events they would respond according to their personality characteristics and those made them more vulnerable to suicide.

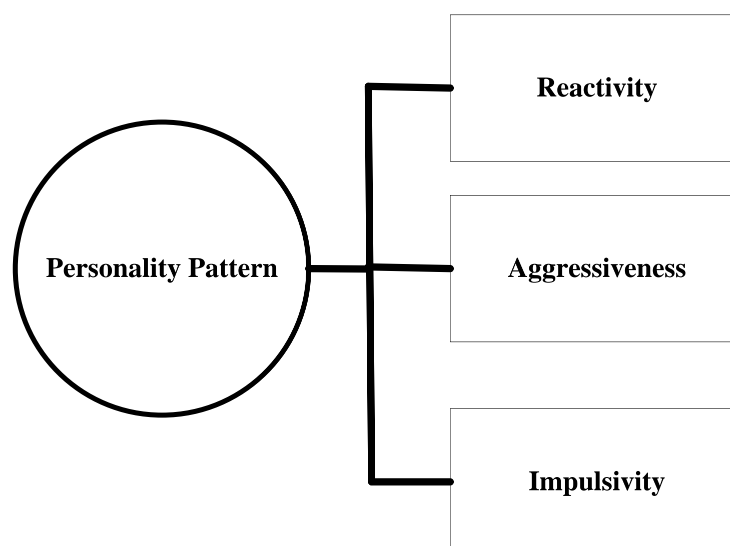

Figure 3.7 Personality patterns of the suicidal individuals

3.2.3.1 Reactivity. Few suicidal individuals were found to have little control over their emotion. Instead their emotions are dictated by someone or something else; by circumstance and the outside environment. They seemed to get affected immediately by the situations and event and act accordingly. Individuals over reactivity to things made their regular life even difficult.

> *"She used to react without reason." [KI-father of attempted case]*

3.2.3.2 Aggressiveness. Few suicidal individuals reported about their aggressive behavior. Their personality was dominated by anger and aggression. As mentioned above this aggressive attitude caused their reactive behavior. They were more prone reacting to anything with aggression at first hand. This particular personality pattern found to impact negatively in their life. However, heightened aggressiveness did not help them to resolve any problem in a healthy way rather their expression of anger hampered their interpersonal relationship.

> *"Yes, when I get angry I throw away things that I get at my reach."[Attempted case]*

> *"When she gets angry she, break things, chops whatever she gets close by with a chopper. We get scared about her action. Mostly she chopped doors." [KI-mother of attempted case]*

3.2.3.3 Impulsivity. Impulsive attitude also has been found among few suicidal individuals. Key informant also validated that individuals were showing impulsivity in different circumstances. This impulsivity was one of the reasons that contributed as predisposing factors of suicide attempt.

“She does what she wants. It’s difficult to understand her mood. She is angry now and cool immediately afterwards. She never did anything with proper thinking.” [KI-husband of attempted case]

3.2.4 Family dynamics. Family refers to the significant caretakers and siblings that a person grows up with, or the first social group a person belongs to, which is often a person's biological family or an adoptive family. Individual’s early experiences have a major influence on how they see themselves, others and the world and how they cope and function in daily lives. It plays an important role in building a person’s personality. Under this category, participant’s significant family dynamics has been categorized. It includes three main sub categories. A flowchart of family dynamics has been presented here (see Figure 3.8)

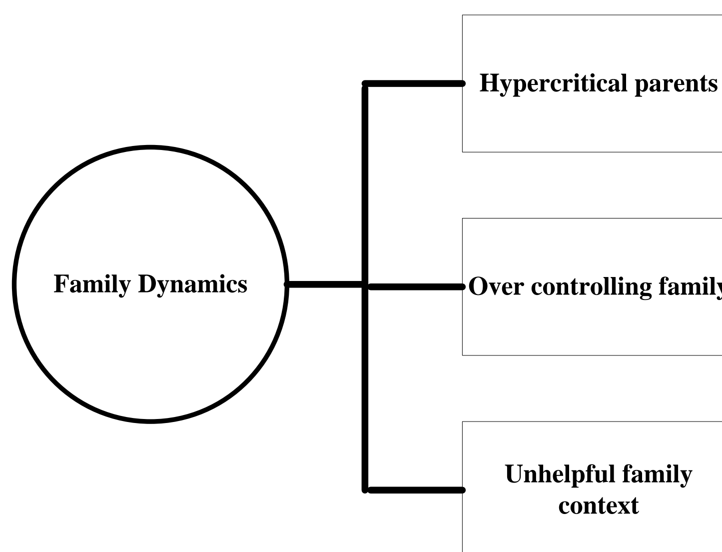

Figure 3.8 History of Family dynamics

3.2.4.1 Hypercritical parents. Few suicidal individuals reported that they got negative judgments from family members. They were judged by their choice of clothes, education, and mannerisms etc. Going outside, making friends were labeled as “bad” by

their parents. Parental discrimination was also found in early childhood experiences of suicidal individuals. It persisted in childhood as well as throughout adulthood. Suicidal individuals explained that their parents used to discriminate between siblings in terms of affection, cloths and other privileges. This chronic discrimination among siblings made them feel vulnerable and unlovable. Thus they became more prone to self-destructive activities.

> *"My parents commented negatively on me again and again. They were purposively pinching me all the time. I feel terribly bad and got frustrated hearing all those negative comments. They meant, I am bad because I want to go out and want to hang out with friends. They do not need daughter like me. I am the one who is ruining their honor in whole family." [Attempted Case]*

3.2.4.2 Over controlling family. Over controlling family system has been found among suicidal individuals. One suicidal individual reported that his/her parents were highly restrictive, rigid and very authoritarian in nature. They were not very emotional or affectionate and were critical if the person failed to meet their expectations. They were fixed on the point that he/she must adhere to rules with no room for negotiation. The consequence of breaking the rule was absolute punishment. This punishment sometimes became very harsh for them. Significant rigidity included not allowing the individuals to go out, not providing education, no friends, not allowing party, getting married at an early age, not staying outside of the home for a long time, not allowing commuting to the university alone etc.

It was found that few suicidal individuals did not have freedom to live life at their own terms. They lacked minimum level of privacy at home or outside. According to them

they had no choice over their cloths, lifestyle or education. They were not allowed to give opinions on any aspect of their life.

The pressure of obeying family rules and regulations and meeting the parent's expectations had significantly influenced their life. They felt pressured when their own choices have been ruled out and they were forced to maintain the way parents wanted them to be.

> *"My mother was becoming more conservative, and start imposing more restriction on me. She was not seeing that other girls [those she used as examples] are wondering around, why guiding me so much? Too much guidance is not good, it makes me feel suffocated. Let me exercise minimum freedom which will not spoil me." [Attempted case]*

3.2.4.3 Unhelpful family context. Families have been found to practice unhelpful negative behaviors. As discussed in above section, parents were practicing authoritarian parenting style. While they were very rigid about rules and their expectations from the person, they significantly were less emotional and affectionate. Suicidal individuals were found to have a strong desired to be loved by their parents, which they felt deprived of.

Non-cooperation to child's needs and demands were another negative behavior among parents. They were less attentive to child's opinion. Unhelpful attitude by the parents generated a hostile feeling toward them in the child. This non-cooperation from parents generated non-cooperation from participants as well.

Appraisement from parents has significant effects on children's life. However, in the present study few suicidal individuals reported that they were not receiving positive

appraisal from parents. That lowered their self-esteem and pushed into depression.

> *"I did not get any love from relatives in childhood, not even from my parents. Both of them only tried to earn money, money, and money." [Attempted case]*

> *"They have hurt me so much; they never thought of me at all. They never bothered how their quarrels, fights and imposition of decisions on me was hurting me, and was affecting my physical health, my family life." [Attempted case]*

3.3 Suicide Context

This category includes all kind of suicide related contextual aspects of individual's life. For individuals, suicidal decision did not come at once. They all had several cultural, social, family and individual contextual predispositions that directly or indirectly pushed them to suicide attempt. This category presents detail description of such suicide contexts found in present study.

3.3.1 Contextual factors. Context provides the foundation for how we feel about ourselves and how we experience others. This foundation begins the day we are born and continues to develop throughout our life span. The greatest influence on an individual's social-emotional development is the quality of the relationships that they develop with his primary caregivers. Positive and nurturing early experiences and relationships have a significant impact on a child's social-emotional development. In this study; unique contextual factors have been explored during interview that significantly contributed to suicidal individual's perception to their life and self as well as their actions. The summery of contributing contextual factors has been presented below (see Figure 3.9).

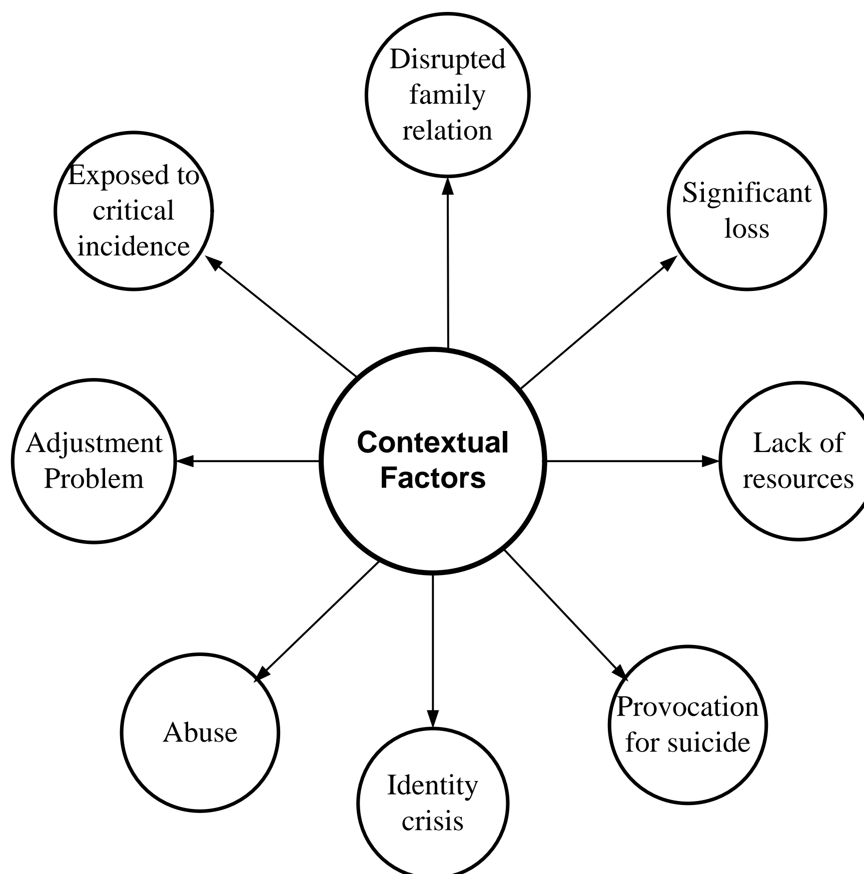

Figure 3.9 Contributing contextual factors

3.3.1.1 Exposed to critical incidence. Most of the suicidal individuals were exposed to a critical incidence immediately before suicidal attempt. Present study revealed that suicidal attempt occurred within maximum 11 hours after a critical incidence. It was one of the very significant contextual factors that precipitated the individuals to commit suicide. These incidence included fight with family members, victimization of physical violence and provocation for suicide.

> *"So later I see she wasn't listening to me at all. She was doing pointless stupid things, so suddenly I got very angry. Actually, I hit her. I slapped her a few times. For a while, she didn't say anything, stayed quiet. Then she went to another room.*

She had been sitting in the middle room, and then went to the bathroom. I didn't know that there was pesticide in the room." [KI-husband of attempted case]

3.3.1.2 Lack of resources. Lack of support from family member was another factor that was found individuals reported that during life transitions or problematic situations family member would not support them. They felt neglected and abandoned as family did not support them when they needed it the most. In certain circumstances, family stood against their wish and demand instead. This lack of cooperation and support from family made them feel helpless and unwanted.

Individuals also reported that they had financial struggles. Few of them were not financially solvent therefore they had to depend on their partner for life expenses. Difficulty dealing with this was one of the very frustrations that lead to suicidal decision.

"He [husband] is busy with his own life. He is doing everything for another girl [lover].He provide everything to that girl that's why he left no money now. I cannot even provide meals for my family. My daughters cannot continue school [because of money]. If a person does not have any support how could she live?" [Attempted Case]

3.3.1.3 Identity crisis. Suicidal individuals were found to be concerned about their identity in society. Due to lack of resources they felt inferior and struggled heavily to establish their own identity among others. Disappointment in such action made them frustrated and desperate.

". . . . even if I earn millions by doing this somity (illegal money lending), I will have no recognition. I cannot declare to society that I am earning money this way.

A woman without educational qualification, without anything, how will I place myself in the society." [Attempted case]

3.3.1.4 Disrupted family relation. One of the very important life crises all suicidal individuals were going through was problem with romantic partner. This includes boyfriend/girlfriend and husband/wife relations. It was found that they were not happy with their partner. Causes included not only understanding problem, emotional problem, and aggression but also physical torture. They reported lack of responsibility and commitment towards the relationship from their partner. Feeling of insecurity in relationship was another problem which contributed significantly.

"I never enjoyed the happiness that a normal girl gets from husband. And I have left everything. Now, after [so many years] if he can think "leave me and seek for another husband, I'm not good [for you]" [Attempted case]

3.3.1.5 Adjustment problem. Individuals were found to have adjustment problems after marriage. One of the key informants reported that his wife was having adjustment issues before attempting suicide. She not only had lack of support from in-laws but also as couple they had negative relationship with each other. The female suicidal cases were having difficult time with her husband as well.

"She could not bear it any more. She could not adjust with others in the family. At the beginning, had troubled adjustment with me while had a positive interaction in the family. Near the end, she achieved positive interaction with me and had a ruined impression about everyone else in the family." [KI-husband of attempted case]

3.3.1.6 Abuse. One of the very common contextual factors found in this study is suicidal individuals were being physically abused by the partner. Almost all female suicidal individuals reported that they experienced physical violence by their partner. This includes sexual pressure and physical torture.

> *"One day at morning we were having breakfast. [He] Found dirt in the water and I change the water. He blamed that it is still dirty and pressed face over the water. Hit me on the head." [Attempted case]*

3.3.1.7 Significant loss. Most of the suicidal individuals went through significant loss events that shaped their life view. For example, they experienced loss of loved ones, loss in business and loss in economic state. Few of them were experiencing multiple loss events that triggered their suicidal tendency.

> *"This is why once I bought him a vehicle. With six lac Taka. Those Laguna vehicles. After incurring loss within a year with that vehicle, he just got me two lac fifty thousand Taka after selling it. The six lac taka vehicle." [Attempted case]*

3.3.1.4.8 Provocation for suicide. During quarreling with each other very often family member was found to provoke them to commit suicide. Sometimes, out of anger partner used to curse by wishing death of the suicidal individuals. Not only partner, parents were also reported to provoke suicide. This negative stroke by closed one was very burdensome and difficult to accept for the suicidal individuals. Provocations of close family members were strong predisposing factors for decision of suicide.

> *"Then he said you die, you marry, you go away with the lang [another guy] it's not my business." [Attempted case]*

3.4 Intervention Aspects

Content analysis of the transcript revealed several aspects that can be clearly linked with intervention of suicide. Suicidal individuals were found to communicate their suicidal intent or plans with family members and friends in different timeframe. They were found to reach out directly or indirectly during their distressful life circumstances. Key informants emphasized that proper support during pre suicide stage could play vital role for the prevention and intervention of suicide. Two important intervention aspects have been elaborated below.

3.4.1 Perception of visible risk by others. The present study revealed that family members and close relatives perceived individual's suicidal risk in most of the case. But they discarded this threat and failed to actively intervene at the right time. This category included some important sub categories which elaborate the phenomena (see Figure 3.10).

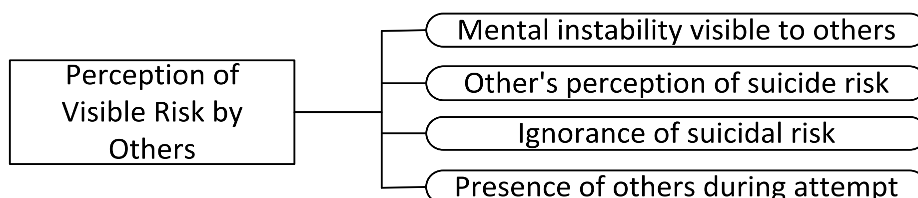

Figure 3.10 Perception of visible risk by others and its sub categories

3.4.1.1 Mental instability visible to others. Suicidal individual's mental instability was visible to other family members and relatives. They could perceive this psychological imbalance as suicidal person was reaching out for people to share their problem. In some cases, suicidal person was communicating their crisis and pain to solve the problem.

> *"Later I understood, as she seemed to be tensed, perhaps something [suicide] would happen. So I decided to consult a doctor coming on 6$^{th\ March}$ [next week].*

> *[Wondering] Why was she tensed? I thought that the doctor may change the previous medicines." [KI-mother of committed suicide case]*

3.4.1.2 Other's perception of suicide risk. Although family members and relatives were seen to ignore observable suicidal risks as mentioned in the previous sections, there were instances where they perceived the risks. Both suicide attempted individuals and key informants reported that they have noticed the suffering of the suicidal person and could relate that they might be suicidal. Their behavior, thoughts, mood and overall circumstances were spreading the message of their mental instability and intention for ending their life. But again, somehow they excluded the risk of suicide.

> *"I told her, listen maa; if you feel such kind [suicidal feeling] of tension, tell me, share with me. Together we will solve it, we will go to doctor." [KI-mother of committed case]*

3.4.1.3 Ignorance of suicidal risk. It was found that while the suicidal person was talking directly about their intention of committing suicide, their family members or relatives often did not take their intention seriously. Rather they excluded the risk of suicide by their subjective understanding.

> *"She would neither kill, nor hurt herself. That's what I thought, that you shouldn't do anything so stupid, so I thought she was just trying to scare me. I did not understand that she would drink savlon, though I saw her take the savlon from my bathroom." [KI- husband of attempted case]*

> *"No, they weren't that serious, they thought that I might just stop eating, but they didn't get that I would go this far." [Attempted case]*

3.4.1.4 Presence of others during attempt. Suicidal individuals reported the presence other family members around during the suicidal attempt. This presence varied in terms of proximity for example, few of them reported of being in the same room during attempt while others reported staying in the same house but in separate room. However, in both cases it was very obvious and direct that the person is going to commit suicide.

> *"My daughter was sitting there. I told her to come out, to go to the other room. But I can't remember if she left to go to the other room, or sat in the veranda. I brought the chair from there. That much I can say. I took an* orna, *stood on the chair and tied around my neck. I don't know anything after that." [Attempted case]*

3.4.2 Direct expression of suicidal intent. Present study revealed two kinds of suicide warning signs which were direct and indirect signs. This category elaborates the directly expressed suicidal intents by the individuals. Their preoccupation with death related talks was noticeable to others. This category contains two main sub-categories namely warning about suicide and talking about death (see Figure 3.11).

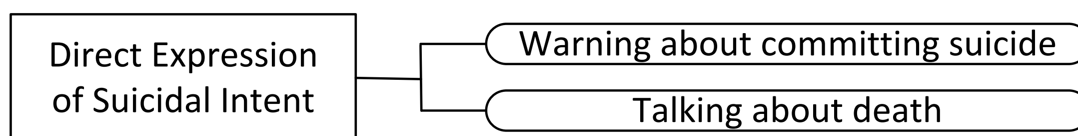

Figure 3.11 Direct expressions of suicidal intent and its sub categories

3.4.2.1 Warning about committing suicide. It was found that individuals were communicating their suicidal thoughts and intentions in very direct term before suicidal attempt. They were found to verbalize the term "suicide" frequently during their extreme

crisis. In some cases they warned family members about their intentions of committing suicide directly.

> *"[my wife said] "I am going to kill myself. You don't know me. My anger goes far deeper than your's". I said, let it be deeper, but why are you going to kill yourself? If you do that, you aren't just going to lose only this life; you will lose any chance at the afterlife as well. You won't be allowed to go to Heaven in the afterlife. I tried to make her understand lots of times." [KI- husband of attempted case]*

> *"She didn't get better; one day while still unwell, she told me that if I did that, she would try it again." [KI- husband of attempted case]*

3.4.2.2 Talking about death. Apart from suicidal warning and homicidal thoughts, individuals were seemed to talk about death more frequently before suicidal attempt than other times. Their suicidal thoughts could have been manifested in their death related talk. Both from suicide attempted individual and key informant interview, it was found that they were preoccupied with death related talks and its consequences.

> *"She would just say that she was going to die, things like that. She would mostly talk about dying." [KI-daughter of attempted case]*

> *"That if I died, they would be in peace. When Ma won't be around, then you will understand what you missed?" [Attempted case]*

CHAPTER 4

DISCUSSION

DISCUSSION

The present study attempted to explore early warning signs of suicide in Bangladesh. Findings were organized into four broad clusters of categories which incorporated ten categories associated with overall suicide process. The broad categories include manifestation aspects, predisposition aspects, suicide context aspects and intervention aspects. Different sub categories that emerged from content analysis were incorporated under these categories. A detailed discussion of all this factors is presented in the following section.

4.1 Manifestation of Suicide in the Form of Warning Signs

Present study successfully discovered different kinds of warning signs of suicide which has been discussed in findings section and clustered as manifestation aspects. Suicide is not an easy process and it does not happen out of the blue. Before this happens suicidal individuals were found to exhibit some significant behavior, thoughts and emotions that manifest their intention to commit suicide. Mandrusiak et al. (2006) hypothesized this proposition in his research. These particular behaviors, thoughts and emotional expressions are considered as warning signs of suicide (Rudd et al., 2006). However, in this study warning signs has been separated into two ways; proximal warning signs and distal warning signs which was also mentioned by Beautrais (2000). The stressors or behavior changes that happen within a few hours before suicide are considered as proximal signs. This means that proximal sign are the most nearest events before suicide (Van Orden et al., 2006). It was found that individuals in the current research have attempted suicide after a maximum of eleven hours following a critical incidence.

In this research it has been demonstrated that during this proximal phase significant behavior change occurred which was completely different from the suicidal person's usual behavior. Which was also supported by Barnes, Ikeda, and Kresnow (2002). Behavior frequency was noticeably different from the normal situation. There was desperation among individuals to implement their decision and at the time they were so emotionally charged that their ability to think rationally was diminished. Suicidal individuals were found to exhibit their warning signs in two ways, directly and indirectly which was also reported by Kral and Sakinofsky (1994). Some direct expression of suicidal intent has been found among suicidal individuals. Direct expression included their warning about committing suicide with significant family and friends. Previous research supports that as their intent of dying got stronger their expression of such thought became more direct (Blumenthal, 1988). Suicidal persons were seemed to communicate their suicidal feelings and thoughts in a consistent manner. They even expressed their homicidal thoughts and plans. This was a significant marker that indicating prospective individual's psychological imbalance and preoccupation with suicidal thoughts. Due to their relationship with heightened and, at times, imminent risk, these direct warning signs were found to be a strong precursor that requires greater and more immediate attention as a possible intervention aspect to prevent suicide (Kral & Sakinofsky, 1994).

In this proximal phase suicidal individuals also exhibited some indirect signs where the individual did not express significant suicidal intention rather depending on critical life circumstances their activities, emotions and thinking process indirectly expressed suicidal intention. Chapman and Dixon-Gordon (2007) also emphasized similar hypothesis in previous study. Individual's mental, physical, emotional and behavioral state might fluctuate from manageable to overwhelming level. Therefore, it is possible that

suicidal feeling would be reflected in specific forms of behavior, actions and verbal cues of the person making these candidates for early indicators for suicide (Farberow & Shneidman, 1961). Suicidal individual were found to engage in some preparatory activities prior to committing suicide. Firstly they were found to get prepared for the attempt such as writing suicide notes, preparing environment for attempt, collecting means etc. Secondly, individuals were preparing themselves mentally with the decision of suicide. These include apologizing to Allah, requesting others for giving up claims and praying before attempt. These indirect expressions of suicide were also easily observable by the family members.

Compared to proximal signs distal signs were relatively remote and the time duration varied from few days to a week before suicide (McClure, 2012). It relates to behavioral signs reflecting person's struggles with their problematic life circumstances in the last few days from the suicide event. These distal warning signs were found to be more prolonged than proximal signs which was also confirmed by Mandrusiak et al. (2006). Therefore, this phase is very important as it involves a longer period of time for intervention and support provision. Roberts (2005) also suggested the importance of taking preventive steps during this phase. It has been found that in the distal phase the suicidal warning signs were expressed in details in the individual's behavior, emotion and cognitive level. Owens et al. (2011) emphasized that individual in this phase seemed to think quite rationally and actively engaged in problem solving.

The process of manifestation of different warning signs in different timeframe can be explained through the communication theory of suicide. Both Shneidman and Farberow (1956) and Watzlawick and Beavin (1967) emphasized the communicative aspects in suicide process. This approach emphasizes such factors as the content, audience, degree of

directness, and purpose of communication (Knizek & Hjelmeland, 2007). According to this model, suicidal behavior is not only perceived as an act that aims at hurting oneself, but also a specific way to communicate something. Thus, the self-destructive suicidal and associated behaviors are actually forms of communication with a particular purpose and content directed toward a specific audience.

Research suggests that individual attempts may be motivated by many different reasons such as escape, communication, altering one's environment, and dealing with an unbearable state of mind (G. Brown, Henriques, Ratto, & Beck, 2002; Chapman & Dixon-Gordon, 2007; Holden, Kerr, Mendonca, & Velamoor, 1998; Klonsky, May, & Glenn, 2013; Schnyder, Valach, Bichsel, & Michel, 1999). Different theories of suicide offer different hypotheses about why people attempt suicide. The theory of suicide by Shneidman (1993) describes psychache (i.e., emotional or psychological pain) as the primary contributor of an attempt. He stated that the threshold of tolerance varies from person to person and when any psychological pain crosses individual's threshold level suicide occurs. Roy Baumeister's escape theory suggests that suicide attempts are the output of a need to reduce aversive self awareness. (Baumeister, 1990). Interpersonal theory of Joiner Jr et al. (2009) states two important domain namely perceived burdensomeness and thwarted belongingness. He stated that interaction of this two can put in the desire for suicide. Other theories highlight the roles of hopelessness (Abramson et al., 2002), problem-solving (Baechler & Cooper, 1979), and interpersonal communication (Farberow & Shneidman, 1961). Whatever the reason a person is considering their inner message was found to be manifested through their emotions, thoughts and behavior in a different timeframe. And these acts are considered as warning signs of their suicidal intention which has been captured by this present study.

4.2 Predisposition of Suicidal Behavior

Previous suicide plans and attempts, long term mental health issues, personality pattern and family dynamics has been found among the suicidal cases as predisposing factors. It was found that suicidal individuals had long term mental health issues, and previous history of sucidal behavior. These risk factors are a significant marker which makes the suicide intention stronger (Beautrais, 2000). He found that compared with single attempters, people who attempts repeatedly show more symptoms and found to have worse coping strategies. Even when suicide attempters resolve the problems that led to their self-harm, they remain at risk for further self-harm in newer problems. Sakinofsky and Roberts (1990) also found the similar findings which showed individuals who repeated a suicide attempt in spite of having resolved their problems included (16%) of all suicide attempts. Additionally there is overwhelming evidence to suggest that mental illness play a major role in the etiology of individual's suicidal behavior (Beautrais, 2000).

It has been seen in this research that individuals who attempt suicide have a common personality pattern like less emotional regulation, reactivity, impulsivity, aggressiveness, and short temperament which is why these individuals have unhealthy coping mechanisms. Research conducted by Hoberman and Garfinkel (1988) supports this proposition. The individuals who have these personality factors and who employ unhealthy coping mechanisms are less adept at handling critical life situations (Beautrais, 2000). Not only that, it has been found in the current research that such factors continuously interact with external factors like family dynamics and different contextual factors. Suicidal individuals of the current study were found to have significant negative family environment and contextual attributors. This included negative parenting, unhelpful environment, aggression in family, financial crisis, lack of freedom, significant loss events

and similar long standing aspects which was also found by Phillips et al. (2002) and Beautrais (2000). These unhelpful and negative contextual determinants make them vulnerable which in turn contributes to reduced coping capability among them. Psychological vulnerability and adoption of negative coping mechanism increase proneness to commit suicide (Kurz, Baindl, Torhorst, & Lauter, 1987).

In critical situation these factors work as a vicious cycle and result in strengthening of the facilitating assumption, "suicide is the only solution". Through this the individual chooses suicide as the final conclusion. When an individual reach that conclusion the warning signs become prominent in their behavior, actions, and thoughts and in emotional expression.

4.3 Scope for Intervening Suicide

Through this study it was possible to receive extensive, coherent, verbatim account from the para suicidal individuals and key informants about the suicide incident, context, manifestation and their interaction. This integrative information from both suicidal individual and key informants added a vast knowledge in understanding the suicide process.

The striking findings of the present study were that persons who commit suicide communicate their suicidal ideas and preoccupation with imminent death prior to the suicidal act. In the majority of instances these communications are repeatedly verbalized, diverse in content, and expressed to many different persons.

It has been elaborated in earlier section that in this research important direct and indirect expression of warning signs has been found. These were mostly from both proximal and distal phases and individuals with suicidal inclinations have communicated these directly to others. Which means the suicidal individual was verbalizing suicidal intention in a very direct way and they communicated those with family members. This hypothesis was also supported by Barnes et al. (2002) . The important phenomenon is that the suicidal person has directly expressed his thoughts, emotions and plans, wrote these and has reached out to others at different times. Current research gave us insight that between the direct and indirect expression of suicide warning signs and actual suicide event, in both proximal and distal phases family members were able to perceive the suicidal risk (Veiel, Brill, Hafner, & Welz, 1988).

Those perceptions were persisted in both distal and proximal phase of suicide. Present study revealed that family person were the first party who actually received these warning signs repeatedly (Van Orden et al., 2010). There were two factors involved in communication of suicidal ideas: the direct expression of suicidal ideas and the perception by the significant family members.

The communication of suicidal intent can be understood from two major perspectives that emerged in this study. One is from the perspective of communicator that is the suicidal person. Since suicidal individuals communicated their suicidal ideations with others there might be four explanations for this which was supported by Robins, Gassner, Kayes, Wilkinson Jr, and Murphy (1959). Firstly, their communications may be considered as a mean of bringing their plight to the attention of others so that they can get help (Barnes et al., 2002). Secondly, the communication may reflect the desire to warn the family members of what they are about to do and therefore in some way prepare them for

their death so that it will be less of a shock (Veiel et al., 1988). Thirdly, even though they wished to die, the communication is also meant as threat (Shneidman, 2004). Fourthly, the person becomes so preoccupied with ideas of suicide and death that they are merely expressing the content of their thought rather than trying to achieve any particular goals through his suicidal communication (Barnes et al., 2002). Robins et al. (1959) also emphasized this discussion of understanding the suicidal individual's inner message of communication of such suicidal intentions.

The other is from response of the key informants in this process. The most common response of the key informants perceived suicidal warning signs were found to be either indifferent to it or were distressed by it. The majority of key informants expressed a marked tension. They were being repeatedly warned of the probable occurrence of dire event. However, somehow they excluded the risk every time. They thought this suicide is not likely to happen and therefore did not engage themselves in an appropriate moment of crisis management. The reason might include denial, stigma, and a lack of knowledge or skill regarding suicide.

4.4 Integrated Model of Suicide Warning Signs in overall Suicide Process

An integrated model of warning signs in overall suicide process was developed based on the findings of the study (see Figure 4.1). As mentioned in earlier section (see 3.1, 3.2, 3.3 and 3.4). It was clear that individual's suicidal process started from the risk and vulnerability factors as reflected in section 4.2. These factors made people vulnerable and this vulnerability (e.g., negative coping, lack of resources) along with the family and contextual factors (e.g., family conflict) trigger the facilitating assumption of suicide. So at

this point, the individual start to believe "suicide is the only solution" and then proceeds towards committing suicide.

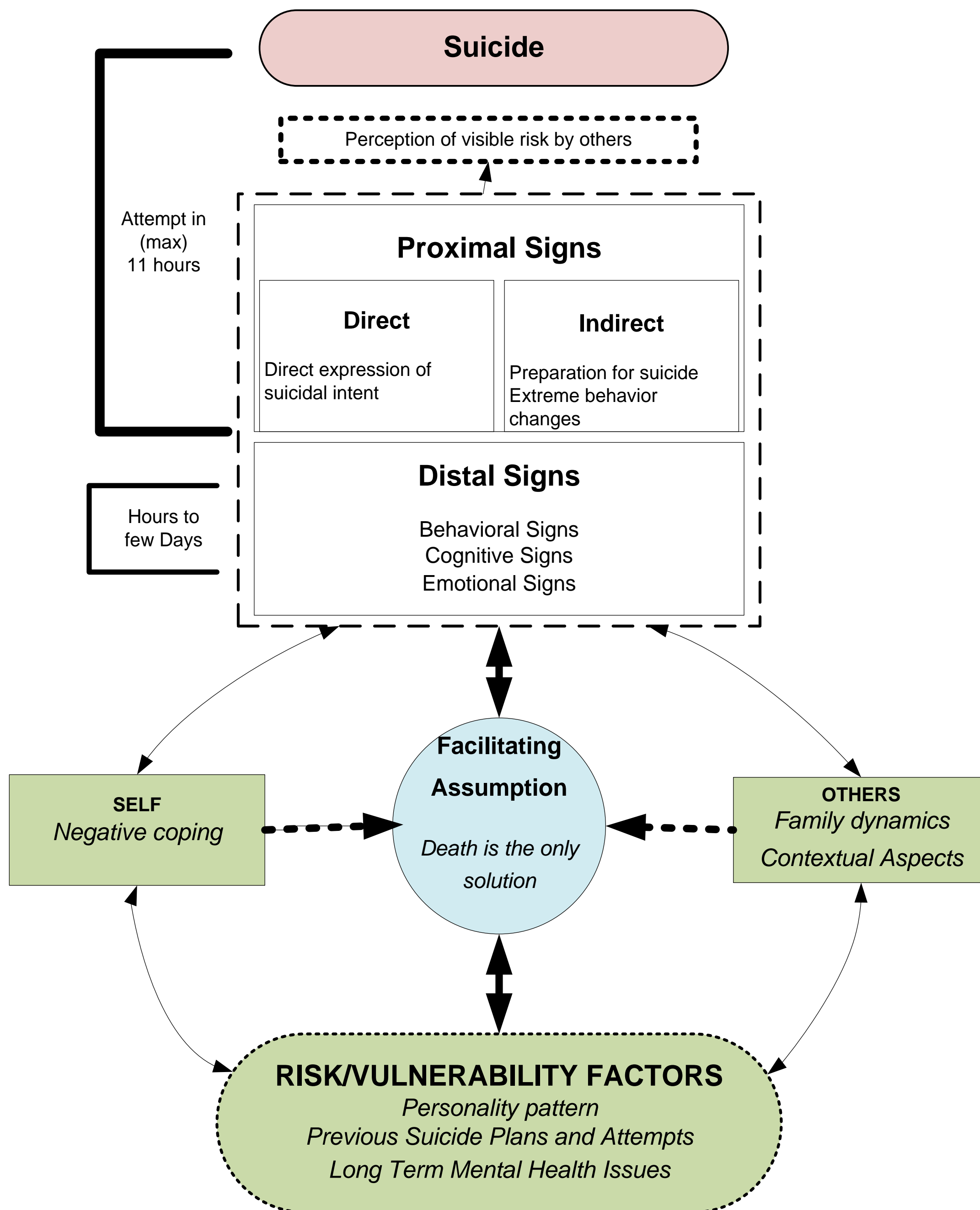

Figure 4.1 Integrated Model of Suicide Warning Signs in overall Suicide Process

From activation of assumption to act on suicide there are some time lapse which may vary from few days to few hours. In this period of time, the suicidal individual demonstrates different kinds of behavior as mentioned in section 4.1 which are categorized

into distal and proximal signs. In these two phases, suicidal individual demonstrates their suicidality in different forms such as direct and indirect forms. These forms are observable and were perceived by the family members and others as mentioned in section 4.1. If the family members do not interfere or intervene suicidal attempts are made in this stage.

From this model it is obvious that these warning signs occupy a space between the decisions of accepting suicide as option to actually committing suicide. During this period family members were found to play an intermediary role. They are the immediate party who can play role in suicide prevention. Because suicidal people reach out to these people and warning signs were visible to these people. If appropriate steps can be taken in proper time before actual suicide event occur, suicide can be prevented in large scale in our country. These steps might vary in a several ways from providing a suicidal individual emotional support by themselves or to bring them in to a psychological intervention system. Therefore, suicide attempt can be prevented if appropriate intervention at this period can be introduced. Although it will not prevent the vulnerabilities in the population but at least suicidal attempt can be prevented. Additional intervention can be introduced to reduce vulnerabilities once a suicidal individual can be identified before committing suicide.

This study signifies the pre suicidal period of any suicidal case where proper intervention can be provided to prevent suicide in a large scale. Previous studies also suggested that suicide can be prevented if intervention is provided before suicidal event takes place (Rudd, 2008; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004; Silverman & Felner, 1995). Findings of the present study strengthen this concern and suggest the demand for a clear intervention policy specially designed for pre suicidal phase. If we want to prevent suicide in mass scale, warning sign based intervention can be considered

as a strong strategy (Rudd et al., 2006; Van Orden et al., 2006). Finally, it can be concluded that this research raise the demand of developing an early warning sign based intervention to prevent suicide in Bangladesh.

4.5 Strength of the Study

Two major strengths of this qualitative investigation can be mentioned here. Firstly this study incorporated perspective of both the suicide attempted individuals and key informants (i.e., the relative of suicidal cases). Thus, the live experiences of both parties gave this study a unique dimension and distinguished it from other studies conducted in this area. Secondly, this study brings the first indigenized data on suicide warning signs in Bangladeshi culture and is believed to serve as a springboard for future research and intervention delivery on the area of suicide prevention.

4.6 Limitations of the Study

Available literature on suicide warning signs has been infested with limitations which are thoroughly discussed in the Chapter 1 (see Section 1.4). The present research attempted to overcome some of these limitations by adopting a phenomenological research approach incorporating the perspective of both suicide attempted individual and key informants of attempted/committed cases. However, there are some limitation which the present study left to address as scope for improvisation in future studies. These drawbacks include small number of sample size, limited variation in sampling, limited inclusion of family members of suicide completed cases, and gender inequality in the number of participants in the in-depth interviews.

4.7 Implications of the Study

This was the first research conducted towards a detailed understanding of suicide warning signs in Bangladesh context. The possible implications of this research are described in the following.

- Identification of these warning signs may play an important role in early detection and subsequent early intervention for suicidal cases.
- This finding can contribute in building awareness among community people about pre suicide specifics and their role in crisis management.
- It can be used in designing national suicide prevention guideline in Bangladesh.
- These findings can largely be utilized as practitioner's guidelines in clinical practice. It has great implications for the clinical psychologist in risk assessment and treatment planning for ensuring client's safety.
- Additionally, this detailed finding on suicide warning signs would enable health providers to implement an appropriate immediate, short-term and ongoing intervention that can assist an individual in crisis to save life over death.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

CONCLUSION AND RECOMMENDATIONS

The aim of the present study was to explore pre-suicidal behavior of suicide cases to identify the pre-suicidal warning signs. A qualitative research design under phenomenological approach was adopted to study the objectives. Using purposive sampling techniques eight participants were selected purposively for data collection. Data were collected through in depth interview. Three groups of participants have been interviewed including, attempted case, key informants of attempted and key informants of completed suicide cases. Since the purpose of the study was to explore pre suicidal warning signs, it explored warning signs in a detailed manner and its discovered its associated contributing factors.

This qualitative investigation found sixty themes of meaning which were categorized under ten broad sections. The present study revealed four important aspects regarding suicide and warning signs such as manifestation aspects, predispositional aspects, suicide context aspects and intervention aspects. However, the findings provided detailed understanding of suicide warning signs and overall suicide process. From the findings of the present study it can be said that suicide is preventable as the suicidal individual provides warning signs in different level such as behavioral, cognitive and emotional warning signs before suicide. Moreover, it was found that a suicidal individual directly expressed thoughts, feeling and behavior regarding their suicidality to the family and friends. They communicate their suicidal intent before the attempt. Their expression of suicidal warning signs ranged from proximal to distal in terms of temporal order. Therefore, it is obvious that if their warning signs can be perceived, they can be provided help and brought under psychological intervention ultimately leading to greater prevention of suicide in Bangladesh.

Another important finding revealed in this study was that people surrounded by the suicidal individual actually were able to perceive their suicidal risk. However, instead of providing help these people excluded the risk subjectively. The probable reason behind this ignorance might be the lack of knowledge about warning signs and stigma around suicide. In either case present study can contribute through its detailed understanding.

Apart from gaining in depth understanding on suicide warning signs this study shed some lights on how this overall suicide process works. Present study also shows the interaction among few major contributing factors such as long term mental health issues, previous history of suicidality, family dynamics and contextual attributors. Additionally, the analysis of that interaction among variables makes understanding stronger and help in getting the picture of this given phenomena as a whole.

The present research has made important practical contributions. There is no published research on understanding suicide warning signs in Bangladesh. Along with phenomenological approach, the present study used the perspective of indigenous psychology. The present research attempted to develop context-specific knowledge suicide warning signs in Bangladeshi culture. However, the finding of the present research can be a considered as a contribution to knowledge in worldwide especially for Asian countries as well. Though few researches have been conducted worldwide on suicide warning signs, they were methodologically limited. Researchers seemed to shy away from conducting phenomenological research incorporating the lived experience from suicidal individual as well as key informants (e.g. family members). For this particular reason present research is unique from others and can play a significant role in providing in depth understanding regarding suicide warning signs.

Recommendations

There were a number of important lessons learned from this unique and challenging study. From these lessons, the following recommendations are made for future research on warning signs of suicide.

1. Further study should be designed with a larger sample size incorporating more variation in the sample. This may include diversity of sample in terms of type of sample, geographical location, gender, socio-economic status, religious differences, and cultural factors.

2. Understanding of the role of family and friends and empowering them to intervene in the crisis moment may significantly contribute in the efforts of preventing suicide. Further studies can be done to assess and plan on this possibility.

3. People were found to be ignorant in perceiving suicide risks. Some possible explanation of this has been offered in the discussion, however, in order to prevent suicide the contributing psychosocial factors for such ignorance need to be thoroughly explored in future research.

4. General public should be educated to recognize the warning signs along with the risks and vulnerabilities associated with suicide through mass campaign using print, electronic and social media. Policy maker should consider this option as an attempt to prevent suicide significantly.

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APPENDICES

Appendix A: Demographic Information Sheet

Demographic Information

তারিখ ঃ কোডঃ

	কেস	কি ইনফরম্যান্ট
১। লিঙ্গ		
২। বয়স		
৩। শিক্ষাগত যোগ্যতা		
৪। পেশা		
৫। কেসের সাথে সম্পর্ক		

ফিল্ডনোটসঃ

Appendix B: Screening Questionnaire (KI)

গবেষণায় অন্তর্ভুক্তি বিষয়ক প্রশ্নমালা

Screening Questionnaire (KI)

এই গবেষণায় সাক্ষাৎকারের জন্য আপনার উপযুক্ততা প্রমান হলে আমরা পরবর্তী আলোচনায় যাবো। সে লক্ষ্যে আপনাকে কিছু প্রশ্ন করবো।

১। আপনার বয়স কি ১৮ বছরের কম?	**() হ্যাঁ () না**
২। সে কি কোন ঘটনার প্রতিক্রিয়ায় আত্মহত্যা করেছে?	**() হ্যাঁ () না**

কোডঃ

Appendix C (a): Topic Guide (Attempted Case)

Topic Guide (Attempted Case)

১। আপনার সম্পর্কে বলেন?

২। কি হয়েছিলো যে কারনে আপনি আত্মহত্যা করতে চেয়েছিলেন?

৩। আত্মহত্যার চেস্টার পূর্বেও অভিজ্ঞতা সম্পর্কে বলেন?

- আচরন
- চিন্তা
- অনুভূতি
- শারীরিক প্রতিক্রিয়া
- বিস্তারিত ঘটনা বাস্তব উদাহরনসহ

৪। কাউকে বলার চেস্টা করেছিলেন?

৫। সম্পর্কগুলো কেমন ছিলো সে সময়ে?

৬। সামগ্রিকভাবে কি কি পরিবর্তন এসেছিলো আপনার মাঝে?

Appendix C (b): Topic Guide (Key Informant)

Topic Guide (KI)

প্রশ্ন	প্রোব
১। মানুষটি কেমন ছিলেন? তার সম্পর্কে যতটুকু জানেন বলুন।	▪ তার জেনারেল প্যাটার্ন- উদাহরণসহ ▪ আচরন কি রকম ছিলো ▪ চিন্ার প্রক্রিয়া ▪ আবেগীয় প্রকাশ ▪ সবগুলোর বাস্ব ঘটনার বিবরণসহ
২। আত্মহত্যা করতে পারে এমন কি কখনো মনে হয়েছে? হলে কি কারনে? না হলে কি কারনে?	▪ কারন ▪ কি কি দেখে ▪ উদাহরন/ঘটনার বিবরন
৩। আত্মহত্যার আগে ওনার মাঝে কোন পরিবর্তন দেখেছেন কি?	▪ কোন রকম স্টেট্মেন্ট থাকলে সেগুলো কি ▪ আচরন কি রকম ছিলো ▪ চিন্া প্রক্রিয়া ▪ আবেগীয় প্রকাশ ▪ সব গুলোর বাস্ব উদাহরনসহ বিবরণ

Appendix D: Contact Form

CONFIDENTIAL

Contact Details

Code

Name:

Address   **Phone**

Notes

Appendix E: Consent Form

সম্মতি পত্র

গবেষণার শিরোনাম: *Exploring Early Warning Signs of Suicide in Bangladesh*

এই সম্মতি পত্রটি গবেষণার রেকর্ড হিসেবে ঢাকা বিশ্ববিদ্যালয়ের (University of Dhaka) গবেষকের কাছে জমা থাকবে।

আমি **ঢাকা** বিশ্ববিদ্যালয়ের **(** University of Dhaka**)** উপরোল্লিখিত গবেষণা প্রকল্পে অংশগ্রহন করার জন্য সম্মতি দিচ্ছি। আমাকে গবেষণা প্রকল্পটি সম্পর্কে বিস্তারিতভাবে বুঝিয়ে বলা হয়েছে এবং আমি এই সংক্রান্ত ব্যাখ্যামূলক বিবৃতি পড়েছি (বা আমাকে পড়ে শোনানো হয়েছে) যা আমার কাছে রেকর্ড হিসেবে রাখা আছে। আমি বুঝতে পারছি যে, সম্মতি প্রদানের মানে হচ্ছে:

আমি গবেষকের কাছে সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি ☐ হ্যা ☐ না

আমি সাক্ষাৎকারটি ক্যাসেটে রেকর্ড করার সম্মতি দিচ্ছি ☐ হ্যা ☐ না

আমি প্রয়োজনে পরবর্তীতে আবারও সাক্ষাৎকার প্রদানে সম্মতি দিচ্ছি ☐ হ্যা ☐ না

আমি আমার পূরন করা গবেষণায় অন্তর্ভূক্তি বিষয়ক প্রশ্নমালাটি আমার সাক্ষাৎকারের তথ্যের সাথে সংযুক্ত করার সম্মতি দিচ্ছি ☐ হ্যা ☐ না

এবং

আমি বুঝতে পারছি যে, আমার অংশগ্রহন স্বেচ্ছামূলক; আমি ইচ্ছে করলে আংশিক বা সম্পূর্ন প্রকল্পে অংশগ্রহন করা থেকে বিরত থাকতে পারি এবং গবেষণায় আহরিত তথ্যের লিখিত অনুলিপি অনুমোদনের পূর্বে যে কোন পর্যায়ে আমার অংশগ্রহন প্রত্যাহার করতে পারি যার জন্য আমাকে কোন ভাবেই ক্ষতিগ্রস্থ করা হবে না।

এবং

আমি বুঝতে পারছি যে, গবেষণায় একক সাক্ষাৎকারের মাধ্যমে যে তথ্য আহরন করা হয়েছে তার প্রকাশনা বা উপস্থাপনায় কোন অবস্থাতেই অংশগ্রহনকারীর নাম-পরিচয় লিপিবদ্ধ থাকবে না বা প্রকাশ করা হবে না।

এবং

আমি বুঝতে পারছি যে, আমার থেকে আহরিত তথ্যের একটি লিখিত অনুলিপি আমাকে দেয়া হবে যা দেখে আমি সেটি গবেষণায় অর্ন্তভূক্ত করার বিষয়ে সিদ্ধান্ত দিতে পারি।

এবং

আমি বুঝতে পারছি যে, আমি যা তথ্য দেব তার গোপনীয়তা রক্ষা করা হবে, এবং এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না যা থেকে আমাকে চেনা সম্ভব।

এবং

আমি বুঝতে পারছি যে, সাক্ষাৎকারের অডিও রেকর্ড ও তা থেকে আহরিত তথ্যের লিখিত অনুলিপি সমূহ একটি নিরাপদ স্থানে সংরক্ষিত থাকবে এবং কেবলমাত্র গবেষক ছাড়া অন্য কারো কাছে তা সহজলভ্য হবে না।

অংশগ্রহনকারীর নামঃ . . . .

স্বাক্ষরঃ . . . . **বা** টিপ্‌সইঃ . . . .

তারিখঃ . . . .

Appendix F: Explanatory Statement

গবেষণায় অংশগ্রহণকারীদের জন্য ব্যাখ্যামূলক বিবৃতি

তারিখঃ

গবেষণার শিরোনামঃ *Exploring Early Warning Signs of Suicide in Bangladesh*

এই ব্যাখ্যামূলক তথ্যসমূহ আপনার কাছে রাখার জন্য

আমি রুবিনা জাহান রুমী, আমার এম ফিল ডিগ্রীর অংশ হিসেবে ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের (Department of Clinical Psychology, University of Dhaka) ডঃ কামরুজ্জামান মজুমদার এর তত্ত্বাবধানে একটি গবেষণা করছি।

গবেষণার লক্ষ্য

একজন মানুষ আত্মহত্যা করার আগে কি রকম আচরন এবং চিন্তা করে থাকে, তার মানসিক অবস্থা কেমন থাকে তা খুঁজে বের করার চেষ্টা করা হবে এই গবেষণার মাধ্যমে।

গবেষণায় যা করা হবে

প্রথমত গবেষণায় অন্তর্ভূক্তি বিষয়ক প্রশ্নমালা ব্যবহার করে দেখা হবে আপনি এই গবেষণায় আংশগ্রহনের জন্য উপযুক্ত কিনা। আপনি উপযুক্ত বিবেচিত হলে, একক সাক্ষাৎকারের মাধ্যমে আপনার কাছ থেকে তথ্য আহরন করা হবে এবং তা অডিও ক্যাসেট ও লিখিতভাবে সংরক্ষন করা হবে।

গবেষণায় অংশগ্রহন করলে যে পরিমান সময় দিতে হবে

গবেষণায় অন্তর্ভূক্তি বিষয়ক প্রশ্নমালাটি পূরন কবতে ৫-১০ মিনিট সময় লাগবে। আপনি উপযুক্ত বিবেচিত হলে, একক সাক্ষাৎকারে অংশগ্রহনের জন্য আপনাকে ৪০ থেকে ৬০ মিনিট সময় দিতে হতে পারে। কিন্তু আপনার দেয়া তথ্যের গুরুত্ব অনুসারে পরবর্তীতে আরও এক বা একাধিক বার আপনার সাক্ষাৎকার দেয়াপ্রয়োজন হতে পারে। প্রয়োজন অনুসারে আমি তার সময় ও তারিখ আপনার সাথে আলোচনা করে ঠিক করে নেব।

সাম্ভাব্য সুবিধা

আত্মহত্যার সনাক্ত করনে বর্তমান গবেষণার ফলাফল তাৎপর্যপূর্ণ ভুমিকা রাখবে বলে আশা করা যায়। আপনি হয়তো অনুধাবন করে থাকবেন যে এই সংকেত গুলো সঠিকভাবে না জানার কারনে আমাদের দেশে বিভিন্ন জায়গায় অনেক মানুষ অকালে প্রান হারাচ্ছে। এই সংকেত গুলো জানা থাকলে একজন আত্মহত্যা প্রবণ ব্যাক্তিকে সাহায্য করা সম্ভব। আমাদের দেশে আত্মহত্যা প্রতিরোধ করা সম্ভব হবে। এই গবেষণায় অংশগ্রহন আপনাকে এই মুহূর্তে প্রত্যক্ষভাবে কিছু সুবিধা না দিলেও আত্মহত্যা প্রতিরোধে সমাজ ও দেশের জন্য গুরুত্বপূর্ণ অবদান রাখবে বলে আশা করছি।

গবেষণায় অংশগ্রহনের সম্ভাব্য অসুবিধা

আমি যে সব বিষয়গুলো নিয়ে কথা বলব তার অনেকগুলোই আপনার পূর্বস্মৃতি ও আবেগ বিষয়ক হতে পারে এবং এসব আলোচনায় আপনার মন খারাপ হয়ে যেতে পারে বা এটি সাময়িকভাবে আপনার মধ্যে অস্বস্তি বা কষ্টের উদ্রেক করতে পারে, কিন্তু এটি আপনার মধ্যে কোন দীর্ঘস্থায়ী ক্ষতির কারন হবে বলে মনে হয় না। তবে আপনি মানসিক সহায়তার প্রয়োজন অনুভব করলে এ ব্যাপারে আপনাকে যথাযথ সহায়তা প্রদান করার চেষ্টা করা হবে।

গবেষণায় অংশগ্রহন প্রত্যাহার

এই গবেষণায় অংশগ্রহন সম্পূর্ন আপনার স্বেচ্ছাধীন। অংশগ্রহন করতে হবে এমন কোন দায়বদ্ধতা আপনার নেই। এমনকি গবেষণাটিতে অংশগ্রহন করার সিদ্ধান্ত গ্রহনের পরও একক সাক্ষাৎকারের ক্ষেত্রে আহরিত তথ্যের লিখিত অনুলিপি অনুমোদনের পূর্ব পর্যন্ত আপনি আপনার অংশগ্রহন প্রত্যাহার করতে পারেন।

গোপনীয়তা

আপনার গোপনীয়তা রক্ষা করার বিষয়টি সর্বোচ্চ বিবেচনায় রাখা হবে। আপনার নাম, ঠিকানা ইত্যাদি অর্থাৎ যা থেকে আপনাকে চেনা যাবে এমন তথ্য একটি আলাদা কাগজে লেখা থাকবে এবং সেটি আপনার দেয়া সাক্ষাৎকারের তথ্য থেকে আলাদা থাকবে। কেবলমাত্র একটি সাংকেতিক চিহ্ন দিয়েই এই দুটোকে একত্র করা সম্ভব হবে এবং সেই সাংকেতিক চিহ্নটি আমি ছাড়া আর কেউ জানবে না। এবং এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না যা থেকে আপনাকে চিহ্নিত করা সম্ভব।

সংগৃহীত তথ্যের সংরক্ষন

সংগৃহীত তথ্যগুলো ঢাকা বিশ্ববিদ্যালয়ের (University of Dhaka) নিয়মাবলী অনুযায়ী সংরক্ষিত থাকবে। এই গবেষণার প্রাপ্ত তথ্য থেকে একটি থিসিস্ লেখা হবে, গবেষণাটির রিপোর্ট প্রকাশনার জন্য দেয়া হতে পারে এবং এক বা একাধিক মৌখিক উপস্থাপনা করা হতে পারে কিন্তু কোন ক্ষেত্রেই অংশগ্রহনকারী ব্যক্তিদের চিহ্নিত করা হবে না।

গবেষণার ফলাফল

যদি আপনি এই গবেষণার ফলাফল সম্পর্কে জানতে চান তাহলে অনুগ্রহ করে আমার সাথে (রুবিনা জাহান রুমী), ইমেইল (rumirj@gmail.com), অথবা ফোন (০১৭৩৭৩৩১০৩১) এর মাধ্যমে যোগাযোগ করবেন। যদি আপনি এই গবেষণার কোন বিষয় সম্পর্কে আরও বেশী কিছু জানতে চান তবে অনুগ্রহ করে মূল গবেষকের সাথে নিম্নোক্ত ঠিকানায় যোগাযোগ করবেন: মুহাম্মদ কামরুজ্জামান মজুমদার, সহযোগী অধ্যাপক, চিকিৎসা মনোবিজ্ঞান বিভাগ, ঢাকা বিশ্ববিদ্যালয়, ইমেইল (mozumder@du.ac.bd), অথবা ফোন- (০১৭১৩০৬৬৪২৩).

আপনার সহযোগীতার জন্য ধন্যবাদ।

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রুবিনা জাহান রুমী

Appendix G: Referral Directory

Referral Directory

	সংস্থার নাম/ **Name of the Organization**	ঠিকানা/**Address**
1	জাতীয় মানসিক স্বাস্থ্য হাসপাতাল National Institute of Mental Hospital (NIMH)	শ্যামলী, শিশুমেলার পাশে Shyamoli, beside ShishuMela
2	ঢাকা মেডিকেল কলেজ হাসপাতাল Dhaka Medical College and Hospital (DMCH)	শাহবাগ, কেন্দ্রীয় শহীদ মিনারের পাশে Shahbag, Near ShaheedMinar
3	নাসিরুল্লাহ সাইকোথেরাপি ইউনিট Nasirullah Psychotherapy Unit (NPU)	ঢাকা বিশ্ববিদ্যালয়, কলাভবনের ৪ তলায় 3rd floor, Kola vaban, Dhaka University

Appendix H: Ethical Approval

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা–১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th floor)
Dhaka-1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-8615583, E-mail: clinpsy@du.ac.bd

Certificate of Ethical Approval

Project Number : **MP150601**

Project Title : **Exploring Early Warning Signs of Suicide in Bangladesh**

Investigators : **Rubina Jahan Rumi** and **Muhammad Kamruzzaman Mozumder**

Approval Period : **01 July 2015 to 30 June 2017**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

Appendix I: Original Quotation and Translated Quotation

	Bangla Quotation	English Translation
1.	পরে আমি বুঝতেসি যে টেনশন যখন আসতেসে মনে হয় কিছু হবে, তো এই ছয় তারিখে ডাক্তারের কাছে নিয়ে যাব যে টেনশন হচ্ছে কেন? মানে আগের অশুধ বোধ হয় চেঞ্জ করবে ডাক্তারে	*"Later I understood, as she seemed to be tensed, perhaps something [suicide] would happen. So I decided to consult a doctor coming on 6th March [next week]. [Wondering] Why was she tenseed? I thought that the doctor may change the previous medicines." [KI-mother of committed suicide case]*
2.	খুন টা করবেনা বা নিজেও কিছু করবে না। এটাই ভাবছি, এত বোকামি তো করা উচিত না, আমার মনে হইসে যে ও আমার শুধু ভয় দেখাইতেসে, যে আমি স্যাভলন যে খাবে এটাও আমি বুঝি নাই, স্যাভলন যে আমার বাথরুম থেকে নিসে, এইটা আমি দেখসি	*"She would neither kill, nor hurt herself. That's what I thought, that you shouldn't do anything so stupid, so I thought she was just trying to scare me. I did not understand that she would drink savlon, though I saw her take the savlon from my bathroom." [KI-husband of attempted case]*
3.	না ওরা এতটা সিরিয়াস হয়নি, ওরা ভাবসে যে এমনি হয়তবা খাওয়া দাওয়া বন্ধ করে দিব বা, এমনি ওরা বুঝে নাই যে এতটা ই করব আমি	*No, they weren't that serious, they thought that I might just stop eating, but they didn't get that I would go this far. [Attempted case]*
4.	আমার মেয়ে ওখানে বসা ছিল। আমি বললাম যে তুই বের হ। ঐ রুমে যা। তয় মেয়ে কি ঐ রুমে গেছে না বারান্দায় বসছে বলতে পারি না। ওখান থেকে চেয়ার টা আনছি। এইটাই বলতে পারি। চেয়ার এনে আমি একটা ওড়না নিয়া গলায় ফাস দিছি। এরপর আর বলতে পারিনা।	*"My daughter was sitting there. I told her to come out, to go to the other room. But I can't remember if she left to go to the other room, or sat in the veranda. I brought the chair from there. That much I can say. I took an* orna, *stood on the chair and tied around my neck. I don't know anything after that." [Attempted case]*
5.	আমি কিন্তু সুইসাইড করবো। আমাকে তুমি চেনো না। আমার রাগ কিন্তু তোমার থেকে বেশি। আমি বলি	*"[my wife said] "I am going to kill myself. You don't know me. My anger goes far deeper than your's". I said, let it be deeper,*

	তোমার বেশি হোক। কিন্তু তুমি সুইসাইড করবা কেন? সুইসাইড কেন করবা, এটা করলে তো তুমি এই পৃথিবী থেকে শেষ পরকালেও কিছু পাবা না। পরকালে বেহেস্ত্ব বলে একটা কথা আছে সেখানে তোমাকে যাইতে দেয়া হবেনা। আমি তাকে বঝাইছি অনেক বার।	*but why are you going to kill yourself? If you do that, you aren't just going to lose onlt this life; you will lose any chance at the afterlife as well. You won't be allowed to go to Heaven in the afterlife. I tried to make her understand lots of times." [KI- husband of attempted case]*
6.	সুস্থ হয় নাই, অসুস্থর মধ্যেই একদিন আমারে বলে যে এরকম করলে আবার করমু,	*She didn't get better; one day while still unwell, she told me that if I did that, she would try it again, [KI-father of attempted case]*
7.	মানে খালি বলতো যে আমি মইরা যাবো। এইটা সেইটা। খালি মরার কথা টাই বেশি বলতো।	*She would just say that she was going to die, things like that. She would mostly talk about dying. [KI-daughter attempted case]*
8.	যে মইরা গেলেই তোরা শান্তি পাবি। যখন মা থাকবো না তখন তোরা বুঝবি যে কি জিনিস?	*That if I died, they would be in peace. When Ma won't be around, then you will understand what you missed? [Attempted case]*
9.	হ্যায় যদি মূল্যায়ন না করে তাইলে আর কোন কেউ কি করবে । আর এই বয়সে আমার দুই মেয়ে আমার সংসার এগুলি কি কেউ গোছে নিবো কখনো? নিবো না।	*"If he does not value it, why would others bother? And at this age with my two daughters and my family, will anyone ever take responsibility of it [me and my children]? No one will." [Attempted case]*
10.	আমার কেউ নাই। আমি বেঁচে থাকলেই বরং সবার ঝামেলা। আমাকে বুঝবে এরকম কাউকে আমি দেখিনা। সবাই সবার মতো আছে। আমার থাকাতে না থাকাতে খুব কি কিছু আসে যায়?	*I have no one. Rather my existence is problematic for all. I do not see anyone who will understand me. Everyone is busy in their life. Does it matters if I am alive or dead? [Attempted case]*
11.	ওকে ছাড়লে কি করবো। কোথায় যাবো? ভাইরা হয়তো একদিন দুইদিন খাওয়াইব। বিয়ের উপযুক্ত মেয়েটা। আমি একটা উপযুক্ত নারী। আমরা কোথায়	*"What will I do if I leave him? Where will I go? May be my brothers will take care of me for a day or two. The girl is*

	যাবো? কি করবো? কি খাবো? এইটা আমার ভিতরে একটা সব সময় ই করছে। যে আমি কি করবো?	*of marital age. I am an adult woman. Where will we go? What will we do? What will we eat? This was always haunting me inside. What will I do?" [Attempted case]*
12.	তখন আমার স্বপ্নগুলো ভেঙ্গে গেল। তখন ভেতরে এই কষ্টটা কাজ করল যে এত কষ্ট হোল যে আমি নিজেকে শেষ করে ফেলব। তাকে পেলাম না যখন, আমার যখন জীবনের সব থেকে বড় চাওয়াটাই পূর্ণ হোল না, তখন আর কী আছে এ জীবনে?	*"My dreams were shattered, this internal pain was so severe that I myself shall end my life. When I failed to get him [as lover], the deepest wish of my life left unfulfilled - what else is left in this life?" [Attempted case]*
13.	বেঁচে থেকে যে আমি বেশি কষ্ট পাচ্ছি এভাবে যে আছি আমি তো সুখে নেই, ভেতরে যদি এখন তীব্র যন্ত্রণা	*"Living is more painful at this moment, I am not happy in this state, there is an extreme amount of pain inside." [Attempted case]*
14.	শুধু শুধু আমি কেন আরো ২০টা ঘণ্টা ২০টা বছর কষ্ট করব কেন? সল্ভ করে ফেলি, এটা মনে হত।	*"Why should I carry this pain another 20 hours, 20 years? Let me solve it now, this is what I thought." [Attempted case]*
15.	মুখ ভার করে থাকতো। কাজকর্মে, কাজ করতো ঠিক ই মানে একটু মুখ ভার থাকতো। রাগ রাগ থাকতো। কষ্ট থাকতো। আমি বলতেছি আমার স্বামী শুন্েছে না, আমাকে অনুমতি দিচ্ছে না যাওয়ার। এগুলাই আরকি। খিটখিট করতো আরকি।	*"Used to have a gloomy face. At work - semmed to work right but kept the gllomy face on. Expression of anger, irritability and pain was there - "I am talking but my husband is not listening, he is not giving me permission to leave.""[KI-husband of attempted case]*
16.	ভাবে আমাকে শুধু খাওয়ায় খাওয়ায় বাচায় রাইখা কি লাভ? তারচেয়ে আমি মরলেই তো ভাল, আমি অনেক রাগ দেখাই, অনেক কান্না কাটি করি কিন্তু তারা কোন	*"What is the meening of feeding me and keeping me alive? It is better if I die. I showed a lot of anger, cried a lot but they were not inclined to change, they will keep*

	কিছুতেই মানবে না, এভাবেই রাখবে আমাকে।	*me like this [not meeting my needs]." [Attempted case]*
17.	এই জিনিস গুলা, খুব মানে হাঁপায় উঠতাম আমি যে মাঝে মাঝে মনে হত আমার শ্বাস নেয়ার কোন জায়গা নাই, দম বন্ধ হয়ে যাওয়ার মত,	*"These things, I used to feel out of breath, sometimes it felt like I have no room to breathe, it was like not being able to breathe at all." [Attempted case]*
18.	একাকীত্ব এবং কেউ না থাকা এবং ঐ তীব্র যন্ত্রণা পুরা আমার চিন্স্তা, চেতনা, ব্রেণ ক্রাশ করে ফেলা, সেটা থেকে ইয়েটা আসলো।	"Loneliness, not having anybody [beside me] and this acute pain overwhelmed my brain and my awareness, thinking and precessing. This thing [suicidal idea] came from that."[Attempted case]
19.	তারপরে মানে আমার জীবনটা প্রথম থেকেই এতো কষ্ট! আমার আর ভাল্লাগতে ছিলো না।	*"From the beginning so much pain in my life! I no more felt like living." [Attempted case]*
20.	মানে কষ্ট থাকে তখন আবার অনেক মেজাজ খিটখিটে হয়ে যায়	*"Meaning there is pain and then again my mental state becomes very irritable." [Attempted case]*
21.	অস্থিরতা ভাব। খালি শুধু অস্থিরতা ভাব	*Restless feeling. Only restless feeling. [Attempted case]*
22.	মানে পড়াশুনা করাবে না, এ জন্য, পড়াশুনা করতে পারব না ক্যারিয়ার হবেনা, এ জিনিসটা নিয়েই আরকি অনেক বেশি টেনশন ছিল।	*"Meaning they would not let me study, that is why, will not be able to study so will not have a career, had a lot of tension regarding this."[Attempted case]*
23.	খুব ছোটবেলা থেকেই অনেক কিছু সহ্য করছি, এরকম কেউ সহ্য করেনা। আমার মতো এরকম কেউ এতো সহ্য করেনা।	*"I have been tolerating many things since my childhood. No one tolerates things like this. No one tolerates this much like me." [Attempted case]*
24.	আমার দেয়ালে পিঠ ঠেকে গেছে।	*"I have my back against the wall."*

		[Attempted case]
25.	সারাক্ষণ এই জিনিস গুলা মাথায় ঘুরত, যে করতে পারছি না বের হতে পারছিনা, সারাক্ষণ ঘরের মধ্যে, কোন কাজ করতে পারছি না জব না পড়াশুনা না। ....সারাক্ষন এগুলাই মাথার মধ্যে ঘুরপাক খেত।	*"Thought about these always occupied me, that I cannot do anything, that I cannot get out of it, staying in the room all the time, can't do job or studies, nothing. . . . . my head was filled with these thoughts all the time." [Attempted case]*
26.	আবার ধরেন বাবাকে একটু ঠিক রাখার জন্য অনেক কবিরাজ টবিরাজ করছে, । উনি কিন্তু কবিরাজ টবিরাজ বিশ্বাস করতেন না। মানে যে যেইটা বলতেছে , যে যার কথা বলতেছে সেই সেখানেই দৌড়াদৌড়ি করতো।	*"To bring dad out of that [extramarital affair], [she] went to numerous traditional healers (kobiraj) although she did not have faith in traditional healers (kobiraj). Whatever others suggested, whoever they suggested, she ran to those places and persons." [KI-daughter of attempted case]*
27.	তখন চিন্তাটা ওরকম ছিলনা, তখন চিন্তাটা ছিল নিজেকে শেষ করে দেয়া এবং তখন সাহস হয়ে গিয়েছিল অনেক,	*"At the time the thought was not like that [rational], the thought was to kill myself and I felt a lot of courage to do so." [Attempted case]*
28.	না আসলে আমি নিজেকে কন্ট্রোল করতে পারছিনা, শেষমেষ আমিই যখন সুইসাইডের এটেম্পট নিলাম, আমার ভেতর সেই কষ্ট পাওয়াগুলো এবং তখন সে অজানা একটা কষ্টের হতাশার একটা ঘোর যখন নিজের উপর কন্ট্রোলটা চলে গেল	*"No actually I cannot control myself, at the end when I myself attempted suicide, all the pain inside that I had and then an unknown painful frustration created a trance, that's when I lost control of myself." [Attempted case]*
29.	একা থাকতে পারত না আমি থাকতাম, ভয় করে খুব ভয় করে। কিন্তু সেই মেয়ে ঐদিন রাতে একা শুলো। তারপরে ওর মাসিরে কাছে জেয়ে সেই তো কারেন্ট নেই, কয় মাসি তোমার মোবাইলে আমার একটা ছবি নেই, এত লকের ছবি তোমার মোবাইলে তো ওর মাসি কয় যে এ কারেন্ট নেই কিছু না, কই যে না ফ্ল্যাশ মেরে উঠবো। ফ্ল্যাশ দিয়ে উঠবো, সেই সন্ধ্যের সময় ওর	*She could not sleep alone; I used to sleep with her. She said, I feel scared. But that girl slept alone that night. She went to her mashi and said there are so many pictures of other people in your mobile but not a single picture of mine. Capture my picture in yor mobile. Mashi said, there is no electricity. She*

	মাসির এই মোবাইলে একটা ছবি উঠায় গেসে।	*said it will be good if you use flashlight. That evening she took a picture in her mashi's phone. [KI, mother of committed case]*
30.	আঘাত পেতাম এবং আঘাতটাকে সহ্য করার জন্য নেশা করতাম। তখনি নেশার থেকে নেশার ঘোরের ভেতরে চলে যেতাম। তখন একটু ভাল থাকতাম। আবার নেশা	*"I got hurt and I took drug to tolerate the pain. Drugs, allowed me to dive into a trance like state. Then I felt slightly well. Then I took drugs again." [Attempted case]*
31.	ওগুলো লিমিটলেস। একটু পর পর দেখা যেত আমার এস্ট্রে ভরে যেত।	*"Those [cigarettes] are limitless. It could be seen that after a short span of time my ashtray used to get filled." [Attempted case]*
32.	আমি একা একা ঘর বন্ধ করে খুব কান্নাকাটি করতাম। যখন কেউ থাকতো না। অনেক সময় মেয়েরা ঐ ঘরে টিভি দেখত আর আমি নামাজ পড়ে অনেক কান্নাকাটি করতাম।	*"I used to lock my room and cry alone when no one was there. Sometimes the girls were there watching TV in the other room and I cried a lot in prayers (namaj)." [Attempted case]*
33.	না আমি কাউকে বুঝতে দেই নাই। মানুষের সাথে যে চলতাম কেউ বুঝতে পারতো না যে আমার ভিতরে এতো কষ্ট। আমি কাউকে বুঝতে দিতাম না।	*"No, I did not let anyone understand. The people I socialized with, no one could understand that there is so much pain in me." [Attempted case]*
34.	না উনি এমনিতেও ঘরে বেশি থাকে না বাইরেই থাকে কিন্তু ঐ টাইমটাতে একটু বেশি থাকতো আরকি।	*"No, in general, she did not stay at home much, she used to stay out of the home, but at that time he used to stay out even more." [KI-daughter of attempted case]*
35.	তার ঐ ছবিগুলোই দেখতাম, একটা স্যাড সং শুনতাম।	*"I used to look at his pictures, listened to a sad songs."[Attempted case]*
36.	তো কান্নাকাটি কইরা আমাকে বলে ঘর থেকে বের হ। তো আমি বলছি কেন ঘর থেকে বের হবো। আমি বের	*After crying a lot she asked me to leave the room. I said why would I leave the room? I*

	হবো না। বলে হ্যাঁ বের হ। কাজ আছে।	*won't. She said, yes leave the room. I have business here. [KI-daughter of attempted case]*
37.	পড়া আল্লাহর কাছে কান্নাকাটি করছি। আমার এমন কষ্ট আইল আমার আর বাঁচতে ইচ্ছা করেনা। নামাজ পইরা আল্লাহকে বলি, আমি নিজের জীবন নিজে দিতে যাচ্ছি তুমি আমাকে ক্ষমা কইরা দিও। আল্লাহর কাছে মোনাজাত ধইরা কান্নাকাটি কইরা নামাজ শেষ কইরা যায় জায়নামাজ ভাজ কইরা রাইখাই আমি কাজটা করছি।	*"After saying prayers (namaj), I asked Allah to please forgive me for taking my own life. I was praying to Allah though Munazat, cried, finished praying (namaj), folded the prayer mat and kept it in its place and right there, did the act [hanged myself]." [Attempted case]*
38.	যত দূর শুনছি ঘটনার আগের দিন খালার বাসায় যান উনি। ঐখানে খালাকে বলে আসছিলো যে এবার যদি কোন একটা সিন ক্রিয়েট ঘটে তাহলে আমি আত্মহত্যা করবো। এই রকম দায় দাবি রাইখেন না। এই রকম কিছু একটা শুনছিলাম আমি।	*"As far as I've heard, she went to khala's (Aunt) house the day before [suicide]. There he told Khala (Aunt) that if anything happen this time she will commit suicide. And asked her to waive all debts and claims in such case. I heard something like that." [KI-daughter of attempted case]*
39.	কস্ট সইতে না পেরে আমি ব্লেড দিয়ে নিজের হাত নিজে কাটছি ৬ মাস আগে।	*"Out of severe mental pain I have cut my wrist with a blade six months earlier." [Attempted case]*
40.	এরপর প্রায় সাত আটদিন আমি খাই নাই, পানি টানিও কিছু খাই নাই।	*"After this I did not eat for seven or eight days, did not even drink water." [Attempted case]*
41.	আর তখন মানে সব কিছুই এলোমেলো তার ঘুমান তার গোসল করা, তারপরে তার রান্না বান্না কিছুই ভাল লাগতো না। এই রকম।	*"At that time, everything was a mess, sleeping, showering, and cooking; she didn't feel like doing anything." [KI-daughter of attempted case]*
42.	আব্বুকে অফিস থেকে ফোন করে নিয়ে আসছে, তো তারপর খাওয়া দাওয়া একদম বন্ধ করে দিসিলাম, আর রুমের ভিতরে থাকতাম, নিজের রুমের দরজা আটকে ভিতরে সারাক্ষণ থাকতাম, বের হতাম না কোন কথাও	*"[after the indicident, my mother] Called my father home from the office. After that I stopped eating, stayed in the room, closed the door and stayed there*

	বলতাম না।	*all the time, did not get out or speak." [Attempted case]*
43.	বাচ্চাদের সাথে খুব খারাপ ব্যাবহার করতাম। মেয়েরা যদি কিছু বলে তাইলে আমি ওদের সাথে চিল্লাচিল্লি রাগারাগি করি।	*I used to behave very rudely with my children. I used to scream and get mad at them when they asked me anything. [Attempted case]*
44.	আমার জন্য তুমি রান্নাবাড়া করো না। হ্যা তারপরে চিংড়ি মাছ রান্না করতেছিল, লবস্টারগুলো লাথি মেরে ফেলে দিলাম কড়াই থেকে, দিয়ে তারপরে ঘরে চলে আসলাম।	*"I said, do not cook for me. Yes - then she was cooking shrimp, I kicked the pan, spilling the lobsters, then came back to the room." [Attempted case]*
45.	আমি মরে গিয়ে তাকে মক্তি দিয়া যাবো। সে প্রায়ই এইরকম কথা বলতো।	*"I will free him [from this burden] by committing suicide. She often spoke like this." [KI-daughter of attempted case]*
46.	এগুলি ভাবছি আমার হাসবেন্ড আজকে তিন মাস সুইসাইড করার তিন মাস আগে থেকে আমার হাসবেন্ড আমাকে টাকা টোকা দেয়া বন্ধ করে দিছে।	*"I'm thinking about these [suicidal ideas], [since] my husband stopped giving me money three months before attempting suicide." [Attempted case]*
47.	আমার বিষয় হচ্ছে মানে আত্মহত্যার চেষ্টা টা মানে এখন থেকে না খুব ছোটকাল থেকেই।	*The matter is, my suicidal attempt is not just for now it started from my early childhood. [Attempted case]*
48.	রোগ লিখেছিল এটা প্রেসক্রিপশনে বোধ হয় আছে নাকি মানসিক রোগ তাই, ব্রেন সিটি স্ক্যান করেছিলাম তাতে কোন সমস্যা হয়নি, এটা মনের রোগ, মানে আসলে তখন বুঝলাম যে এটা মনের রোগ	*"Mental illness was written on the prescription. [Although] We did brain CT scan, they found nothing, it was a psychological illness." [KI-mother of suicide committed case]*
49.	না আমি তো মনে করেন সব সময়ই দুশ্চিন্তার মধ্যে থাকি। সব সময়ই এই দুশ্চিন্তার মধ্যেই থাকি। আমার প্রেসার হাই, মানে টেনশন করলেই প্রেসার বাইরা যায়।	*"No, I mean, I'm always worried. I had anxiety all the time. My BP is high and whenever I become tensed my BP increases." [Attempted case]*

50.	একটু তেই সে রিএক্ত করতো।	*"She used to react without reason." [KI-father of attempted case]*
51.	হ্যাঁ, আমি অনেক যখন রেগে যাই তখন হাতের সামনে কোন কিছু থাকলে আমি ছুড়ে ফেলে দেই,	*"Yes, when I get angry I throw away things that I get at my reach."[Attempted case]*
52.	ও রাগ হইলেই এটা ভাংবে ওটা ভাংবে দরজা ধাক্কাবে বটি দিয়া এইটা কোপাইবে অইটা কোপাইবে এই আর একা থাকে ভয় ও লাগে কি কইরা বসে না না বসে, বটি দিয়া দরজা কোপাইবে, বেশিরবাগ ই দরজারদিকে কোপ দেয়	*"When she gets angry she, break things, chops whatever she gets close by with a chopper. We get scared about her action. Mostly she chopped doors." [KI-mother of attempted case]*
53.	যখন যা মন চায় করে। এই রাগ এই ভালো বুঝা কঠিন হয়ে যায়। চিন্তা কওে কাজ করে নাই কখোনও।	*"She does what she wants. It's difficult to understand her mood. She is angry now and cool immediatelty afterwards. She never did anything with proper thinking." [KI-husband of attempted case]*
54.	নগেটিভ কথাগুলো খুব মানে ঘুরেফিরে ঐ একি কথা মানে আমাকেই ই করে কথাগুলা বলতেসে আমাকেই খোঁচা মারছে সারাক্ষন এগুলা শুনতে শুনতে শুনতে শুনতে আমি মানে ফাস্টেটেড আমার ভাল্লাগত না শুনতে। যে আমিই খারাপ কারন আমি বাইরে জাইতে চাই, ফ্রেন্ডদের সাথে ঘুরতে চাই।এরকম মেয়ে তাদের দরকার নাই। সারা বংশে আমিই নাকি তাদের সম্মান নস্ট করে ফেলতেছি।	*"My parents commented negatively on me again and again. They were purposively pinching me all the time. I feel terribly bad and got frustrated hearing all those negative comments. They meant, I am bad because I want to go out and want to hang out with friends. They do not need daughter like me. I am the one who is ruining their honor in whole family." [Attempetd Case]*
55.	আমার আম্মু আরও বেশি কনজারভেটিভ হয়ে যাচ্ছে, আর বেশি আমাকে আটকাচ্ছে কিন্তু, আম্মু এটা দেখছে না যে ওনাদের মেয়েরা তো ঠিক ই চলতেসে, তুমি আমাকে আরও বেশি কেন গাইড দিচ্ছ? বেশি গাইড তো ভাল না, অতিরিক্ত গাইডে ওতো এই যে আমার দম বন্ধ হয়ে যাওয়ার মত অবস্থা, আমাকে কম পড়ো ততটুকু স্বাধীনতা দাও যতটুকুতে আমি খারাপ না হই	*"My mother was becoming more conservative, and starts imposing more restriction on me. She was not seeing that other girls [those she used as examples] are wondering around, why guiding me so much? Too much guidance is not good, it makes me feel*

		suffocated. Let me excecise minimum freedom which will not spoil me." [Attempted case]
56.	যে ছোটকাল থেকেই কোন আত্মীয় স্বজনের ভালোবাসা পাই নাই বা বাবা মায়ের আদর-টাদর পাইনাই। দুইজনেই দুই দিক দিয়া শুধু টাকা ইনাকেমের , টাকা টাকা। আত্মীয় স্বজন এর কাছ থেকেও কোন ভালোবাসা পাই নাই।	*"I did not get any love from relatives in childhood, not even from my parents. Both of them only tried to earn money, money, money." [Attempted case]*
57.	এতো যন্ত্রণা দিছে কখনো আমারে মূল্যায়নই করেনি। যে তাদের মাঝে যে তারা যে ঝগড়া গুলি করতেছে তারা যে হানাহানি গুলি করতেছে তারা যে সিদ্ধান্ত্ম গুলি আমার উপর চাইপা দিতাছে সব কিছু এগুলার জন্য যে আমার মনের উপরে আমার শারীরিক জীবনে আমার পারিবারিক জীবনে যে কতোটুকু অত্যাচার কতটুকু কষ্টে ভুগতেছি এই গুলা কখনো এরা মূল্যায়ন করেনি। বাবা মা দুইজনেই না। দুইজনে মূল্যায়ন করেনি।	*"They have hurt me so much; they never thought of me at all. They never bothered how their quarrels, fights and imposition of decisions on me was hurting me, and was affecting my physical health, my family life." [Attempted case]*
58.	তো পরে দেখি আরও, কথা শুনেছে না। উলটাপালটা কাজ করতেছে তো হটাত করে আমার খুব রাগ উঠে গেছে। পরে আমি আসলে গায় হাত তুলছিলাম। চড় থাপ্পর মারছি। কিছুক্ষণ কোন কথা কয়নি, নীরব ছিল।তারপর অন্য রূমে চলে গেছে/। মাঝখানের রূমে বসা ছিল। তারপর বাথরূমে ঢুকে। পিঁপড়ার ওষুধ যে ঘরে আছিল আমি জানতাম না।	*"So later I see she wasn't listening to me at all. She was doing pointless stupid things, so suddenly I got very angry. Actually, I hit her. I slapped her a few times. For a while, she didn't say anything, stayed quiet. Then she went to another room. She had been sitting in the middle room, and then went to the bathroom. I didn't know that there was pesticide in the room." [KI-husband of attempted case]*
59.	সে তার জীবন নিয়া আছে। আরেক মেয়ের জন্য সকল কিছু করতেছে। এটা সেটা সব টাকা পয়সা শেষ। আমার ঘরে নুন পানি চলে না। মেয়েদের স্কুলে যাওয়া	*"He [husband] is busy with his own life. He is doing everything for another girl [lover].He provide everything to that*

	বন্ধ। সব দিক দিয়া যদি এরকম হয় তাইলে একটা মানুষ কেমনে বেঁচে থাকে?	*girl that's why he left no money now. I can not even provide meals for my family. My daughters can not continue school [beacuase of money]. If a person does not have any support how could she live?" [Attempted Case]*
60.	চিন্ত্মা করলাম কি যাহ টাকা পয়সা কি আমি যদি আরও লক্ষ টাকা পয়সা ইনকাম করি এই সমিতি করে আমার তো মূল্যায়ন নাই। কারো কাছে আমি সমাজে পরিচয় দিতে পারি না যে আমি ইনকাম করতেছি এইভাবে এইভাবে। মেয়ে মানুষ আমার শিক্ষার যোগ্যতা নাই কোন কিছু নাই। আমি কি পরিচয় দিবো সমাজে।	*". . . . even if I earn milions by doing this somity (illegal money lending), I will have no recognition. I cannot declare to society that I am earning money this way. A woman without educational qualification, without anything, how will I place myself in the society." [Attempted case]*
61.	বা কোন একটা স্বামী একটা স্বাভাবিক মেয়ে যে রকম একটা আনন্দ পায় কখনোই পাইনাই। আর এখন তো মনে করেন এগুলি সব কিছুই ত্যাগ দিয়ে আসছি। আসার পর সে যদি এখনো মনে করে যে সে আমারে ছাইরা পারলে দেখো একটা , আমি ভালো না।	*"I never enjoyed the happiness that a normal girl gets from husband. And I have left everything. Now, after [so many years] if he can think "leave me and seek for another husband, I'm not good [for you]" [Attempted case]*
62.	ওর আর সহ্য হয়না। সহ্য হয়না বলতে বাসার সবার সাথে ম্যাচিং করতে পারেনাই। আমার সাথে প্রথম দিকে ম্যাচিং হয়নাই। তখন পরিবারের সবাইকে ভালো জানতো। শেষের দিকে সে আমাকে ভালো জানছে মোটামুটি তখন আমার ফেমিলির সবাই খারাপ। ম্যাচিং করতে পাওে নাই এইটা স্বাভাবিক।	*"She could not bear it any more. She could not adjust with others in the family. At the beginning, had troubled adjustment with me while had a positive interaction in the family. Near the end, she achieved positive interaction with me and had a ruined impression about everyone else in the family." [KI-husband of attempted case]*
63.	একদিন ভর বেলা আমরা সবাই মিলা নাস্ত্মা খাইছি। তো পানির মধ্যে ময়লা। ময়লা বলছে আমি চেঞ্জ কইরা দিছি। দেয়ার পরেও কয় এহনো ময়লা। এই কথা কইয়াই পানির উপরে আমার মুখ জাইতা ধরছে।	*"One day at morning we were having breakfast. [He] Found dirt in the water and I change the water. He blamed that it is still dirty and pressed face over the water. Hit*

	মাথায় আঘাত করতেছে।	*me on the head." [Attempted case]*
64.	এ জন্য ওরে একবার গাড়ি কিনে দিছিলাম আমি। ছয় লক্ষ টাকা দিয়ে। পড়ে ঐ লেগুনা গাড়ি গুলি। ঐ গাড়ি দিয়াও এক বছরের ভিতরে লস করে আমারে মাত্র আড়াই লাখ টাকা বিক্রি কইরা আইনা দিছে। ছয় লাখ টাকার গাড়িটা।	*"This is why once I bought him a vehicle. With six lac Taka. Those leguna vehicles. After incurring loss within a year with that vehicle, he just got me two lac fifty thousand Taka after selling it. The six lac taka vehicle." [Attempted case]*
65.	তখন ও বলতো তুই মর না তুই বিয়ে কর না তুই লাং নিয়া জাইজ্ঞা মার দেহার বিষয় না।	*Then he said you die, you marry, you go away with the lang [another guy] it's not my business. [Attempted case]*
66.	আমি বলতেসি কি শোন মা, তোর যদি এরম ধরনের টেনশন আসে, তুই আমারে বলবি আমি শেয়ার করবি তুই আমার সাথে, দুইজনে সমাধান করব, তারপরে ডাক্তারের কাছে যাব	*"I told her, listen maa; if you feel such kind [suicidal feeling] of tension, tell me, share with me. Together we will solve it, we will go to doctor." [KI-mother of committed case]*