ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

PERCEIVED PRECIPITANTS AND PSYCHOLOGICAL EXPERIENCES OF PERSONS WHO HAVE ATTEMPTED SUICIDE

(ANALYSIS OF SUICIDE ATTEMPT CASES TREATED AT THE AMANUEL MENTAL SPECIALIZED HOSPITAL OF ADDIS ABABA)

BY

HEWAN MULUGETA

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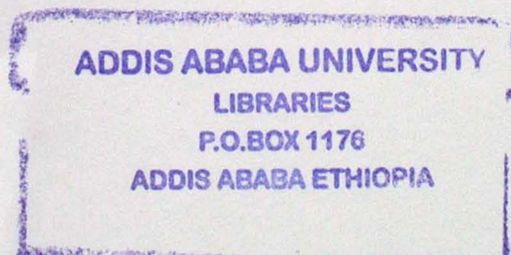

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(ANALYSIS OF SUICIDE ATTEMPT CASES TREATED AT THE AMANUEL MENTAL SPECIALIZED HOSPITAL OF ADDIS ABABA)

HEWAN MULUGETA

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of Master of Arts in Counseling Psychology

JUNE, 2009

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ADDIS ABABA UNIVERSITY

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By: Hewan Mulugeta

Approved by Board of Examiners

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LIST OF ABBREVIATIONS AND ACRONYMS

AGP: Annals of General Psychiatry

CBT: Cognitive Behavioral Therapy

ECT: Electro Compulsive Therapy

FGD: Focus Group Discussion

MDD: Major Depressive Disorder

ABSTRACT

The main purpose of this study was to find out perceived precipitants and psychological experiences of suicide attempters and the treatment available to them at the Amanuel Mental Specialized Hospital of Addis Ababa. Five people who had attempted suicide (3 male, 2 female), their parents or care givers as well as two Psychiatrists who had direct involvement with the suicide attempters were conveniently selected from in-patients of Amanuel Mental Specialized hospital as participants of this study. Data for the study was collected through interview and from patients' medical files.

Qualitative case study research was used to analyze the data gathered. Results of the study showed that psychiatric illness was the main cause for the suicide attempts made by the participants. Psychiatric illnesses as depression, schizophrenia, psychosis and some others as mild retardation and epilepsy were the diagnosed causes of suicide attempts. Some factors to whom the causes were attributed in the suicide attempters were stressful life events, being dependent or unemployed and hereditary factors. Hopelessness, worthlessness, suspiciousness, sadness and anger were the psychological experiences encountered by the suicide attempters which were directly related to the diagnosed psychiatric illnesses in some of the participants.

As to available services at the Amanuel Mental Specialized Hospital, psychotherapy and medical treatments were attended by all suicide attempters. Antidepressants, Antipsychotics and ECT (Electro Compulsive Treatment) were types of medication which were made available for the suicide attempters. Individual, group and family therapy were also given for the suicide attempters.

It was recommended that curing the already inflicted psychological problems and trying to address the precipitants of suicide to be important intervention strategies to prevent further suicide cases.

1. INTRODUCTION

1.1. Background of the Study

Belonging to one of the poorest third world African countries, Ethiopia has many challenges that contribute to its low economic, health, social and political development. Suicide is one of the serious health as well as social issue which need attention since it is affecting productive man power. As World Health Organization explained, suicide is among the top three causes of death in the population aged 15-34 years, where there is a massive loss of societies of young people in their productive years of life (WHO, 2008).

The World Health Organization estimated that 877,000 deaths were due to suicide attempt in the year 2002, the majority of which (85%) occurr in low- and middle- income countries. WHO also maintained that attempted suicide can be up to 40 times more frequent than completed suicide. Moreover, self afflicted injuries represented 1.4% of the global burden of diseases in 2002 and was expected to increase to 2.4% by 2020.

Globally, approximately one million people kill themselves every year. The World Health Organization (WHO) has declared suicide a major global public health problem and called on member states to devise and implement national suicide prevention strategies. Suicides in the world occur in low and middle income countries, though data are unavailable for 73% of these countries. Overall there are no data on suicide for more than half of the world's countries, most of which are developing countries in Asia, Africa and South America. Although data from African countries are lacking, there are isolated reports which indicate that suicidal behaviour occurs in these countries as well. Studies have been published from Tanzania, Nigeria, Zimbabwe, Uganda, Egypt, and Ethiopia. One of the emerging causes of suicidal behaviour in African countries is HIV/AIDS, which needs to be recognized and managed effectively (Khan, 2005).

Khan (2005) also added that many literature on the area of suicide listed reasons for why people attempt suicide. Suicide reports from developing countries frequently highlight interpersonal relationship problems, domestic disputes and financial problems as the underlying causes of most suicides. Mental illness is rarely mentioned or is implicated in only a small number of suicides.

Suicide related literature exhaustively discussed the causes and process of suicide but few has said about its consequences. Overholser (2003) maintained that although a great deal of research has been conducted on suicidal behaviour, less is known about the consequences of suicide attempts. Adolescent suicide attempters are at heightened risk for continued psychological and behavioural dysfunction, repeated suicide attempts, and completed suicide. In fact, approximately 30% of adolescents who commit suicide have a history of prior attempt. Therefore, it is important to understand the post-attempt course in adolescents in order to give treatment and secondary prevention effort.

1.2. Statement of the Problem

In developing countries like Ethiopia, where priorities are given for reduction of population growth and poverty, the issue of suicide is almost forgotten or given very little attention even if the problem still exists. As WHO (2005) put it, although data from African countries are lacking, there are isolated reports which indicate that suicidal behaviour occurs in African countries.

The development of mental health in Ethiopia it is not different from most African countries. Kebede, Alem and Jacobson (1999) maintained on their research that, in Ethiopia the priority of status of mental health in the National Health policy has not been yet into either strategies or actions to control illness. One important reason is the lack of data on the extent of mental disorders in the general population.

Since little is known about suicide, people who suffer the consequences of suicide attempt are left without help. A study on suicide attempt and ideation among adults in Addis Ababa, by Kebede and Alem (1999) showed the prevalence of current suicidal ideation to be 2.7%, lifetime prevalence of suicidal attempt to be 0.9% and most of the attempts (66%) occurring when participants were under 25 years of age. Hence the issue of suicide attempt in Ethiopia especially its consequences should be studied well in order to create an awareness on the problem and suggest intervention strategies.

In order to setup psychosocial interventions and reduce the risk of suicide, a thorough understanding about its cause, the psychological experiences that suicide attempters encounter and kinds of treatments and social interventions being provided as well as suggested solutions are crucial. However, despite higher prevalence of suicide and suicide attempt in developing countries and the world at large, very few attempts have been made to study on the issue of suicide (WHO, 2008).

Studying this loosely treated issue will catch the attention of the society who are directly or indirectly touched by the problem and initiates the health sectors to reconsider and revise the little attention given for mental health particularly for suicide and suicide attempts. With these convictions, the study dealt with the following research questions.

1.2.1. Research Questions

In order to systematically examine issues related to suicide, the researcher formulated the following research questions:

1. What are the major factors that motivate the attempters to attempt suicide?
2. What are the psychological experiences of the people who have attempted suicide?
3. What kinds of treatments are made available by the Amanuel Mental Specialized Hospital for suicidal patients?

4. What social interventions need to be employed to reduce suicide attempts?

1.3. The Objectives of the Study

The general purpose of this study was to explore into the perceived precipitants and the psychological experiences of people who have attempted suicide. Specifically, the objectives of this study were:

1. To explore into major factors that led the attempters to attempt suicide.
2. To explore into the major psychological experiences of the people who have attempted suicide.
3. To find out possible intervention strategies for suicide attempts.
4. To provide research based information for other researchers.

1.4. The Significance of the Study

This study is believed to have significance in raising and dealing with the issue of suicide attempt. Investigating the causes and the psychological experiences of suicide attempters can provide important baseline information for drawing future prevention and intervention strategies. Especially for research undertakings in developing countries where suicide is not a priority issue, this study might contribute a lot. As Henden (2008) put it, there is a need for more and better information on suicidal behaviour in developing countries. Data collection at district, provincial and national levels needs to be developed. Hence, this study is hoped to have the following significances:

1. The findings of the study might help in creating awareness on the issue of suicide to parents, care givers and/or guardians of suicide attempters, schools, the media and the society at large.
2. The findings of the study are also hoped to provide information and possible intervention strategies for governmental and non-governmental organizations, especially those that are directly

concerned with the health sector of the country to establish regional centres for suicide monitoring and surveillance.

3. The people who have attempted suicide can also be beneficiaries from this study in getting proper treatment and attention from health professionals and parents and/or care givers.
4. The study might instigate governmental and non-governmental health sectors to give special attention and consideration to the service they are giving to their suicidal patients.
5. The study might also serve as a stepping stone for researchers who endeavour to study suicide related issues.

1.5. Delimitation of the Study

The setting of the study was delimited to the Amanuel Mental Specialized Hospital of Addis Ababa. The setting was selected by the researcher since it was the most appropriate place to locate people who have attempted suicide with limited resources (time and money).

1.6. Limitations of the Study

The study has some limitations that might affect generalizations made on the basis of the findings of the study.

- The study dealt with only five cases of people who have attempted suicide and are admitted to Amanuel Hospital between April 16 and May 10, 2009. Hence the number of cases treated by the study might pose some limitations.
- Since the research was conducted in a very limited time interval, unequal number of gender (2 female and 3 male) in participants was expected and faced. This unequal representation of the male and female gender might also pose a limitation for the findings.
- The fact that the study was conducted on people who have attempted suicide and who were attending treatment in a mental hospital setting might also prove to be one major limitation. Had a population based study was conducted the findings might have been different.

1.7. *Definition of Terms*

Suicide: the act of ending one's own life deliberately.

Suicide attempt: thinking and trying to end one's own life.

Suicide attempters: Persons who tried to kill themselves and admitted at the Amanuel Mental Specialized Hospital.

Suicidal behavior: thoughts, feelings, and actions of individuals related to attempting suicide.

Suicidality: suicidal behavior which include both suicidal thought as well as action.

Perceived precipitants: causes/motives for the suicide attempts of attempters as reported by themselves and their important others.

Psychological experiences: emotions and feelings related to suicide attempters, as reported by themselves and their important others.

Important others: Individuals who have close and significant ties and relationships with the suicide attempters as parents, siblings, guardians, friends etc

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2. REVIEW OF RELATED LITERATUR

2.1. History of Suicide

It appears that suicide has occurred at least as long as human beings have kept written accounts of their history. Historical writing from literate early civilization provides some records of the incidence of suicide and of attitudes toward it. Many of this writings are religious in nature and are more concerned with the ethics of suicide than with accurately portraying its incidence and social ecology (De Cantazaro, 1981).

Suicide appears to have been quite common in Greek and Roman civilizations. It was mentioned with some admiration in ancient regards and in Homer, opposed by Pythagoras and other early philosophers, and actively encouraged by the cynics, the stoics, and the Epicureans. Honor suicides (to avoid capture, slavery, and murder) appear to have been frequent among the Greeks, the Romans, and their neighbors. Hippocrates notes that young maidens were afflicted with menstrual problems and accompanying mental disorders were commonly suicidal. Suicide by widow following her husband's death was also unknown. Among the Jews, suicide was apparently rare, which may be consistent with the current low rates of suicide in Israel. Among the early Christians suicide may have been common, especially in consequence of severe persecution, and it may have been viewed quite favorably martyrdom. Suicide was frequently discussed in religious writings from India. The Brahmins, for example, viewed suicide quite favorably, suggesting that it provided a passport to heaven (Giddens, 1971).

In china, suicide after defeat in battle, after death of a husband, in insolvency, or in dishonor was viewed favorably. In Japan, suicide may have been fairly widespread. In the teaching of Islam, suicide has been condemned with consistency and severity, being viewed as unacceptable in any circumstance (Curran, 1987). Therefore, the issue of suicide has been known since long ago in the history of mankind.

2.2. Definition of Suicide and Suicide Attempt

Durkheim (1897) defines suicide as, "the termination of an individual's life, resulting directly from a negative or positive act of the victim himself, which he knows will produce this fatal result".

Carr (2002) has also defined suicide as, "the intentional act of self destruction committed by someone knowing what he/she is doing and knowing the probable consequences of his/her actions."

2.3. Understanding Suicide Attempt

When we talk about suicide there are numerous terms which are very closely related to suicide and create confusion. Some of these terms are self harm, suicide attempts, suicide ideation, suicide intention etc. Mclaughlin (2007) maintains that there are numerous terms that are used to explain what suicide related behavior is. However, just because a practitioner can put a name to a particular behavior, does not mean that can understand it. From the outset, it is important to acknowledge that most, if not all, terms used were meant well and make points that are well taken and seem justifiable when originally proposed. In suicide related behavior, the terminology used by practitioners tries to focus on the person's behavior (self injury, self poisoning, parasuicide) or on the practitioner's understanding of the person's intention (gestured suicide, attention seeking) sometimes the terms used are open to misinterpretation by other professionals.

When Mclaughlin (2007) explained about attempted suicide, the most significant part of the definition of attempted suicide is that the person was prepared to die or intended at some level, to die. For instance, it could be concluded that for those who attempt suicide, some will have had a very high intention of killing themselves. In fact some authors suggest that the intention to kill oneself is low in some cases of suicide-related behavior. Hence, careful look at the definition of terms related to suicidal behavior is needed.

2.4. Prevalence of Suicide and Suicide Attempt

Literatures have been showing that prevalence of suicide and suicide attempt is increasing from time to time. Global suicide rates have shown a steady increase over the last 50 years and are projected to increase to 1.53 million by the year 2020. This is despite significant advancements in recognition and treatment of depression and other mental disorders, the introduction of more effective and safer Psychotropics (including anti-depressants) and improvement in mental health services in many countries. In countries like Finland and England suicide prevention programmes have successfully lowered suicide rates. Why then have global suicide rates continued to rise? Part of the answer may lie in the fact that while there have been gains in suicide prevention in developed countries it has been offset by huge increase in many developing countries. Incidences of suicide are usually reported as rates per 100,000. Thus countries with rates of more than 30/100, 00 (e.g., Lri Lanka, Lithunia, Lativia) are considered high rate countries, those with rates between 10-29/100,000 (e.g. China, Slovenia, Japan) as middle rates countries and those with rates has than 10/100,000 (e.g. Egypt Jordan) as low rates countries (WHO, 2005).

Curran (1987) explained while committed suicide among adolescents increases at a disturbing rate, attempted suicide has become a phenomenon of truly epidemic proportions. Data on attempted suicide is pontifically elusive and difficult to quantify with certainty. However, it is clear that teenager in particular, and young persons in general, are greatly overrepresented in national and worldwide figures on rates for attempted suicide. (Fleischmann et al, 2008) attribute 50 percent of all attempted suicide to those under the age of 30 and points out that the modal age is dropping. Attempted suicide is far and away the most common and characteristic form of suicidal behavior among the middle aged and elderly is relatively rare. In other words, the ratio to attempted suicide reverses itself with increasing age.

Stone (2007) also added that the figures for adolescent suicide and attempted suicides are impressive and rising. However, the bad news is that they are unanimously judged to be grossly underestimated. The actual rates of committed and attempted suicide one unknown and in the case of young persons, especially difficult to ascertain.

According to official statistics, about a million people die by suicide annually, more than those murdered or killed in war. According to 2005 data, suicides in the US out number homicides by nearly 2 to 1 and ranks as the 11th leading cause of death in the country, a head of liver disease and Parkinson's diseases. According to a 2008 report from the Johns Hopkins Bloomberg School of Public Health's, center for Injury Research and Policy, the rate of suicide in the United States is increasing for the first time in a decade. Worldwide suicide rates have increased by 60% in the past 50 years, mainly in developing countries. According to the World Health Organization, china, India and Japan may account for 40% of all world suicides (Wikipedia, 2008).

Salomon (2007) maintained, suicide is the third leading cause of death in young people between 13 and 20 and is the 11th leading cause of death for people of all ages.

Even if suicide is not big issue for discussion in the society and on the media like HIV/AIDS, it still exists being one of the causes for death in Ethiopia. Based on the study of suicide attempt and ideation in a perspective sample of 10,203 adults in Addis Ababa in 1994 Kebede and Alem (1999) explained, the prevalence of suicidal ideation was 2.7%. Lifetime prevalence of suicidal attempt was 0.9%. Most of the attempts (66%) occurred when subjects were under 25 years of age. Hanging was the preferred method for men and poisonings for women. There were no significant associations between suicide attempt and sex, ethnicity or religion. Current suicidal ideation was more common in men than women, odds ratio (95% confidence interval), OR (95% CI): 0.67 (0.48, 0.93). There was a statistically significant trend of decreasing risk of ideation with increasing age and educational attainment.

There was a 68% decrease in the risk of ideation in the 60 years of age and above group compared to the 15–24 year group: OR (95% CI): 0.32 (0.16, 0.62). Marital status, ethnicity, and religion were not associated with suicidal ideation. As studies in Ethiopia and other countries showed, prevalence of suicide and suicide attempt is increasing despite lack of clear statistics that show the exact number.

2.5. The Cause for Suicide and Suicide Attempt

People die every minute, every hour and day due to many reasons. It might be by accident, disease or just being old aged and suicide is also one of the causes for death. Simon (2006) maintains that suicide is the third leading cause of death in young people between 13 and 20 and the 11th leading cause of death for people of the all age. But the question is "Why people commit or attempt suicide"? Researchers tried to answer this question in many ways.

Spirito and Overholser (2003) explained Suicidal acts are usually triggered by a recent disruption in the person's daily functioning. In our 1989 review article, family problems were the most common precipitants, followed by difficulty with peers and then school problems. In Britain, the stressors most commonly encountered involved difficulties in current relationships with family members, friends, and boyfriends/girlfriends, with the younger adolescents reporting more family/parent problems and fewer peer or boyfriend/girlfriend problems. Arguments with parents often precede adolescent suicide attempts and completed suicide. However, it must be kept in mind that conflict with parents is also common among high school students who do not attempt suicide. The precipitants to adolescent suicide attempts are typically everyday stressors, particularly interpersonal conflict.

The main causes or risk factors for suicide and suicide attempt by many research articles and books are the following:

2.5.1. Mental Illness

Data regarding mental illnesses as risk factors indicate that depression, manic depression, schizophrenia, substance abuse, eating disorders, and severe anxiety increase the probability of suicide attempts and completions. Nine out of 10 people who commit suicide have a diagnosable mental illness and up to three out of four individuals who take their own life had a physical illness when they committed suicide. Behaviors that tend to be linked with suicide attempts and completions include violence against others and self-mutilation, like slitting one's wrists or other body parts, or burning oneself. Generally, the absence of mental illness, including substance abuse, as well as the presence of a strong social support system, decreases the likelihood that a person will kill him- or herself (Salomon, 2007).

2.5.1.1. Schizophrenia

One of the known mental illnesses that cause suicide is schizophrenia. As Marder (2001) explained patients with schizophrenia frequently suffer from more than one psychiatric disorder. More than half will experience some form of depression during their lifetime. This combination is often associated with impaired social adjustment, treatment non-compliance, multiple hospitalizations and relapse for psychosis. The rate of suicide among individuals with schizophrenia is about 10 percent, highlighting the importance of recognizing and treating depression associated with schizophrenia.

Fenton (2000) maintained this arguing that as many as half of all patients with schizophrenia experience suicidal ideation and/or make suicide attempts. Compared to other patient groups, suicide attempts in schizophrenia appear to be 1) of greater violence and lethality, and 2) more likely to be unexpected or "out of the blue". (Kosky et al, 2002) also added that schizophrenia occurs in 1 per cent of the population. Suicide is the major cause of premature death in persons with schizophrenia with 10 per cent of persons diagnosed with schizophrenia committing suicide. Among patients with schizophrenia who die by suicide, males outweigh females by a

ratio of 4: 1, with males usually committing suicide before 30 years of age and females before 40 years of age. The profile of those who suicide are usually young, single, unemployed, males in the first 10 years of onset of a severe chronic form of the illness. Fifty percent of suicide patients with schizophrenia have made previous suicide attempts.

2.5.1.2. Epilepsy

Studies have shown that epilepsy is one of causes for suicide. Meador (2008) showed on their studies that, Patients with epilepsy are known to have co morbid affective disorders and a higher risk for suicide compared with the general population. Individuals with epilepsy have a higher risk of suicide, even if coexisting psychiatric disease, demographic differences, and socioeconomic factors are taken into account.

Family issues also play a central role in many adolescent suicide attempts. Prolonged and progressive family disruptions, inadequate family relationship, and ineffective parent-child relationships may result in adolescent suicidal behavior. Multigenerational familial difficulties, such as isolation, abandonment, long-lasting feuds, emotional cutoffs, violence, and abuse, may also result in an adolescent's suicidal behavior. Family influences on the suicidal behavior of adolescents have therefore been investigated from multiple conceptual bases including familial psychopathology, such as a family history of suicidal behavior, family composition, family histories of abuse, and family conflict. Adaptive factors including perceived support, communication, and problem solving have also been studied (Berman et al, 2006).

2.5.1.3. Anxiety and Depression

Spirito and Overholser (2003) state that anxiety disorders can lead to symptoms of depression, and vice versa. The isolation from having anxiety can cause more stress, and this can bring on symptoms of depression. Depression and anxiety together create a higher risk for suicide than either

of them alone. Duffy and Ryan (2005) further explained that better than 80% of persons who commit suicide are depressed at the time of their attempt and an early review of follow-up studies by Guze and Robins (1970) suggested that the lifetime incidence of suicide among clinically depressed persons is 15%. A more recent study indicated that fully 30% of patients with a major affective disorder die by suicide. Not surprisingly, treatments found to be effective for treating depressive disorders, such as cognitive therapy, are often used with suicidal patients.

Depression leads people to focus mostly on failures and disappointments, to emphasize the negative side of their situations, and to downplay their own capabilities or worth. Someone with severe depression is unable to see the possibility of a good outcome and may believe they will never be happy or things will never go right for them again. Depression affects a person's thoughts in such a way that the person doesn't see when a problem can be overcome. It's as if the depression puts a filter on the person's thinking that distorts things. That's why depressed people don't realize that suicide is a permanent solution to a temporary problem in the same way that other people do (Nock, 2008).

2.5.2. Suicidal Ideation

Suicidal ideation is an important precursor to attempted suicide. However, only a small proportion of adolescents who think about suicide actually go on to attempt it. Adolescents who have attempted suicide report more frequent thoughts about both death and suicide than do their non suicidal peers. One study documented that 90% of a community sample of adolescents that reported a suicide attempt also reported suicidal ideation. As the severity of suicidal ideation increases, the adolescent becomes more likely to make a suicide attempt. Of the small group of students in the Dubow *et al.* study who reported extremely troubling suicidal ideation, 49% had made a suicide attempt (Stone, 2002) .Suicidal ideation can include thoughts about reasons for dying, specific plans to make an attempt,

consideration of the availability of the intended method, and attitudes toward accepting the suicidal thoughts.

2.5.3. Substance Abuse

Yufit and Lester (2005) stated that high rates of suicidal ideation and prior suicide attempts have been reported by adolescents who were receiving treatment for substance use or abuse. In one study of 298 adolescent patients (ages 13 to 19) who abused drugs (predominantly marijuana, hashish, and alcohol), 67% of the patients reported suicidal ideation, and 30% admitted to at least one prior suicide attempt.

Similarly, Nock (2008) maintained that teens with alcohol and drug problems are also more at risk for suicidal thinking and behavior. Alcohol and some drugs have depressive effects on the brain. Misuse of these substances can bring on serious depression. That's especially true for some teens that already have a tendency to depression because of their biology, family history, or other life stressors. The problem can be made worse because many people who are depressed turn to alcohol or drugs as an escape. But they may not realize that the depressive effects alcohol and drugs have on the brain can actually intensify depression in the long run. In addition to their depressive effects, alcohol and drugs alter a person's judgment. They interfere with the ability to assess risk, make good choices, and think of solutions to problems. Many suicide attempts occur when a person is under the influence of alcohol or drugs. This doesn't mean that everyone who is depressed or who has an alcohol or drug problem will try to kill themselves, of course. But these conditions especially both together increase a person's risk for suicide.

2.5.4. Hopelessness

Based on the observations of previous researches, Wilson (2009) commented that in her investigations of the characteristics associated with adolescent suicide attempts that, many researchers have focused on hopelessness. Hopelessness has been defined as a lowered expectation of obtaining certain

goals and a diminished belief in the likelihood of finding success. The study of hopelessness and suicidality exists both in conjunction with, and separate from, the study of depression and suicidality. Approximately 14 published studies in the past decade have examined the relation between hopelessness and adolescent suicide attempts. Like the studies of depression, these samples span a variety of settings, such as emergency departments (ED), pediatric medical units, psychiatric inpatient programs, and residential treatment facilities. Data support widespread clinical observations that adolescents who attempt suicide are characterized by hopelessness. When the relation between hopelessness and suicidal behavior is evaluated in isolation, a far more complex picture emerges when hopelessness is investigated in the context of other variables.

When Yufit and Lester (2005), explained about the importance of treating hopelessness, they said, "When working with suicidal patients, treat hopelessness first" has become something of a truism in the practice of cognitive therapy. Abundant research indicates that feelings of pessimism that accompany depression often contribute to suicidal ideations and motivate suicidal behavior. Suicidality can stem from the individual's belief that his or her problems are so excruciatingly painful that only death can provide relief. Suicidal individuals tend to view their difficulties as both unendurable and unsolvable. Given this predicament, suicide comes to be seen as a viable option. There is substantial evidence that suicidal individuals tend, as a group, to view their difficulties as insurmountable and feel hopeless in the face of these problems (Beck, Brown, Berchick, Stewart, & Steer, 210 Intervention and Treatment of Suicidality 1990; Beck, Brown, & Steer, 1989).

Studies with clinically depressed adults suggest that hopelessness may, in fact, mediate observed relations between depression and suicide. When levels of hopelessness are controlled, associations between severity of depression and suicide typically are reduced to no significance. Hopelessness has been found to be a more powerful predictor of suicidal

intent than severity of depression among suicidal ideators (Nekanda-Trepka, Bishop, & Blackburn, 1983). Moreover, the level of pessimism appears to discriminate suicidal from non suicidal patients with equivalent levels of depression (Ellis & Ratliff, 1986). Hopelessness has been found to predict completed suicide among individuals diagnosed with major affective disorders (Fawcett et al., 1987), schizophrenia (Drake & Cotton, 1986), and alcohol abuse (Beck, Weissman, & Kovacs, 1976). Finally, longitudinal studies suggest that hopelessness may be a useful long-term predictor of completed suicide (Beck, Brown, & Steer, 1989; Beck, Steer, Kovacs, & Garrison, 1985; Fawcett et al., 1990). In a prospective study of 1,958 outpatients, for example, hopelessness was found to be strongly associated with eventual suicide.

In addition to the above mentioned points there are also many other factors that can cause suicide. As Salomon (2007) hidden historical risk factors, the things we don't often think about, can also contribute to a person's chances of becoming suicidal. A history of physical or sexual abuse during childhood has been associated with greater risk. A history of someone in the family, who had attempted suicide, even very long ago, remains a strong factor. It should not be surprising that certain historical factors, such as a person's prior attempts, remain risk factor even decades later. Having serious head injury or neurological disease can also raise risks.

The American Journal of Psychiatry, (2007) listed the following as risk factors for suicide.

- One or more diagnosable mental (e.g., major depression) or substance abuse disorders
- Impulsivity
- Adverse life events
- Family history of mental or substance abuse disorder
- Family history of suicide
- Family violence, including physical or sexual abuse

- Prior suicide attempt
- Firearm in the home
- Incarceration
- Exposure to the suicidal behaviour of others, including family, peers, or in the news or fiction stories
- The strongest risk factors for attempted suicide in adults are depression, alcohol abuse, cocaine use, and separation or divorce.
- The strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviours.

As argued by many literatures and studies, psychiatric disorder or mental illness is the main cause for suicide and suicide attempt. Life stressors like family dysfunctions, substance abuse, previous suicide attempt and family history of suicide and suicide attempts are also risk factors.

2.6. *Psychosocial Impacts of Suicide Attempt*

People experience different psychosocial problems after attempting suicide. Even if a lot has been said about the nature and causes of suicide, enough attention has not been given for the consequences of suicide attempt. It is very essential to study the effect of suicide in order to develop appropriate prevention and intervention strategies. Lukas and Seiden (2007) maintained this by saying that although a great deal of research has been conducted on suicidal behavior, less is known about the consequences of suicide attempts. Adolescent suicide attempters are at heightened risk for continued psychological and behavioral dysfunction, repeat suicide attempts, and completed suicide. In fact, approximately 30% of adolescents who commit suicide have a history of a prior attempt. Therefore, it is important to understand the post-attempt course in adolescents in order to guide treatment and secondary prevention efforts.

Giddens (1971) explained the social effects of suicide attempt based on the research made in London on 138 patients who were admitted to a mental observation ward, ninety-seven cases resulted in temporary hospitalization and treatment. In twenty –one cases hospitalization was permanent, while in twelve cases admission was followed by death not attributable to self injury within two to three months. In eight cases the suicidal attempt had achieved a temporary removal from the scene of conflict. These were patients who were discharged from the observation ward within two weeks. It was also showed that the proportion of cases in which the suicidal attempt had failed to prevent separation, lose or break, and greater dependence.

AS cited in the studies of Lester and Lester (1971), Pillay and Wassenaa studied 40 adolescent suicide attempters. Those who had received no treatment by the time of the 6-month follow-up showed no spontaneous remission in the hopelessness they demonstrated at baseline. However, patients who received treatment improved significantly with respect to hopelessness. Specific markers of adjustment have also been examined, including school functioning, social relationships, family functioning, behavior, and psychopathology. Regarding school functioning, Spirito and colleagues (1992) found that only 67.9% of suicide attempters seen in a general hospital and 72.8% of suicide attempters seen in a psychiatric hospital sample were attending school regularly when contacted at 3-month follow-up. Poor family functioning is a correlate of adolescent suicide attempts, and, in fact, family difficulties persist at follow-up for many of these adolescents.

De Leo and Diekestra (2002) added that anger is a common mood state among adolescents who attempt suicide. Aggressive behavior often accompanies this angry affect. A few studies have reported on aggressive behavior, rather than relying only on the self-report of anger, in clinical samples of adolescent suicide attempters. Aggressive behavior has been found to be strongly related to suicide attempts among female psychiatric

patients and associated with conduct disorder diagnoses among both male and female adolescents.

2.7. Treatment of Suicide Attempt

Suicidal patients need treatments to control further self injury and intervention should also be a primary concern to prevent suicide. De Leo, and Diekstra (2002), also argued that suicide prevention is still sadly neglected today by governments and public health authorities, despite the fact that in several Western countries the phenomenon has become the first cause of death among the younger age groups, with a higher mortality rate than for road accidents. The World Bank and the World Health Organization deem that suicide causes at least 800,000 deaths per year throughout the globe and that the number of attempted suicides is probably ten times higher. It follows that the people involved each year in suicidal behaviour are several million in number, often leaving a long-term legacy of emotional, social and economic distress.

2.7.1. Medication

2.7.1.1. Anti depressants and ECT

Anti depressants and anti psychotics are the two common medications given for suicidal patients. As explained in Nardezzii et al (2008), prescribed medications should be those that are necessary to treat the associated disorder. The choice of antidepressant is based on its scientific support, the unique manifestation of symptoms, and the patient's past response to treatment (when known). For the treatment of suicidal patients, anti depressants and anti psychotics are effective in reducing positive and negative symptoms. ECT (Electro Compulsive Therapy) also remains a viable option for the seriously depressed suicidal patient. Antidepressant drugs do not work quickly. Thus, ECT should be considered in all cases where a rapid response is essential.

Electroconvulsive therapy is a treatment for depression that uses electricity to trigger a seizure. It is most often done in a hospital's operating or recovery room while you are asleep and pain-free. You receive medicine to relax you (muscle relaxant) and to prevent you from feeling pain. A small amount of electric current is delivered to the brain to cause seizure activity. It lasts for about 40 seconds. Medicine is given to prevent the seizure from spreading throughout the body. ECT is usually given once every 2 - 5 days for a total of 6 - 12 sessions. Because general anesthesia is used for this procedure, you will be advised to not eat or drink before ECT. ECT is a highly effective treatment for depression, most commonly severe depression. It can be especially helpful for treating depression in patients who:

- Cannot take antidepressant drugs
- Are suicidal
- Are pregnant and severely depressed
- Have certain heart problems
- Are psychotic

It is also used to treat bipolar disorder, people who are rigid and not responsive (catatonic), and some psychotic disorders (Medical Encyclopedia, 2008).

2.7.2. Psychotherapy

There is a major role for psychotherapy in most cases of high suicidal risk. Recent research studies have been conducted to seek improvements in the treatment of depression in adolescents and suggest that combined treatment with medication and psychotherapy for suicidal patients may be beneficial in treating depressed adolescent patients with suicidal risk.

2.7.2.1. Cognitive Behavioural Therapy

Cognitive Behavioural Therapy is mostly used in treating suicidal patients. As Henden (2008) explained, CBT's problem-solving technique helps people identify clear links between their life problems and their suicidal thoughts and behaviours. Further, it assists identification of strengths, skills and resources, while teaching them a systemic method for overcoming their problems and enhancing their feelings of control and competency. In addition to helping suicidal people discover their internal personal resources, the major goal of CBT is to encourage the development of the person's social resources. This might include weekly scheduling of pleasurable social activities and the broadening of the person's network of social contacts. Identification of strengths, skills and resources is fundamental also to solution focused therapy. An integral part of CBT is to help people identify and target suicidal cognitions. Part of their learning process often involving 'cognitive restructuring' is that they learn to recognise thinking patterns that lead to suicidal ideation and develop strategies that tackle cognitive distortions. One way of doing this might be to encourage the person to address the advantages and disadvantages of taking the suicide option, which would include listing the reasons for living and those for dying. Introducing training in social skills by way of modifying clients' behaviour can result in both reduced depression and suicidality.

So if people who had attempted suicide are treated it is possible to prevent suicide not to be completed .A patient after completed her treatment said,"*....anyone who read this, whether professionals or individuals similarly afflicted , will understand that suicide is a process in which intervention- and hence prevention- is always possible, but timing is crucial.*" (Brigges et al, 2008).

WHO (2005) suggests the following possible solution for preventing suicide in the developing countries.

- **Managing DSH (Deliberate Self Harm)**

Data from many developing countries is lacking but clearly people who carry out DSH acts form a pool from which many of future suicides are recruited. While the medical management of DSH is important and needs attention, the underlying psychological issues are rarely addressed. There is need for every DSH subject to undergo a psychiatric evaluation and be offered psychological help, no matter how innocuous the act may appear. Emergency room personnel in developing countries need to be trained in both medical and psychiatric management of DSH cases.

- **Controlling methods of suicide**

Controlling access to common methods has been found to effect suicide rates. In the developing world ingestion of pesticides is one of the most common methods for committing suicide. In Western Samoa, a small Pacific island nation, the use of paraquat, a highly toxic herbicide was linked to rising suicide rates from 6.1/100 000 in 1971 to 31.1/100 000 in 1981. This fact was widely publicized in a social-educational campaign on suicide prevention undertaken across the island. Subsequent rates showed a dramatic decrease.

- **Window Of Opportunity**

There is invariably an interval between onset of suicidal thoughts/ideation and the act of suicide, which may vary from hours to days and weeks. In developing countries this is frequently overlooked, partly because of ignorance but also because families and subjects do not know where to seek help. Even when they do realize something is wrong, they lack resources to seek help. In India only 24 of 269 suicide victims had been in contact with a mental health

professional or family physician or were on treatment before the suicide.

Studies using the psychological autopsy studies from India, China and Taiwan have shown that majority of suicides suffer from mental illness, of which depression is the most common disorder. With better mental health services depression can be treated successfully. A number of studies have shown the effectiveness of both pharmacological and psychological therapies in developing countries such as India, Pakistan, Chile and Uganda.

- **Targeting young married women**

There is urgent need that any programme of suicide prevention in developing countries must address the high prevalence of psychological distress in young married women. Issues of early marriage, pressure to have children (especially a male offspring) early in the marriage and domestic violence are factors that correlate strongly with suicidal behaviour in young married women in developing countries.

- **Need for review of the law**

In many developing countries, especially Islamic countries, suicide and deliberate self harm are illegal acts. Although prosecution is rare, the act is frequently exploited by the police in order to blackmail the victim and his/her family and extort money from them. Whatever deterrent value the law may have had appears to have lost its utility, as evidenced by the rising rates in countries like Pakistan. Such laws need to be reviewed and, where possible, repealed. This would help families and hospital to seek help for the survivors of an attempt without the fear of being persecuted by the legal authorities. It would also help in the diagnosis and registration of suicides, leading to more accurate estimation of the problem.

As literatures and studies explained above, suicide and suicide attempts are related with many factors like mental illness and socioeconomic factors and it is also explained that there are some psychosocial problems that could be encountered by the attempters. It is also discussed that suicide and suicide attempt can be prevented.

3. METHODS AND PROCEDURES OF THE STUDY

3.1. Introduction

In this chapter, the research setting, the design of the study, participants and procedures used to conduct the study are outlined. The method that was used to analyze the data as well as ethical considerations regarding the study are also described here.

3.2. Research Setting

The research setting for this study was Amanuel Mental Specialized Hospital which is located in Addis Ababa. In Ethiopia there is only one mental hospital, Amanuel Mental Specialized Hospital. It was built by Italians some sixty years ago as a general hospital which was later transformed into a mental hospital.

Due to the fact that more people who have attempted suicide could be located with less time and resources at the hospital, the researcher conveniently selected this research setting.

3.3. Research Design

This study has attempted to explore into the perceived precipitants and the psychological experiences of people who had attempted suicide. Hence, a qualitative case study research approach was considered to be appropriate for the study.

As Peter (1994) stated, qualitative research is an exploration and systemization of the significance of an identified phenomenon. Gall, Bong and Gall (1996) also indicated one of its focuses on intensive study of specific instances to be cases of phenomenon.

3.4. *Research Participants and Sampling Technique*

The population of the study constituted people (9 in number) who have attempted suicide and who were attending treatment at the Amanuel Specialized Mental Hospital of Addis Ababa from April 16 to May 10, 2009. The study participants were however five people who were admitted to the hospital as in-patients after attempting suicide, who gave their consent, and whom health care professionals approved for interview.

Besides, parents or care givers as well as medical professionals in the hospital were approached to triangulate and supplement the data. Consequently two parents (both mothers), two siblings (a brother and a sister), one female care giver and 10 health care professionals (constituted the study participants.

In support of the small number of study participants of this study, Merriam (1988) contend that, sampling in a qualitative study usually tend to treat small number of people nested in their context. Moreover, it studies in-depth unlike quantitative studies, which rather aim for larger number of stripped cases and seek statistical significance. Darlington and Scott (2002) however maintain qualitative research to be labour intensive and time consuming from data collection through analysis, so there are often practical constraints on the number of people who can be interviewed. In studying of client and family in relation to mental illness, it would be wise to limit the number of each group. Similarly, if a combination of methods is to be used, say observation, document analysis and interview, this will limit the total number of participants possible relative to available research resources.

The sampling procedure has highly demanded the advice of medical professionals who were in charge of the attempted-suicide patients in the hospital. This was because the physical and psychological wellness of the patients had to be taken into consideration. Therefore, the key informants (nurses and physicians) directly participated in the process of selecting participants for the study on convenience base.

The selection of key informants, including parents, siblings and care givers also took place with a convenience sampling technique. If it was not for such sampling technique, it would have been very difficult to get the study participants and the key informants that would suffice the case study design. Moreover, nurses and psychiatrists were selected on purposive base where direct involvement in services rendered to the suicide attempters was taken as criterion.

3.5. Data Gathering Techniques

An interview was used to collect data from the suicide attempters, their parents, siblings, or care givers. Moreover, to collect data from physicians in the hospital an interview was used. Focus group discussions and patients' medical history files were also used as roots for gathering important information for the study. Personal observation was also employed for further understanding and strengthening the data gathered with other instruments.

i. Interview

Semi-structured interview guides were used to collect data from suicide attempters, their parents, siblings, or care givers as well as psychiatrists. The interview guides were developed by the researcher after a thorough review of the suicide literature and informal conversations with a psychiatrist at the Amanuel Hospital. The interview guides were then given to health care professionals at the hospital and some graduates of measurement and evaluation in psychology for comments which led to some improvements.

The in-depth interview guides emphasized on finding out risk factors that led the attempters for the suicide attempt and their psychological experiences. The kind of treatment they were being provided was also explored by the interview guides. Interview guides for psychiatrists further inquired possible interventions that need to be made available for suicide attempters.

ii. Focus Group Discussion

Conducting Focus Group Discussion was found to be appropriate to have a good insight into the overall conditions of suicide attempters. Thus, semi-structured focus group discussion guide was developed, including questions as: "What major factors led the attempters to attempt suicide?", "What psychological experiences were faced by the attempters?" and "What kinds of treatments were available for the attempters?"

Hence, two FGDs were held where one of them took place in the small office of the hospital men's ward and the other in the office of women's ward. Generally, four psychiatry nurses, three clinical nurses and one health officer who were in charge of the selected suicide attempters in the hospital participated in the FGDs.

iii. Document Review

The patients' medical history file was also chosen as important source of secondary data that helped in triangulating the information gathered from primary sources. The files helped the researcher in providing important information about the suicide attempters':

- Childhood history
- Medical history
- History of substance abuse
- Current diagnosis
- Characteristics of their diagnosis
- Kind of treatment being given
- Day to day (progress) note

iv. Personal Observation

Since the study took place in the research setting (Amanuel Mental Specialized Hospital). This gave the researcher a chance to personally

observe the overall activities going on around the patients. Hence, the researcher had the chance when one of the patients experience seizure, observe a recent result of physical injury on one of the patients' body after suicide attempt in the hospital, and witnessed when 'an informal psychotherapy' as the psychiatrists called it, awas being administered for one of the suicidal patients.

3.6. Pilot testing

A pilot study was conducted with two people who have attempted suicide and were on treatment in the hospital as well as a parent. The interview guide questions were also checked by a fellow PHD student in Addis Ababa University. This was done to ascertain the validity of the interview guideline before employing the instrument for data gathering. The instrument was also tried out on one health professional in the hospital.

The researcher made some modifications on the interview guide based on the collected feedbacks from the pilot test. The participants of the pilot study were excluded from the main study in order to avoid response bias.

3.7. Data Collecting Procedure

Obtaining permission from the Amanuel Mental Specialized Hospital of Addis Ababa to conduct a research activity was the first step. Second was facilitating how and when the interview was going to be conducted. This was done with a psychiatric nurse who had a great experience with interviewing patients for other research in the hospital. A room which is used for administering group and individual therapy for patients in the hospital was selected to conduct the interview. Rapport with the interviewee was developed quickly since the researcher was going to the research setting (Amanuel hospital) on daily basis. This helped the researcher to observe convenient time to conduct the interview since all of the participants have their own time for taking their medications. After convenient time was observed, the purpose of the research was briefly explained to the interviewee, exact date for the interview was set by convenience of the

interviewee and the researcher. The same was done to the parents, siblings or care givers as well as health care professionals.

On the other hand, the two focused group discussions were held in such a way that 8 health professionals, where 4 psychiatric nurses, 3 medical nurses and 1 health officer from both men's and women's wards were selected.

After asking their willingness for the FGD, the researcher made brief explanation about the general purpose of the study. Then the FGD was held guided by the prepared semi-structured discussion guide.

The researcher could not include psychiatrists in the FGD since they had very tight schedule in the hospital. But it was managed to conduct interview for two psychiatrists.

Almost all of the interviews with the participants were tape recorded except one parent and care giver of the suicide attempters. One of the FGD was also not recorded because one of the participants in the FGD was not willing. Hence careful note was taken during the discussion. Information of the people who have attempted suicide was also taken from their medical history file documented in the hospital for additional information.

3.8. Ethical Considerations

The responsibility of reviewing the ethics of the instrument used to collect data for this study was shouldered on the ethical committee of the Amanuel Specialized Mental Hospital.

After seeing and making some ethical corrections on the interview questions, the hospital's ethical review committee granted the researcher to use the questions and conduct the research in the hospital. Some other ethical precautions taken by the researcher included:

- ❖ The researcher first articulated verbally the objectives of the research to all participants in the study.

- After assuring the willingness of participants to give information, the researcher explained their right to withdraw themselves from the study at any time and stage they want.
- Consent was also sought from the suicide attempters to review their medical history file.
- Tape recording was also carried out taking into consideration the willingness of all participants.
- The same procedure was followed at the FGDs. Thus, one of the FGDs was not tape recorded since one of the participants was not willing.
- Pseudonyms were used for all participants to protect and respect their privacy. These include names of the suicide attempters, their parents, siblings or care givers, psychiatrists and participants of the FGDs.

3.9. Data Organization and Analysis

The data collected through an in-depth interview and FGD were tape recorded and transcribed after repeated and careful listening. The data collected from interview, FGD, note taking and patients file were then categorized and presented case by case and then in line with the research questions.

4. DATA PRESENTATION AND DISCUSSION OF RESULTS

4.1. Introduction

This part of the study covers the presentation and analysis of the narrative stories of the participants. The main purpose of this study was exploring the major factors of the suicide attempts, the psychological experiences, and the kind of treatment given for the selected suicide attempt patients in Amanuel hospital. Exploring the kind of social intervention that should be employed to reduce suicide attempts was also one of the aims of the study.

To understand factors that motivated the patients to attempt suicide and their psychological experiences, their case stories are presented first and an analysis follows based on a series of themes using the research questions as a lead.

4.2. Presentation of Cases

This part encompasses the presentation of the histories of the participants. While presenting the cases, information from the interviews with the suicide attempters, their parents and/or care givers and medical history files was utilized.

Table 1: **Demographic Characteristics of the participants and key informants**

Name	**Age**	**Sex**	**Educational level**	**Marital status**	**Parents and/or care givers of the suicide attempters**
Abay	32	F	8th	Married	Mother
Nuru	31	M	College diploma	Single	Brother
Senay	22	M	4th	Single	House Maid
Muna	45	F	3rd	Divorced	Sister
Taye	21	M	10th	Single	Mother

Table 2: Demographic characteristics of health professionals

Name	Sex	Age	Experience in years	Specialization
Dr. X	M	37	8yrs	Psychiatrist
Dr. Y	M	48	14yrs	Psychiatrist

Table 3: Demographic characteristics of FGD participants

Name	Sex	Age	Experience in years	Specialization
A	M	21	1 yr	HO
B	M	35	3 yrs	PNS
C	F	28	2 yrs	C/N
D	F	28	4 yrs	PNS
E	M	33	4 yrs	PNS
F	F	29	3 yrs	PNS
G	F	25	4 yrs	C/N
H	M	26	2 yrs	C/N

Key to specializations:

- HO = Health Officer
- PNS = Psychiatry Nurse
- C/N = Clinical Nurse

4.2.1. Background Histories of the Participants

All the back ground histories of the participants bellow were gathered from the participants themselves, their parents and/or care givers and their medical history file. The information includes demographic history, family history, the onset of their suicide attempt and experiences.

Abay

Her bed is the first which is found next to the ward door. She usually sits on her bed or on a bench in the corridor sewing table cloth by hand. One can tell from her calm face that there is a lot going on in her mind. She always puts on a scarf over the hospital pyjama. Abay is a 30 years old, born in Addis Ababa around Mekanisa and grew up in Shashemene. She has one sister and four brothers of which she is the eldest. She started schooling at the age of six and she was a very clever and polite student. Unfortunately she failed the grade 8 national examination and got upset which made her quit her education at that level. Abay got married at an early age with her own will and has three daughters. But her marriage could not make her as happy as she wished. "It turned my whole life upside down" as she expressed it.

How it starts....

> *It was in 1989 E.C that I got married to my husband in Awassa town. When he told me that he has a wife and two children, I hesitated a little but you know it is love....so we got married. He is a Muslim police officer. I loved him so much that I changed my religion and became Muslim.*

She was sewing a table cloth as usual while telling her stories for the researcher. Her voice is low but audible enough that it was like she was narrating a tragic story from a book. She continued...

> *I moved in with him and started to live in a town called Welkite where all his families and relatives live. There he started to treat me like a doll (with a sardonic smile). He was so secretive that he never told me about his income or salary. He didn't want me to have contact with my family. I was alone, had no one to talk to. He didn't give me enough money for house consumption. He is a police man so he was hardly at home. I and my poor children were forced to eat roasted corn every night. (Her eyes filled with tears).*

After taking a deep breath Abay started talking again. This time her face turned red and she was nodding her head. She explained how their marriage went from bad to worse. "The biggest problem was his family." she continued....

> *ውይ! ውይ! የሱ ነገርማ? You see I am from Oromo family and my husband came from Gurage family. But it has never been an issue for us but it was for his family from the very beginning. They never want me to be with him. They have very poor attitude about equality of ethnic groups. My husband was a good person but they fed him with their evil thoughts. He listened everything they told him. Peace left our home for good; our home became a battle field. I got so depressed and felt alone, I had no one to tell my grief. I left my family, I left everything for him, but he..... (She could not finish it).*

She held her forehead with her both hands and kept quiet for a while and she continued again.

> *At that time I was pregnant with my last baby. My husband had never been there during my pregnancy to take care of me. No one was there, when I gave birth to my baby. I had to go to hospital alone. He finally came and saw our baby girl and said "...a girl?? Again!!(አሁንም ሴት!) and left without even giving me a greeting. After that I got very sick and came to my parent's house.*

The attempts.....

Abay could not remember much after she went to her family. Hence more information was obtained from her mother. It was difficult to talk to her mother. After a number of efforts her mother told the researcher that she did not want to remember anything about her daughter because what she has gone through was painful enough. But she said she would try to tell the

researcher some specific information which she did finally without any push from the researcher. She said....

> *Abay is becoming well so it is very painful to go back and remember what was happening to her. She came through a lot of miseries one could bear in life. My daughter had an unhappy marriage. She was abused by her husband. He made her not to have any contacts with any of us and relatives. She told me that he thought she loves her family more than him. But this is a rootless accusation because she has lived with him for about eleven years holding all the problems with her. Why would she do that if she didn't love him? She has been sick for the last two years but her illness was aggravated after the delivery of her last baby two months and three weeks ago. (Her face began to be covered by sweat)*

Abay's mom is a 53 years old graceful woman. She has dark skin and has a very fit body for her age. She has recently retired from her office work and now she is taking care of her own business in Shashemene with her husband. When she explained her daughter's suicidal behavior she said the following trying to hold her tears inside.

> *I remember two years ago when she told me that she feels to hang herself and feels no interest to live. (ታነቂ ታነቂ ይለኛል) But we took her to holy water in Awassa and she got well after. She was relatively healthy two months and fifteen days ago. But she got seriously ill after she gave birth to her last baby. She started to talk alone with multiple languages at a time, insult people and became sleepless at night. She collects garbage, eats cotton taken from the mattress and she became incontinent to urine and faeces.*

“Above all…” as Abay’s mom explained how the illness got serious:

> *She started trying to kill herself repeatedly. You could not trust to leave her alone for a minute. She tried to kill herself with any possible way she could .I caught her once holding a knife with her two hands trying to put it right in to her belly. She tried to hang herself with a rope and a scarf at different times. She deliberately ran to catch open electric wire. She always said “the police are coming, they’re going to kill me, he comes to poison me” She became very suspicious .She never ate food unless you tasted it first .She became negligent for herself and her hygiene.*

As her mother explained, it became impossible to control Abay. Her suicidal behavior became very serious. Hence they chained her and took her to holy water for treatment. They stayed for a month but there was no significant change in her health. During their stay at the holy water Abay disappeared. After a few minutes people found her trying to hang herself with her scarf on a tree and saved her. That was when her parents decided to bring her to Amanuel hospital.

As can be seen from the narration of the story, Abay had a very difficult life. The main cause for her disturbed life was, the disagreement she had with her unsupportive husband. The unfair treatment by her in-laws along with her being fully dependent on her husband made her life even worse. All these problems were enough to make Abay’s psychological well being in question. She started acting strangely, doing things which were not expected from a psychologically well person. She has become suspicious, lost the interest to live and further tried to kill herself several times. She became uncontrollable. Her suicidal behavior increased from time to time till she came to Amanuel hospital and got treated. After being admitted to the hospital, she has been given medication and psychotherapy. As her mother explained, the treatment being given to Abay was good and she has shown good progress from time to time.

Nuru

Nuru is of medium height with a fit body. He likes to stoop his head when he walks. He looked tired when the researcher first met him. He is polite and calm with a very low voice. Since he seemed depressed and tired most of the time, limited information was gathered from him.

He is 32 years old and the 3rd child for his parents. He lives with his four brothers and sisters. Most of the family members are engaged in family business. Unlike his brothers and sisters Nuru gave all his attention for his education. After finishing his high school studies, he joined Unity University and graduated with a diploma in accounting. According to his brother, Nuru has some behavior that is unlike all his brothers and sisters. He is impatient and gets angry easily. His brother added

> *It was very difficult to know what he wants and feels. No one has asked him personal questions since he is so quiet and serious. He used to be very fear full as a child. When he was in 1st grade, a teacher threatened him so bad that he never fought with students.*

How it starts.....

> *"After I finished my high school studies I started to work with my elder brother as an assistant on our family car. While we were driving a serious accident had happened and my brother died while I was seriously injured on my leg. I got into hospital, got treated and became completely fine. After that I have joined Unity University and started to pursue my education in accounting."* (Nuru)

Nuru was relatively healthy before four years according to his brother. His brother added

His behavior started to change and he became very isolated and very quiet more than ever before. Especially after the death of our father when he was a 2nd year student in college, he started to worry about everything. But he still continued with his studies and made it to his graduation. But he couldn't find a job after graduation for five years which made him very angry and depressed. During these years his illness became obvious. He started to talk alone, became very anxious and sleepless. He also became so isolated and very suspicious towards people.

His brother added

At his puberty age Nuru was so different from all his brothers and sisters. He was impatient, quarreled with everybody with no reason and he had difficulties to come to an agreement in any issue raised between the family members. After the car accident he had, added to the death of our father, Nuru became so furious and developed a very paranoid behavior. He stayed at home talking alone and accusing every one of talking and gossiping about him. He thought policewere chasing him to kill him. He was so suspicious of the maid in the house thinking that she would go to the police and tell them that he had raped her. He also thought that people would rob them. So he became sleepless. He always said he heard voices and he banged his bedroom wall to wake everyone up.

According to the information in his medical file, Nuru told the doctors that he had sexual intercourse with a commercial sex worker. During that specific moment, there was a smoke smelling like shisha (ሺሻ) in the room and he couldn't remember whether he used the condom properly or not. So he has great worries that he might get HIV.

The attempts....

As his brother explained, Nuru's strange behavior is getting worse from time to time. He has been taken to traditional medications but he refused to go there after he attended the lesson given by the sheik (Muslim religious leader) at the mosque. He said "People told the sheik that I raped a girl, that's why he was teaching us about girls."

In the meantime Nuru wanted to work with a relative on a car as an assistant driver as he used to be years ago. But he could not concentrate on the job since he kept thinking that police were chasing him. The driver of the car, who is a close relative of the family, reported to the family that Nuru tried to hang himself with his own belt when they were stopped by the police for a regular check by the road.

This was the first suicide attempt Nuru made. After that he started seeing a doctor at Ammanuel hospital as an outpatient. He started to take drugs prescribed by the doctor. This time Nuru started to have some sleep at night but there was no progress as such.

When his brother explained about Nuru's serious suicide attempts, he said

> *He continued to make serious attempts to kill himself. He kept thinking that people were talking about him. He couldn't resist the thought that people are talking about him. He said "he heard people saying he raped someone." So he tried to burn himself. Once he was caught drinking a chemical for washing clothes (በረኪና). After a few days again his mother and sister saved him when he was hanging himself with a rope in a shower room. Everyone in the family became worried. Nuru seemed more depressed than ever.*

The day that Nuru carried out his last and very dramatic suicide attempt was when he was found cutting his throat with a knife. He was immediately taken to Addis Ababa Balcha Hospital and the doctors saved his life. The next day he was brought to Ammanuel hospital and admitted as an inpatient.

As can be understood from the above story, Nuru has gone through stressful and depressive life moments. The main cause for these psychological experiences was the fact that he could not find a job after he has graduated from college. This caused him to be very depressed and further led him to attempt suicide repeatedly. He continued to encounter abnormal psychological experiences. Finally he was taken to Amanuel hospital for psychiatric treatment. There he began to take medications with psychotherapy. Nuru and his brother explained that the treatment has helped him to cope with his problems.

Muna

Her way of talking, her loud voice with her easy and friendly communication skill tell that she is from around Harar town. (People from Harar are known for their easy and sociable character). Muna is a 45 years old woman who is very easy to communicate with. She smiles now and then even if her two front teeth are broken. She was born in Dire Dawa and grew up with her brother and three sisters. She is the second child in her family. She used to chew chat and smoke cigarettes. She got married when she was very young but got divorced after five years of marriage. She has no children. As to her educational background, Muna went to school only up to 3rd grade.
Her 48 years old widowed sister, who has 3 children, described Muna starting from her childhood as follows

> *Muna used to be very aggressive and difficult as a child.*
> *She ran away from home with her friend when she was 15*

and went to a small town called Chelenko. There she got married at 16. We never heard from her until she came to our mother's funeral after 5 years. Her marriage didn't last long so she started to live in Dire Dawa with her sister. But she was a very difficult person to live with. So we sent her to Djibouti. There she lived for 16 years selling electronics as a job. As people in Djibouti were telling us, she was the same aggressive person who always fought with others. She got into prison for 3 years even but she finally was found innocent of the crime she had been accused of. A year later the government of Djibouti asked all foreigners to leave the country so she came to Addis Ababa and started to live with me.

How it starts....

When she came to Addis Ababa from Djibouti, as her sister reported, she was very sick. She was diagnosed with TB and started medical treatment. But her behavior was worse than before. She quarreled over silly things with everyone in the house, especially with the house maid. She threw objects and insulted her. She became sleepless. She started to threaten everyone with death. "እገላችኋለው!"

When Muna explained the situation in her sister's house, she said:

You see I am from Dire Dawa. People from there are completely different from here (Addis Ababa). Even the culture is quite different. They don't understand me at all especially the maid is my biggest enemy. Every step she makes, it is to make me upset. My sister knows this but she preferred to say nothing, because she was scared that the maid might leave. This made me very angry and loses my patience. So at times I felt like killing the maid or myself. They gave me a small room in the house not to fight with the maid. But this made me to be isolated and think

> *about many things alone. I couldn't sleep at night. I would say to myself "What am I doing here? Why don't I have a job and be free?" I have been tested for HIV and found positive a year ago. But it has never been my biggest reason for my anger, it's my family. They are my problem.*

The attempt......

The fact that Muna could not agree with any of the family members made everyone so worried. She became more aggressive and suspicious of everyone. They took her to a Muslim traditional treatment in Dire Dawa but the elderly man saw her and said she was fine. So they brought her back to Addis Ababa. But her behavior was not improved. Muna complained that her sister was not giving her the proper care that she should give her as a sister.

> *She didn't want me to live with her. I heard people talking that I shouldn't live with my sister. No one loves me because I have no job. I got upset with this and tried to hurt myself. I drank poison once.*

Her sister described Muna's repeated suicidal attempts as follows:

> *She got angry with no or silly reasons all the time. She feels hopeless and worthless. When she gets angry she runs to kill herself. We saved her life several times while she tried to kill herself. A year ago she put 5 liters of gasoline on her body to burn herself. After that, till she was admitted to the hospital, she repeatedly tried to kill herself. Once I saved her while she was swallowing a rat poison. The other time she tried to hang herself with a rope. The final attempt she made was a month ago. After she had a little argument with me, she went out from the house, bought a chemical for washing clothes (በረኪና) and drank it. She did this around Ammanuel hospital which is*

a few kilometers away from our home. People saw her when she drank the poison and took her to the hospital.

Muna has passed through many difficult ups and downs in her life as seen from the story narrated above. She had hard times when she was in Djibouti. She was in prison for three years and was very sick. She had uncomfortable life in her sister's house. She became dependent on her sisters and kept on fighting with them. All these life stressors left Muna with the only option beingto kill herself. Hence she attempted suicide many times since she could not cope with her problems. She became very sad, hopeless and kept on thinking about death. Her suicidal behavior increased from time to time till she got into Amanuel hospital and started medication and psychiatric treatment. As the nurses told the researcher, she has progressed a lot after the treatment she got in the hospital.

Senay

The 22 years old Senay looks very old for his age. He has a stitch right on the middle of his head resulted from a suicide attempt by hitting his head with hammer before being admitted to the hospital. Even if he has big and strong body features, he looks weak and has a very slow gait. He was born in Tigray and moved to Addis with his parents when he was very little. He has one sister and two brothers. He is the second child in his family. His sister who is the main source of income for the family lives abroad. His father died ten years ago and his mother is getting weak from her age and recently gets sick frequently.

Senay had epilepsy since he was 8 years old so he couldn't push further in his education beyond 5th grade. He has spent all his childhood and adolescence years travelling from town to town and church to church looking for a holy water with his parents.

On his medical history file, his brother told the doctors that Senay usually preferred to be alone and had difficulties in being sociable starting from his childhood.

How it starts....

Senay tried to explain his condition to the researcher with some chopped sentences and sometimes vague words as follows.

> *I live with my two brothers. One of them is my elder and the other is younger than me. My sister lives abroad. I don't know anything. I only learned up to grade 5. I can't work anything because I am sick. I have epilepsy. When my father died I got very upset and quit my education. My brothers make me upset all the time. And they also make my mom upset. They drink alcohol and come to our house. When I get mad I break things and hurt myself. (He showed the researcher how he hurt his head with a hammer and scratch marks on his abdomen from slashing with a broken glass).*

According to his medical history, Senay used to see a doctor five years ago which he stopped doing so. After that he started to show suicidal behavior.

The attempt......

The main information about Senay was taken from the girl who always came to take care of him in the hospital and from his medical history file.

This woman named Werke is a 20 years old, small sized charming girl. She has a big cross tattoo (ንቅሳት) on her forehead and another zigzag tattoo on the edge of her chin. She has lived with Senay's family for the past five years and she is like a daughter to the family. She is a grade 2 student at the night classes. She explained Senay's condition as

> *His mom told me that his illness started when he was eight years old. He fell down in a river while he was playing and got bewitched. After that he has never been healthy. His parents spent their whole life taking him to different churches for holy water but Senay never showed any progress.*

When Werke described about his aggressiveness in the house, she said

> *When he gets angry, usually with little or no reason, he will be very aggressive. He breaks everything, TV, window, glasses in the house. He burns all his clothes. He hates his brother and fights with him all the time. I heard him saying "I will kill him!"*

As Werke said, he started to make serious suicide attempts two years ago.

> *He has been injuring himself for the last two years in different ways. He banged himself with electric poles, he slashed his body with broken glasses, and he tried to hang himself with rope many times. He became very angry while he is doing all these so it would be very difficult to make him stop. He threw objects when someone tried to help him. One day while he was sitting beside me, he just got upset suddenly as he always does, got into the house and brought a hammer and started hitting his head. He got very seriously injured so we took him to the nearby clinic. There they gave him first aid then his brother brought him to this hospital.*

Senay was admitted to an acute ward. As the clinical nurse in the ward explained to the researcher, Senay is a very suicidal patient who sometimes gets very aggressive. The researcher found out that he made a suicide attempt in the hospital a day after he had an interview with the researcher. When he became very aggressive and started to attack other patients in the

ward, the nurses transferred him to an emergency ward for closer medical treatment.

In the emergency ward, Senay continued his attempts even more frequently. As one of the medical nurses reported, he had a series of seizures and Senay made four serious suicide attempts within a day. First he broke the clipboard in the emergency room and tried to cut himself, and then he started to bang himself on the wall. After a few hours again he went out from his room held a big stone and started hitting his chest. He was stopped by the help of the hospital guards. And finally he ran to the main gate jumped to the wall and tried to get into moving cars. So the nurses were forced to chain him to his bed for the night.

According to the story narration above, Senay had multiple problems that led him to attempt suicide. He lived all his life with epilepsy without any progress. The loss of his dad and the fact that his mom is getting sick made him angry and hopeless. He had difficulties in speech that hindered him in expressing his feelings. So he kept everything to himself and that made him angry and sad. All these psychological problems with his frequent suicide attempts forced his parent to bring him to Amanuel hospital for medical and psychological treatment.

Taye

He is very tall and dark skinned with big round eyes. Taye who is 22 years old, was born and grew up in Addis Ababa. He has one sister who is studying abroad and a brother who has serious mental illness. Taye is the youngest and the last child for the family. His father died ten years ago. His parents were divorced six years before his father died.

He has good computer skills though he stopped his school at ninth grade. His mom said

He was an average student at school. He is a very quiet and good boy. But he prefers to be alone and isolated at most times. He smokes cigarettes as his father used to and his older brother.

Taye is a Psychiatric patient and has been receiving treatment as an outpatient starting from 1996 E.C. As one of the Psychiatric nurses in his ward explained to the researcher, while he was receiving treatment, he stopped taking his medications properly and started smoking and chewing chat (ጫት). He is even suspected of taking other drugs too. His mother states that she saw him taking drugs once.

How it started...

After interrupting taking his medications, Taye started to develop a character of being suspicious and isolated. He started talking and laughing alone. As his mom described Tay's conditions, she said

He became very suspicious towards ever one and everything. He usually says," the TV is talking about me." He told me that he hears voices that command him to do bad and evil things. He always says "ኤጭ አምቢ!" .He sits alone very quietly most of the time. He also says, "The sky is covered by dark fogs. "ሰማዩ ጭጋግ ለብሰዋል". I took him to the church for a prayer since I have faith in Jesus Christ that he can cure my child. But Taye couldn't stay for more than ten minutes during the prayer. He usually walks out interrupting the prayer to smoke cigarettes. Therefore it didn't work out for him.

During the "interview", rather to say "informal conversation" with the researcher, Taye was talking about people who have powers in doing many things that ordinary people cannot do. He said he believes there are such kinds of people and they are the ones who are causing him not to see things

properly. He also said that he sometimes see things that will happen in the future.

The attempt...

Taye continued to act strange from time to time. He refused to wear clothes that have texts on them. He complained that he could not bear the voice that he was hearing. As his mother reported Taye usually does not talk much by his nature. He kept things for himself. So I can say he even tolerates his illness by keeping all his pains inside. But this could not help him rather it hurt him so bad that he became very stressed out and depressed. One specific day, as his mom explained the incident,

> *I heard him screaming very loud from his room. I looked for him in his room but he was not there. After few minutes I found him in a bath room lying on the floor with a thin rope tied on his neck. If it wasn't for his weight he would have died. He was trying to kill himself by hanging. Fortunately the rope was so thin so he fell dawn and got a minor head injury. He also got cut on his neck from the rope. I brought him to Amanuel hospital that day.*

> *We took care of him and gave him everything he needed. He has his own room, with a computer, TV and everything else he wanted. As to my knowledge he has never felt sad or show the sign of hopelessness. But he is such a quiet boy that it is very hard to tell what was missing in his life.*

The story narration above can tell us that there is a psychiatric illness in Taye's family. The existence of a psychiatric problem specifically schizophrenia, was the major reason for Taye's suicide attempt. In addition, he smokes and takes drugs which made his illness relapse and made him

end up in hospital. The psychological experiences he encountered were due to his illness. He started to take his medication with the psychotherapy properly after being admitted to the hospital. His mom has reported that the treatment he is being given in the hospital is good.

4.3. Discussion of the Results

4.3.1. Major factors for Suicide Attempt

As many research results in suicide have shown, chronic mental and physical illnesses, substance abuse and history of suicide in the family are some of the factors for suicide attempt in adolescents and adults. In this study, the major factors for suicide attempt in the selected suicide attempt patients were the following:

4.3.1.1. Depression

Depression is one of the main factors that motivate people to attempt suicide. Researchers have shown that 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.

Almost all of the participants in this study have been diagnosed with different kinds of depression. According to the information gathered from the hospital patients' medical file, Nuru has been diagnosed with Major Depressive Disorder (MDD) with psychotic features. At the time of diagnosis, he had no insight and his thought content was characterized by persecutory delusion. This was best described with his own words while diagnosed by the health professionals. He said

> *People are talking about me. I heard them saying I raped a girl. And police are looking for me to kill me. They are going to arrest me.*

When his brother explained about Nuru's delusionary thinking, he said

He thinks everyone is talking about him. Even when the sheik was preaching, he thinks he was talking about him and refused to go to the mosque. He usually sits alone and talks to nobody. Since he is so quiet and serious no one dares to approach and ask him what is the matter.

Concerning the relation between depression and suicide attempt, one of the Psychiatrist who was directly involved with Nuru's case explained, the fact that he had no job added with the loss of his dad might bring him into depression and eventually attempt suicide because the depression has not been treated quickly.

Literature also shows that unemployment can cause depression. As Wilson, (2009) explained the most common outcome from unemployment is depression. It's important during a time of unemployment to seek out as much social and emotional support as possible. A loss of hope is a big predictor of suicide, so trying to stay hopeful during the jobless time of one's life is essential to straying from depression and potential suicide risk.

The other participant who was diagnosed with psychotic depression is Muna. At the time of diagnosis when she was first admitted into the hospital, she had no insight and had persecutory delusion. This can be explained by her own words which briefly illustrate her delusionary thoughts. She said

I heard people talking about me. They don't want me to live with my sister. I heard them telling my sister to get rid of me from her house.

She also said that because she has no job, life is hard to live in someone else's house. As she explained this she said

> *I always think at night, "What am I doing here? Why don't I get a job and get out of here?" Nobody loves me because I have no job. I had a job once but I have no more. I can't ask my sister to buy me everything I want. All these made me angry.*

Supporting this, Wilson (2009) said a chain of adversity can begin with unemployment that can eventually lead to depression and suicidal thoughts. Losing a job that one depends upon (both financially and personally) contributes to individuals losing a sense of personal control, which can lead to hopelessness and despair.

Taye was also diagnosed with a Major Depressive Disorder (MDD). According to the information on his medical file he was also diagnosed with Schizophrenia six years ago. Patients who have Schizophrenia, as a psychiatrist explained have high depression most of the time.

As a study conducted by Pompili et al (2008) showed, patients with depression and schizophrenia are nearly three times more likely to attempt suicide than people with clinical depression alone and may be less likely to communicate suicidal intent to health care professionals. They are also more likely to use highly lethal methods in their suicide attempts.

The other participant who was diagnosed with another type of depression was Abay. Her depression is called Postpartum Psychosis. Postpartum psychiatric disorders refer to those mental disturbances, which occur in women of childbearing age within four weeks of childbirth.

Information collected from her medical file showed that her illness was aggravated just after she gave birth to her baby. She had auditory and visual hallucination. As her mom reported to the health professionals during the diagnosis, that can illustrate Abay's hallucination, she used to say:

> *The police have come..... They have knives..... They are going to slaughter me.*

Abay who is a 32 years old woman used to chew chat and just had her baby when her illness got worse. She had an unhealthy relationship with her husband as she herself and her mom reported. She said

> *My husband doesn't give me enough money for household. So me and my children eat roasted corn every night. We always fight in the house and we have no peace at all. I have no one around to support me and tell my problems to and no job to support myself and my children. My mother in-law and her family do not like me because I am the second wife from different ethnic background. I used to take medicine because I was diagnosed with TB. So I had to interrupt taking birth control. And I became pregnant and gave birth to a baby girl. All of my children were girls. So my husband was not happy when I gave birth to a baby girl again. He said, "You gave birth to a girl again?" and left me alone without even giving me a greeting.*

In line with this, a study in Uganda showed important risk factors for major depression include onset of depression under age 40, postpartum period, lack of social support, stressful life events, and current alcohol or substance abuse. It was also found out multiple risk factors for postpartum depression associated with postpartum psychiatric illnesses. Personal vulnerability, personality traits and social factors such as unplanned pregnancy, occupational instability, unemployment of the woman or her partner and low income, have been cited. Moreover, family factors such as single parenthood, marital discord, divorce and polygamy were also reported. Other social factors including poor social support from the father of the child or the woman's own, birth abnormalities, female sex, and absence of breast-feeding (Wilson, 2009).

Similarly the FGD discussants have emphasized women who have no social support, such as Abay who was frequently hit by her husband and hated by

the family members of her mother in-law, would experience depression.

Senay was also another participant who was diagnosed with MDD with Psychotic features. He is an epileptic patient since he was eight years old. He has paranoid delusions as his medical file explained. This can be illustrated by his own words during the interview with the researcher. He said

> *There this woman with dread hair who sometimes comes and tell me to kill myself. She said, "Why don't you hang yourself or cut your throat with a knife?"*

As many researches have indicated, depression is a common problem in patients with epilepsy. As studies indicated in Meador (2003), the prevalence of depression in epilepsy has been reported to range from 3% to 60% compared with 2 to 4% in the general population. The prevalence of depression in epilepsy appears to be higher than depression in other chronic diseases of similar severity. For example, a population-based study of 181,000 individuals found that lifetime prevalence of depression for patients with epilepsy was 29% compared to 17% in diabetes, 16% in asthma, and 8.7% in those without chronic disease.

As the Psychiatrist explained about Senay's case, "He hears voice which is a clear symptom of psychotic patients, these voices might tell him to kill or harm himself which he did frequently. So the attempt made by a psychotic patients is impulsive, it is out of their control." Therefore psychotic depression has been found as a major factor for participants in this study to attempt suicide. Studies also showed that patients suffering from psychosis are at elevated risk of suicide, with at least 20% of them making a suicide attempt in their lifetime (Nardezzii & et al, 2008).

4.3.1.2. Schizophrenia

Schizophrenia is a mental illness that most of the time leads people to attempt suicide as many literatures and studies show. It is also one of the

causes for suicide attempt observed in this study. From the participants in this study, two of them were diagnosed with Schizophrenia.

Taye is one of the participants who were diagnosed with Schizophrenia. According to the information from his medical file, Taye had this illness since five years ago. He has persecutory delusion and auditory hallucination. He had no insight when he was admitted to the hospital. He has thought broadcasting, disordered and/or bizarre thinking. During a conversation between the participant and the researcher, Taye said,

> *I think people who have power inside them are disabling me not to see things. For example I see the mountains and the sky overlapped to each other. A man is always telling me to follow him to the Babylon. He stood in front of me and said "Come my child, we will go to the Babylon."*

In line with this Nowack (2006) stated that people with schizophrenia often suffer terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them. These symptoms may leave them fearful and withdrawn.

As the nurses who took his history when he was first admitted to the hospital explained to the researcher, he used to take medicines prescribed by physicians but he stopped taking his medication and started to take drugs and smoke cigarettes hence the illness relapsed. Supporting this, studies have illustrated that people with schizophrenia seem to be driven to smoke, and researchers are exploring whether there is a biological basis for this need. In addition to its known health hazards, several studies have found that smoking interferes with the action of antipsychotic drugs. People with schizophrenia who smoke may need higher doses of their medication. Solomon (200) also added that this disorder runs in families and has the character of relapsing.

When his mom explained about the nature of Taye's illness and how it starts to relapse she said

> *His older brother has Schizophrenia and has been hospitalized for many years. His uncle and nephew had the same kind of illness too. He was taking his medication properly. But he started to chew and smoke again and became reluctant to take his medicine properly. He became isolated and stressed. I don't know why but he doesn't like to wear clothes which have texts on them. And he said the TV is always talking about him he hears voices that tell him to do bad things.*

Supporting the above, the Psychiatrist in charge of Tay's case illustrated hallucinations and illusions are disturbances of perception that are common in people suffering from schizophrenia. Caruso (2004) also added that voices may describe the patients' activities, carry on a conversation, warn of impending dangers, or even issue orders to the individual. Sometimes the delusions experienced by people with schizophrenia are quite bizarre; for instance, they might think that people on television are directing special messages to them.

Solomon (2009) who is a Psychiatrist in Amanuel, added that Schizophrenia is caused by genetic factors and has a character of relapsing by its nature. Some of the symptoms which can be observed when it starts to relapse are: stress, sleeplessness, depression, anger, being reluctant to taking prescribed medicines and there are some unique behaviors on the patient like wearing full black colored clothes, whistling continuously, buying lots of lottery tickets and others.

The other participant who was diagnosed with paranoid Schizophrenia is Nuru, also has some symptoms of schizophrenia like persecutory delusion

and loss of concentration. Marders (2001) illustrates that in paranoid schizophrenia, delusions are often focused on the perception that you are being singled out for harm. As his brother reported, Nuru used to say the following

> *The neighbors and our relatives are planning to take our property. Everyone is talking about me. The house maid is going to tell to the police that I raped her.*

As the psychiatrist who was in charge of Nuru's case explained, delusions are false personal beliefs that are not subject to reason or contradictory evidence and are not explained by a person's usual cultural concepts. Marders (2001) further added that patients suffering from paranoid-type symptoms roughly one-third of people with schizophrenia often have delusions of persecution, or false and irrational beliefs that they are being cheated, harassed, poisoned, or conspired against. These patients may believe that they, or a member of the family or someone close to them, are the focus of this persecution.

As indicated in the Annals of General Psychiatry (2007), at least 5–13% of schizophrenic patients die by suicide, and it is likely that the higher end of this range is the most accurate estimate.

4.3.1.3. Epilepsy

Epilepsy could be one of the major causes for people to attempt suicide. As in Meador (2008), rates of suicide attempts have been reported to be elevated among people with epilepsy. Among people with epilepsy, psychiatric comorbidity is common, and rates of mood disorders, particularly major depression, have consistently been reported to be elevated.

The current study has also shown out that one of the participant's major precipitant factors for his suicide attempt was epilepsy and other psychotic features and depression which were directly related to epilepsy.

Senay is a 22 years old man who has been living with epilepsy for fourteen years. He has also had a series of seizures. According to the secondary information gathered from his medical file and the Psychiatrist's explanation about the cause of his epilepsy, Senay fell down in a river while playing when he was very little; this might have caused a head injury. One of the causes for epilepsy and seizures is a head injury.

Senay is diagnosed with epilepsy with psychotic feature plus MDD with para-suicidal behavior; he is also diagnosed as having a mild mental retardation. Senay also has poor speech which hinders him to express himself and communicate with people. His father has died recently and his mom is sick. As the Psychiatrist explained, all these multiple problems which Senay has are, reason enough to make him angry, depressed and finally lead him to attempt suicide.

The FGD discussants also agreed on the fact that Senay has multiple and complicated problems. So he suddenly gets angry and attempted suicide, even in the hospital more than five times.

Studies showed that a history of depression increased the risk of epilepsy, but the startling finding was that people with epilepsy were 4 times more likely to have attempted suicide before ever having a seizure, even after other factors were taken into account like drinking alcohol, having depression, age, and gender.

4.3.2. Observed Psychological Experiences of the Suicide Attempters

People who have attempted suicide could have faced different psychological experiences. Psychological experiences like hopelessness, worthlessness, anger, sadness, loneliness or withdrawal and suspiciousness are observed in people who have attempted suicide in this study.

4.3.2.1. Hopelessness and Worthlessness

From the five participants in the study three of them have experienced hopelessness. This can be briefly explained by the words of the participants themselves.

"There is a feeling inside of me which says "kill yourself"....
I don't want to live any more.......
I want to die....." (Abay)

The above was reported by her mom.
Abay who had a very stressfull life experience in her marriage, has passed through difficult situations in her life. She had attempted suicide several times. As one of the FGD discussants explained, she had suicide ideation and attempt even in the hospital while she was undergoing treatment. She insisted on being given a room to be alone. This was to create a suitable situation in which to kill herself.

"I know nothing, I can't work....
I don't want to live being like this......
I have no hope anymore......" (Senay)

This was reported by a clinical nurse who was in charge of the patient for a weekend. The nurse said Senay said this when he found himself chained to with his bed after making series of suicide attempts within a day in the hospital. Similarly the FGD participants and the Psychiatrist emphasized the fact that Senay has multiple and complicated situations such as his loneliness, his difficulty of speech and especially his series of seizures, which could make him hopeless.

"I have no job....
Nobody loves me.....
I have no child......
My sister prefers her house maid to me....

I have no use for no one.....

So why don't I kill myself and get relief from all these......" (Muna)

This was reported by herself during the diagnosis.

Muna had lived in Djibouti for 16 years and she spent three of the years in prison. She has been living with HIV/AIDS for almost two years now and had TB before that. She has no job and has disagreements with her sister. The FGD also revealed that she has serious disagreements with her sister and the fact that she has no job which left her with no choice but to be dependent on her sister, which in turn made her hopeless. So the only coping mechanism she used was trying to kill herself.

"I am useless...

I am HIV carrier....."

He cries sometimes.... (Nuru)

As the Psychiatrist and the FGD discussants explained, feeling hopeless and worthless is one of the symptoms and psychological experience of psychotic and paranoid schizophrenic patients.

4.3.2.2. Anger and Sadness

Anger and sadness are also among the observed psychological experiences faced by the people who had attempted suicide.

Abay and Muna share these two psychological experiences. They both have stressfull and dependent life. Both of them are jobless and have no peace at the house they are living.

My husband doesn't support me in anything in the house. He prefers listening to what his relatives tells him to me. It has been three months since I got sick but he didn't even come once here to visit me. (Abay)

The maid in the house always made me angry. And my

sister did nothing about it. This makes me angry and sad. So I always wanted to kill myself or the maid when I got mad. (Muna)

Senay has also experienced anger and sadness most of the time. When the Psychiatrist elaborated Senay's case, the fact that he has difficulty in speech meant he kept everything inside. He can't let out what he is feeling and this makes him very angry and aggressive. In addition he experiences seizure frequently and found himself chained with his bed because he hurts himself most of the time. All these made him sad when he came to himself from seizures and was told what he was doing. This can be further elaborated in his own words. Senay said:

I became very angry when my dad passed away. My brothers make me angry all the time and there is this woman who always comes and tells me to kill myself. I couldn't resist her; she makes my head very intense. This time I become very angry and try to hurt myself. And my mom is very sick; if she dies I will not have anyone around me.

As one of the FGD discussants said, Senay is always sad when he is asked about his mom. And he always asks about his family. There is only one woman who lives with his family who comes and visits him. This makes him very sad. And when he found himself chained to his bed he always asks the nurse not to chain him but rather to tell him not to disturb. But he doesn't remember any of the things he was doing before that.

Spirtito and Overholser (2003) stated that anger is a common mood state among adolescents who attempt suicide. Aggressive behavior often accompanies this angry affect. Few studies have reported on aggressive behavior, rather than relying only on the self-report of anger, in clinical samples of adolescent suicide attempters. Aggressive behavior has been

found to be strongly related to suicide attempts among female psychiatric patients and associated with conduct disorder diagnoses among both male and female adolescents.

4.3.2.3. Suspiciousness

Suspiciousness is also commonly experienced by suicide attempters specially those who are diagnosed with psychosis disorder. As almost all of the participants in this study were diagnosed with psychosis disorder, they have experienced suspiciousness.

Abay is one of the participants who was diagnosed with postpartum psychosis. According to her medical file she had experienced stress, worthlessness and suspiciousness. As her mom reported to the health professionals during diagnosis, she was very suspicious towards everyone including her family members. She said:

> *She thinks people are trying to poison her. She always shouts saying "He comes with poison..... he is going to poison me and kill me." So she never eats any food unless you taste it first.*

Muna was also diagnosed with Psychosis MDD. In addition to her feelings of hopelessness, worthlessness and anger she had experienced suspiciousness towards everyone around her. During her diagnosis she reported that:

> *Everyone is talking about me. I heard them telling to my sister to get rid of me from her house. They don't like me. They want to avoid me. The house maid does everything to annoy me deliberately.*

As the FGD discussants elaborated on Muna's suspicious behavior, they said even if it is the nature of her illness that made her suspicious towards

people, people who are living with her are not giving her the attention she should be given. Hence she has developed more anger and suspiciousness.

Taye and Nuru who were diagnosed with schizophrenia had also experienced suspiciousness. As the literature states this might be due to the voices that they hear. This can be briefly elaborated in their own words.

> *The neighbors are planning to take our property. People are talking about me. I heard them saying that I raped a girl. They are going to infect me with HIV/AIDS. If we let the renters to stay longer in our house they might say that the house is theirs. (Nuru)*

> *I heard the TV talking about me. People who have powers are making my mind not to work properly. The medicine is making me sick. (Taye)*

Concerning the feeling of suspiciousness of the participants the psychiatrist explained that it is common to develop suspiciousness in Psychotic and schizophrenic patients.

Other psychological experiences like feelings of irritability, anxiousness and feelings of guilt were also reported on the patients' medical history file.

As the information obtained from the medical files showed, most of the participants in the study share the feeling of irritability. When Nuru's brother reported:

> *Even if Nuru has a little different behavior from all of us, recently he became too sensitive and gets angry with very silly matters.*

Senay's care giver and the ward nurses in the hospital also reported

> *He suddenly gets angry with no reason. He fights with his*

brother at home and with other patients after he was admitted to the hospital.

Muna's sister also reported

She feels as if everyone is trying to make her angry. She always says that the house maid is making her angry and she insulted her with no reason. But the poor maid doesn't respond anything to what Muna is doing.

Abay on the other hand always feels guilty as if she did something wrong. As the FGD discussants explained, she blamed herself for everything. She said:

It is all my fault that I ended up like this. God is punishing me because I have changed my religion. That is why I am here separated from my children.

4.3.3. The Type of Treatment Given for the Suicide Attempters

All the participants in this study were patients who were admitted to Amanuel Specialized hospital for treatment. They are being given different treatments according to their illness. As to the researcher's observation, the patients are being given medical treatment by the ward nurses and there is one Psychiatrist who comes every morning, sometimes every two days, to watch the patients. There is (what the psychiatrists call) "informal therapy" given for the patients when the psychiatrists come to visit the patient. This is done in the ward's little office where all the ward medical and psychiatry nurses and the psychiatrist gather and discuss the patient's case with the patient and their families or care givers if they are available.

As noted by Naradezzi et al (2008), prescribed medications should be those that are necessary to treat the associated disorder. The use of medications or other somatic therapies for the treatment of the disorders associated with

suicidality includes anti depressants, anti psychotics, Electro Compulsive Therapy (ECT) and psychotherapy.

At the focus group discussion, the discussants tried to briefly explain the different kinds of treatment given for the suicide attempters. The following will explain the steps and the treatment that suicide attempters are given in the hospital.

4.3.3.1. Medical Treatment

- First the patients will be observed clearly and their past history concerning their medical history (onset of illness, course of illness, substance use history and treatment history) and family history will be taken from the patients and their family or care givers.

- After differentiating their illness they will be given different medicines depending on the type of their illness. Most of the time people who are thought to be at risk of attempting suicide are depressive, psychotic and schizophrenic patients. So the patients will be tried with anti-depressants and anti- psychotics according to the case, from 4 to 6 weeks till the patient starts responding to the medicine.

The other treatment given for the suicide attempters is Electro Compulsive Treatment (ECT). This treatment is given for patients when they do not respond to the anti depressants and anti psychotic medicines, and when the thoughts of suicide ideation and attempts continue. The patients will not interrupt taking the medicines (anti depressants and anti psychotics) while they are given the ECT. As mentioned in Medical Encyclopaedia (2008), ECT remains a viable option for the seriously depressed suicidal patient. Antidepressant drugs do not work quickly. ECT should be considered in all cases where a rapid response is essential.

The researcher has also observed that ECT was administered for two of the participants in the study because they were attempting suicide and kept their suicidal ideation while they were being given the medications. These two participants were Abay and Senay. As explained by one of the focus group discussants Abay was found by her mom when trying to hang herself with a chain she found in her ward corridor. The other focus group discussant also explained that Senay never stopped attempting suicide even after the ECT.

When asked about the type of treatment being given in the hospital, the interviewee (patients, their parents, siblings and care givers) replied, "It is good. Medications are being properly administered."

4.3.3.2. Psychotherapy

According to the psychiatrist and the focus group discussion there are also psychotherapy treatments for suicidal patients in addition to medical treatment in the hospital.

There are individual, group and family therapy services in the hospital. As one of the discussants in the focus group discussion explained, the type of psychotherapy applied most of the time is CBT (Cognitive Behavioral Therapy). Some times IPT (Inter Personal Therapy) is also used.

As Kosky et al (2002), have also added about the use of CBT that, this suicide prevention cognitive-behaviour therapy (CBT) based intervention is applied within the context of a crisis intervention model (given the urgent and transient nature of suicidality) and supplements standard case management. The therapy aims not only to address state-related risk factors, but also to provide: psychoeducation about the mechanisms of suicidality; coping strategies for suicide ideation; coping strategies to assist with the desensitisation of the impact of triggers; strategies to access

assistance, augment protective factors such as 'hope' in recovery, self-esteem; education about psychosis; and assist with adjustment to losses.

The information gathered from the patients' medical file showed that psychotherapy was being administered in parallel with the medication for the suicidal patients. Individual therapy will help the patients to get insight about their problems and cope with their problems. Family therapy is very important for the patients and their parents and/or guardians for creating awareness about the patients' problem and better handling. The patients said that the group therapy they are given in the hospital is good.

One of the Psychiatrists didn't deny that the therapy being administered in the hospital is not so organized. Counseling should be administered by trained counselors and psychiatrists but it is being administered by Para counselors who have limited skills of giving therapy to suicidal patients. This is due to a shortage of psychiatrists in the hospital. As a study by Kebede and Alem (1999) suggested, the number of psychiatrists in Ethiopia is very small, hence psychiatry nurses and psychologists have expanded roles.

4.3.4. Social Intervention to Reduce Suicide Attempt

The findings of this study indicated that the signs of suicidal behaviors are not known by the parents or care givers, and it is the last option to bring suicide attempters to health services for treatment before it gets serious. As to the information obtained from patients' medical history and the interview with parents siblings and care givers, the patients came to hospital when they failed to be treated by traditional treatments like holly water (ፀበል) kalicha or awaki (አዋቂ) and became out of control and highly suicidal. This can be illustrated by the case histories of each participant in the study. The participants of the FGDs explained this issue as the following.

Abay spent more than two months on traditional treatment in Awasa and Addis Ababa. She had attempted suicide several times by hanging herself,

holding open electric wire and cutting herself with a knife. The last suicide attempt she made was around the place where she was taking the traditional treatment. She was found when trying to hang herself on a tree. Then she was brought to this hospital being chained.

Nuru was also showing some signs of suicidal behaviors for four years. He has been attempting suicide by hanging himself with his own belt and a rope. But he was taken to kalchas (awaki) where sheiks (Muslim preachers) give traditional treatments. Since he had already developed suspiciousness, he refused to go there more than once. When his behavior got difficult to be controlled and finally he was found cutting his throat with a knife, his brother brought him to this hospital.

Muna's case was not different from others. She had multiple suicide attempts by drinking poisons, hanging and burning herself. Her sisters took her to Kalchas in Dire Dawa. But they were told she was completely fine. But her suicidal behaviors got worsen even after that. As her sister reported, one of her neighbors advised her to take her to Amanuel hospital. Fortunately, Muna made her last suicide attempt around her house which was very close to the hospital. So people found her drinking poison and took and brought her to the hospital.

Senay is the other participant in the study who spent almost all his life touring the country looking for holy water treatment with his parents. He was 8 years old when his epilepsy and seizure started. All those years, he has never been to a proper psychiatric treatment. His parents believed that he was bewitched as a child when he was playing by the river. His suicidal behaviors became very serious from time to time. He became very aggressive and the methods he used to attempt suicide were dangers. Finally he was brought to hospital after he hit his head with a hammer and got seriously injured.

Taye, who was diagnosed with schizophrenia, was in treatment for five years as an outpatient. But he interrupted taking his medications properly. This

was may be with his or his parent's reluctance. As his mom reported she used to take him to a protestant church for a prayer. But he interrupted the prayer in the middle because he wanted to smoke every now and then. Hence his illness relapsed and he made a suicide attempt which was the immediate cause for his admission in the hospital.

As can be observed from the above stories of the participants by the focus group discussants, people who are living with or around the patients did not know the signs and the consequences that suicidal behavior might bring. All of them preferred to use traditional treatments until the illness got very serious and came to a life threatening situation.

A research by Shibre and colleagues, as cited in Kebede,Alem and Rashid (1999) supports the above by saying that in Ethiopia, widespread beliefs that severe mental illnesses are due to demon possessions, bewitchment by evil spirits or the 'evil eye' have existed for many years. Over a million Ethiopians are estimated to suffer from schizophrenia and affective disorders and millions of their family members struggle to cope with the consequences.

The focus group participants and the psychiatrists briefly explained about things that should be done to prevent suicide attempts. They said education should be provided for society about the possible causes of suicidal behavior, and what to do when these signs are observed on people around school, work areas and in the community at large. Teachers at schools and the Mass Media can play a great role in creating awareness about suicide and related issues in society.

Studies state that most of the major factors that lead people to attempt suicide are treatable. *Fenton (1991)* in his study said that while schizophrenia patients were once largely confined to institutions, with the availability of better treatments (including new medications to alleviate hallucinations, delusions and disorganized thinking), most people with schizophrenia live and function in the community. He further added that

some form of case management or individual psychotherapy combined with medication is probably the most common treatment provided for schizophrenia patients in the United States. Therapists have long believed that assisting the patient to acknowledge, bear and put into perspective the painful feelings associated with the illness is the central psychotherapeutic task for these patients.

As stated in Goldsmith (2001), suicide is considered a possible complication of depressive illness in combination with other risk factors because suicidal thoughts and behavior can be symptoms of moderate to severe depression. These symptoms typically respond to proper treatment, and usually can be avoided with early intervention for depressive illness. Caruso (2004) also added that depression occurs because of an imbalance of chemicals in the brain. It is an illness and it is highly treatable.

Table 4: Summary of the Case Analysis

Name	Main Diagnosis	Characteristics of the diagnosis	Number and method used for the attempt	Psychological experiences of the attempters	Treatments Given for the attempters
Abay	• Post Partum Depression • Psychosis	• Visual and auditory hallucination • Stress	▪ 2 (hanging) ▪ 1 (cutting with knife)	▪ Hopelessness ▪ Worthlessness ▪ Sadness ▪ Suspiciousness ▪ Irritability ▪ Guilty feeling	▪ Anti psychotic and anti depressants ▪ ECT ▪ psychotherapy
Nuru	• Psychosis MDD • Paranoid Schizophrenia	• Persecutory Delusion • Stress	▪ 2 (hanging) ▪ 1 (burning himself) ▪ 1 (cutting knife)	▪ Hopelessness ▪ Worthlessness ▪ Anger ▪ Suspiciousness ▪ Irritability ▪ Anxiousness	▪ Anti psychotic and anti depressants ▪ ECT ▪ psychotherapy
Senay	• Epilepsy • Psychosis MDD • Mild retardation	• Paranoid Delusion • Stress	▪ Multiple (hanging, cutting with sharp things, biting with hammer)	▪ Hopelessness ▪ Worthlessness ▪ Sadness ▪ Irritability	▪ Anti psychotic and anti depressants ▪ ECT ▪ psychotherapy
Muna	• Psychosis MDD	• Persecutory Delusion • Stress	▪ 2 (drinking poison) ▪ 1 (burning herself)	▪ Hopelessness ▪ Worthlessness ▪ Sadness ▪ Suspiciousness ▪ Irritability	▪ Anti psychotic and anti depressants ▪ ECT ▪ psychotherapy
Taye	• Schizophrenia • MDD	• Persecutory Delusion • Auditory Hallucination	▪ 1(hanging)	▪ Stress ▪ Suspiciousness	▪ Anti psychotic and anti depressants ▪ ECT ▪ psychotherapy

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this section, the summary, conclusions and recommendations are presented based on the findings of the study.

5.1. Summary

This study tried to explore into the major causes and the psychological experiences of suicide attempts in five selected suicide attempters taken from the Amanuel Mental Specialized hospital. The study also tried to investigate the different kinds of treatment these patients were provided with and the social intervention that should be employed to prevent suicide attempt. Data which were essential for the study were collected from five suicide attempters in the hospital, their parents, siblings, and care givers on convenience base and some health professionals (clinical nurses, psychiatric nurses and Psychiatrists) which were all selected through a purposive sampling technique. Focus group discussions and patients' medical history files were also other sources of data for this study. Information gathered through these instruments were presented and discussed qualitatively based on the research questions.

Accordingly, it has been understood from the study results that the major cause for suicide attempts that was observed in this study were psychiatric illnesses. All of the suicide attempters in the study were diagnosed with one or more psychiatric illnesses. Different kinds of depression (post partum, psychotic depression), schizophrenia, psychosis as well as mild retardation and epilepsy were the diagnosed causes of suicide. Factors that caused the psychiatric illness on the suicide attempters include, stressful life events, being dependent or unemployed and hereditary factors. Depression and psychotic disorders were the two psychiatric problems that were perceived as being one of the causes for suicide attempt in all of the participants. According to the information gathered, the patients attempted suicide several times. Hanging, drinking poison, burning their body, slashing and

cutting body parts with sharp materials like broken glasses, stones and knives, holding electric wire and beating oneself with stone and hammer were methods of suicide attempt used by the attempters.

The type of the psychiatric illness diagnosed seemed to relate with the type of psychological experiences encountered by the suicide attempters. The psychological experiences which were encountered by the attempters included hopelessness, suspiciousness, worthlessness, sadness and anger.
All the attempters were attending medical and psychological treatments. Medications included anti psychotics, anti depressants and Electro Compulsive Treatment (ECT) and psychotherapy included individual, group and family counseling. As suggested by the FGDs and psychiatrists, a lot has to be done in creating awareness about suicide and related issues to prevent suicide and suicide attempts.

5.2. Conclusions

Based on the above findings and discussion of the results, the researcher drew the following conclusions:

1. Findings with regard to the major precipitant factors that led the attempters to suicide attempt revealed that:
    - Psychiatric illness was the main precipitant factor for all of the patients to attempt suicide.
    - Stressful life events, unemployment or being dependent and hereditary factors were the other related factors that precipitated the attempters' suicide attempt.

2. In this study, it was also revealed that the suicide attempters encountered different psychological experiences. Hence , it was found that:
    - Hopelessness, worthlessness, anxiousness, guilt, suspiciousness, sadness and anger were the main psychological experiences encountered by the attempters.

- The psychological experiences which were encountered by the attempters seemed to relate with the diagnosed psychiatric illnesses.

3. Regarding the kind of treatments being given for the suicide attempters in the Amanuel Mental Specialized Hospital, the findings of the study revealed that:
    - Medications were the kinds of treatments which were being given for the suicidal patients by the health professionals in the hospital.
    - Psychotherapies such as individual, group and family therapy were also being given for suicidal patients by psychologists.

4. Concerning the social intervention that should be carried out to prevent suicide attempts, the findings of the study revealed that:
    - All of the suicidal patients were brought to the Amanuel Mental Specialized Hospital after their illness got serious. This was because most of the parents, siblings or care givers believed traditional treatment was the appropriate and best treatment for the suicidal patients.

5.3. Recommendations

Based on the findings of the study and subsequent conclusions, the researcher forwarded the following recommendations.

- As the study findings indicate, suicide attempters go through deleterious psychological experiences that need to be redressed through various interventions.
    - Considering the fact that there exists only one mental health care hospital in Ethiopia, establishing mental health care facilities in all parts of the country seems very crucial. This might help individuals who have attempted suicide benefit from

psychosocial intervention services that might be extended through the mental health care facilities.

- Provided that suicide attempters use various mechanisms to end their life that might adversely affect their physiological and physical functioning, health care facilities need to extend corresponding treatments healing their inflicted harms. This might further prevent lasting consequences of the inflicted harms on individuals who attempt suicide.
- Establishing and maintaining support groups for individuals who make an initial suicide attempt is another potential approach to reduce further suicide attempts and complete suicide.
- Developing training programs for clinicians who can help patients find alternative ways of dealing with interpersonal conflicts and other stresses and thus reduce the risk of suicidal behavior.
- Encouraging family, friends and other important others of the suicide attempters to try to understand and provide sincere social support to the attempters.
- Training personnel in the villages, towns, schools and work places to recognize, treat and refer individuals with risk of suicide to appropriate mental health facilities.

➢ Although the already prevailing psychological experiences of persons who attempted suicide need to be attended to, there is a need to prevent other suicide attempt cases from occurring.

- Providing early treatment for different kinds of mental illnesses could prevent suicide attempts. And implementing a specially tailored kind of treatments for suicide attempters based on the diagnosis might be also helpful.
- Creating awareness on the issue of suicide in the general society needs to be the first step in preventing suicide attempts. To do this public mass media can play a great role.
- Providing counseling trainings for psychologists and nurses in

the hospital in order to upgrade their competence in counseling suicidal patients might also prove helpful.

- Establishing a free phone line that can be used to report about suicide attempts as well as to receive help generally about mental health and specifically about suicide and suicide attempts is necessary.

- Therefore, the researcher calls upon school curriculum developer and health service policy makers to reconsider and work on the area of teaching and creating awareness concerning mental illness generally and suicide attempt specifically and related consequences.

➢ There is a need to conduct further population based studies with regard to the psychological problems of suicide attempt and its root causes. Community based studies could help in further understanding the issue and developing new intervention strategies in alleviating the problem. Hence, the researcher kindly calls upon other researchers to further extend the present research to cover comprehensive issues related to suicide and suicide attempts.

REFERENCES

Alem, A. and Kebede, D. (1999). **"Suicide Attempts among Adults in Butajira, Ethiopia."** Acater Psychiatriaca Scandinavica, Supplementum 397:70-6.

Alem, A. and Jacobson, L. (1999). **"Awareness and Attitudes of a Rural Ethiopian Community toward Suicide behavior. A Key informant Study in Butajira, Ethiopia."** Acater Psychiatrica Scandinavica, Suppleentum 397:65-9.

American Journal of Psychiatry (2008). **Suicide warnings Signs, Symptoms, Causes, facts, Treatments and Statistics.** Retrieved from http://www.medicinenet.com/suicide/page7htm

Berman, A.L., Gobes D.A, & Silverman M.M. (2006). **Adolescent Suicide Assessment and Intervention.** Washington DC., American Psychological Association.

Briggs, S., Lemma, A. & Crouch, W. (2008). **Relating to Self-Harm and Suicide**. Psychological perspectives on practice, theory and prevention. New York, Routledge press.

Bryman, A. (2004). **Social Research Methods** (2nd ed.). Great Britain, Ashford Color Press.

Carr, A. (2002). **Depression and Attempted Suicide.** UK, The British Psychological Society and Blackwell Publishing Ltd.

Caruso, K. (2004). **Schizophrenia and Suicide.** Retrieved from http://www.suicide.org.so/index.htm/

Curran, D.K. (1987). **Adolescent Suicidal Behavior.** United State, Hemisphere Publishing Corporation.

Darlington, Y. & Scott, D. (2002). **Qualitative Research in Practice:** Stories from the Field. Philadelphia, Open University Press.

De Cantanzaro, D. (198). **Suicide and Self-Damaging Behavior:** A Sociological Preventive. London, Academic Press, INC.

De Leo, D. & Diekstra, R.F.W. (2005). **Suicide Prevention.** English, Kluwer Academic Publishers.

Duffy, D. and Ryan, T. **New Approaches to Preventing Suicide.** London, Jessica Kingsley Publishers.

Durkheim, E. (2005). **Suicide.** England, Routledge and Kegan Paul Ltd.

Fairbairn, G.F. (1995). **Contemplating Suicide:** The language and ethics of self harm. London, Routledge Ltd.

Fenton, W. (1991). **Natural history of schizophrenia subtypes**. *Archives of General Psychiatry,* 48, 969–77

Fleischmann, A., Bertolote, J.M., Wasserman, D., Dezeo, D. & Bolhari, J. (2008). **Effectiveness of Brief Interrelation and Contact for Suicidal Attempters: A randomized Controlled trial in five countries.** Bulletin of the World Health Organizations 86: 703-709.

Gall, M.D., Borg, W.R. & Gall, T.P. (1996). **Educational Research.** New York, Longman Publisher.

Giddens, A. (1971). **The Sociology of Suicide.** London, Whitefriars Press Ltd.

Goldsmith, S.K. (2001). **Suicide Prevention and Intervention.** Washington D.C, National Academy Press.

Henden, J. (2008). **Preventing Suicide.** England, John Wiley and Sons Ltd.

Jones , J.E, Herman, B.p, Barry, J.J, Gilliam, F.G & Meader K.J. (2008). **Suicide Behavior:**Rates and Risk factors for suicide, suicide, ideation, and suicide attempts in chronic epilepsy. Retrieved from http://www.neurologyreviews.com/CME/NR-Epilo.pf

Khan, M.M. (2005). Suicide Prevention and Developing Countries. London, The Royal Society of Medicine Press.

Kosky, R. J., Eshkevari, H.S. Goldney, R.D. & Hassan, R. (2002). **Suicide Prevention.** New York, Kluwer Academic/Plenum Publishers.

Lester, G. & Lester, D. (1971). **Suicide:** The gamble with death. New Jerssy, Prentice-Hall, Inc.

Lukas , C. & Seiden H.M. (2007). **Grief Living in the Wake of Suicide.** London, Jessica Kingsley Publishers.

Marder, S.R. (2001). **Schizophrenia.** Los Angeles, Retrieved from http://www.esi.opics.com/schizophrenia/interviews/Dr-StephenR-Marder.htm/

McLaughlin, C. (2007). **Suicide – Related Behavior: Understanding, caring and therapeutic responses.** England, John Wiley and Sons, Ltd.

Meador, K.J .(2008). **Suicide in Patient with Epilepsy.** Retrieved March 8, 2008 from http://www.PubmedcCentral.nih.gov/articlerender. fcg i ? artid=2265807

Medical Encyclopedia (2008). **Electro Compulsive Therapy.** Retrieved from http://medlineptus.gov/

Merriam, S.B. (1988). **Case Study Research in Education:** A Qualitative Approach. San Francisco, Jossey Bass Publisher.

Nardezzii, L., Burkins, J.A., Henschen, G., Frampton, K.K., & Stock, T.T. (2008). **Magellan Clinical Practice Guideline for Assessing and Managing the Suicide Patient.** Magellan Health Services.

Nowack, M.K. (2008). **Suicide and Suicidal Behavior.** Johns Hopkins Blooming School of Public Health, Retrieved from http://epirev.oxfordjournals.org/cgi/content/abstract/30/1/133.

Pampili, M., Amador, T.X., Girardi, P., Friedman H.J.,& Herrow, M. (2007). **Suicide Risk in Schizophrenia:** Learning from the past to change the future. Rome, Biomed Central Ltd.

Peter, E.(1994) **Qualitative Methods in Psychology:** A Research Guide. Great Britain, Biddles Ltd, Guilford and Ging's Lynn.

Rosman, G.B., &Rallis, S.F. (2003). **An Introduction to Qualitative Research**: Learning in the field. English, Sage Publication.

Salomon, R.M.D (2007). **Psychological Disorder:** Suicide. New York, An Imprint of Infobase Publishing.

Simon, R.I. Sibert E.H. (2006). **The American Psychiatric Publishing Text book of Suicide Assessment and Management.** Arlington, American Psychiatric Publishing. Inc.

Solomon, T. (2009). **Mental Health:** Depression. Addis Neger,077,17. Addis Ababa, Birehanina Selam Printing Press.

Solomon, T. (2009). **Mental Health:** Schizophrenia. Addis Neger,082,17. Addis Ababa, Birihanina Selam Printing Press. (No. 082)

Spirito , A. & Overholser, J.C. (2003). **Evaluating and Treating Adolescent Suicide Attempters: From research to practice.** California, Elsevies Science Academic Press.

Stone, G. (2007). **Suicide and Attempted Suicide:** Suicide Risk in Schizophrenia. New York, Retrieved from http://www.annals.general-psychiatry.com/content/6/1/10/

WHO (2005). **Preventing Suicide:** A Resource for Teachers and Other School Staff. Geneva,Mental and Behavioral Disorders Department of Mental Health.

Wikipidia (2008). Suicide. Retrieved from http://en.wikipidia.org/wiki/suicide

Wilson, A. (2009). **Unemployment can triple the Risk of Suicide:** A Bad Economy Increases the Number of Suicides. Relived from http://www.suite 10/.com

Yufit, R.I. & Lester, D. (2005). **Assessment, Treatment, and Prevention of Suicidal Behavior**. New Jersey, John Wiley and Sans. Inc.

APPENDICES

APPENDIX A

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

Interview Guide for Suicide Attempters

The following interview guide is prepared for a study conducted by a graduate study in Counseling Psychology. The study's main purpose is investigating causes and psychological experiences of people who have attempted suicide. The study also explores the kind of treatment being given to suicide attempters and some suggestions on social intervention that should be employed to prevent suicide attempt. Your information will be of great help for the accomplishment of the study. The confidentiality of your responses is highly assured. Great thanks in advance for your cooperation.

1. General information

- Age -----------------------
- Sex-----------------------
- Level of education------------
- Marital status-------------No of children-----------
- Region you came from-----------

2. History before the attempt

- Child hood behavior
- Quality of relationship with family and friends
- Medical illness
- History of mental illness
- Psychological disturbance (depression, hopelessness, etc)
- Alcohol and substance use in the family and yourself
- Previous suicide attempt in the family and yourself
- Previous treatment for medical or psychological illness

3.During and after the attempt

- Reasons for the attempt
- Place of the attempt took place
- Method used to attempt the suicide
- Number of the attempt

4.Treatment

- Medical and psychological treatment

APPENDIX B

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

Interview Guide for Important Others of the Suicide Attempters about the Attempters

The following interview guide is prepared for a study conducted by a graduate study in Counseling Psychology. The study's main purpose is investigating causes and psychological experiences of people who have attempted suicide. The study also explores the kind of treatment being given to suicide attempters and some suggestions on social interventions that should be employed to prevent suicide attempt. Your information will be of great help for the accomplishment of the study. The confidentiality of your responses is highly assured. Great thanks in advance for your cooperation.

1. **General information**
    - Age -----------------------
    - Sex-----------------------
    - occupation------------
    - Marital status----------
    - No of children-----------
    - Region you came from (Address) -----------
    - Relation with the attempter------------

2. **History before the attempt**

- Child hood behavior
- Quality of relationship with family and friends
- Medical illness
- History of mental illness
- Psychological disturbance (depression, hopelessness, etc)
- Alcohol and substance use in the family and yourself
- Previous suicide attempt in the family and yourself
- Previous treatment for medical or psychological illness

3. **During and after the attempt**

- Observed reasons for the attempt
- Place of the attempt took place
- Method used to attempt the suicide
- Number of the attempt

4. **Treatment**

- What kind of medical and psychological treatments are being given for the attempter?
- Is there any counseling service in the hospital for the suicide attempters?
    - ➢ If yes, do you think it is satisfactory?

APPENDIX C

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

Interview Guide for the Health Care Professionals in Amanuel Hospital

The following interview guide is prepared for a study conducted by a graduate study in Counseling Psychology. The study's main purpose is investigating causes and psychological experiences of people who have attempted suicide. The study also explores the kind of treatment being given to suicide attempters and some suggestions on social interventions that should be employed to prevent suicide attempt. Your information will be of great help for the accomplishment of the study. The confidentiality of your responses is highly assured. Great thanks in advance for your cooperation.

1. **Background Information**
   - Age -------------------
   - Sex -------------------
   - Specialization-------------------
   - Experience -------------------

2. **About the suicide attempter**

   - What is the main cause of his/her suicide attempt?
   - What kind of psychological experiences are observed on the attempter?

3. **Treatment**

- What kind of medical and Psychological treatments are being given for the attempter?

4. **About psychological treatment service in Amanuel hospital**

- What kind of psychological treatments are being rendered in the hospital for suicide attempters?
- Do you think the service is satisfactory?

5. **Psychosocial intervention**

- What kind of social support do suicide attempters need?

APPENDIX D

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF PSYCHOLOGY

Focus Group Discussion Guide

The following interview guide is prepared for a study conducted by a graduate study in Counseling Psychology. The study's main purpose is investigating causes and psychological experiences of people who have attempted suicide. The study also explores the kind of treatment being given to suicide attempters and some suggestions on social interventions that should be employed to prevent suicide attempt. Your information will be of great help for the accomplishment of the study. The confidentiality of your responses is highly assured. Great thanks in advance for your cooperation.

1. General Information

- Age --------------------------
- Specialization--------------------
- Experience------------------------

2. Questions about the patient

- What do you think the cause of his/her suicide attempt?
- What kind of psychological experiences did the attempter encountered?

3. Questions about treatments in the hospital

- What kinds of treatments are made available for the suicidal patients in the hospital?
- Is there any counseling service for suicidal patients and their parents and/or care givers?
- If yes, Who is responsible for administering the service in the hospital?

4. Questions about social intervention that should be employed to prevent suicide and suicide attempt.

- What do you think must be done to prevent suicide and suicide attempt?

APPENDIX E

በአዲስ አበባ ዩኒቨርሲቲ

በድህረ ምረቃ ትምህርት ቤት

የሳይኮሎጂ ትምህርት ክፍል

እራሳቸውን ለማጥፋት ለሞከሩ

የዚህ ጥናት ዋና አላማ ለጥናቱ የተመረጡ ሰዎች ለምን ራሳቸውን ለማጥፋት ሙከራ እንዳደረጉና ምን አይነት የስነልቦና ችግር እንደገጠማቸው መፈተሽ ነው። ከዚህ ጥናት የሚገኘው መረጃ ችግሩን ለመቀነስ በሚደረገው ጥረት ላይ ከፍተኛ አስተዋጽኦ ይኖረዋል። ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዝና ለጥናቱ አላማ ብቻ የሚውል ነው። የርስዎም ግልፅ የሆነ መልስ የጥናቱን አላማ ከግብ ለማድረስ ከፍተኛ ጠቀሜ አለው።

1. አጠቃላይ መረጃ
    - እድሜ ------------
    - ፆታ --------
    - የትምህርት ደረጃ -------
    - የጋብቻ ሁኔታ (ያገባ ወይም ያላገባ) -------
    - የልጆች ብዛት -----------
2. ራሱን /ሷን ለማጥፋት ሙከራ ያደረገው ሰው ታሪክ
    - የልጅነት ፀባይ (አስተዳደግ)
    - ከቤተሰብና ጓደኛ ጋር ያለው ግንኙነት (ሁኔታ)
    - ህመም / በሽ
    - የአእምሮ መረበሽ (ድብርት ፤ተስፋቢስነት፤ የመሳሰሉት)
    - የራስና የበቴሰብ የአልኮል መጠጥ አወሳሰድ
    - ከቤተሰብ አባል ውስጥ ወይም በራስ ላይ ከዚህ በፊት የተደረገ ራስን የማጥፋት ሙከራ ካለ
    - ከዚህ ቀደም ለአእምሮ ህመም ወይም ለሌላ የህክምና አገልግሎት ተጠቅመው ያውቃሉ?
3. ራስን ለማጥፋት ሙከራ በተደረገበትና ከዚያ በኋላ ስላለው ሁኔታ
    - ድርጊቱ የተፈፀመበት ቦታ
    - ድርጊቱ የተፈፀመበት መንገድ ወይም መሳሪያ
    - ድርጊቱ ለምን ያህል ጊዜ እንደተደጋገመ
    - ለድርጊቱ መፈፀም ምክንያት የሆኑ ነገሮች
4. ራሳቸውን ለማጥፋት ለሞከሩ ሰዎች የሚሰጥ የህክምና እርዳታ
    - የመድሀኒትና የስነልቦና ህክምና

APPENDIX F

በአዲስ አበባ ዩኒቨርሲቲ

በድህረ ምረቃ ትምህርት ቤት

የሳይኮሎጂ ትምህርት ክፍል

ለ ወላጆች / ለተንከባካቢዎች

የዚህ ጥናት ዋና አላማ ለጥናቱ የተመረጡ ሰዎች ለምን ራሳቸውን ለማጥፋት ሙከራ እንዳደረጉና ምን አይነት የስነልቦና ችግር እንደገጠማቸው መፈተሽ ነው። ከዚህ ጥናት የሚገኘው መረጃ ችግሩን ለመቀነስ በሚደረገው ጥረት ላይ ከፍተኛ አስተዋጽኦ ይኖረዋል። ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዝና ለጥናቱ አላማ ብቻ የሚውል ነው። የርስዎም ግልፅ የሆነ መልስ የጥናቱን አላማ ከግብ ለማድረስ ከፍተኛ ጠቀሜታ አለው።

1. አጠቃላይ መረጃ
    - እድሜ ----------
    - ፆታ ------
    - የሚሰሩበት ሙያ ------
    - የጋብቻ ሁኔታ -------
    - የልጆች ብዛት --------
    - አድራሻ (ክልል) --------
    - ራሱን ለማጥፋት ሙከራ ካደረገው ሰው ጋር ያለው ቅርበት ------
2. ራሱን /ሷን ለማጥፋት ሙከራ ስላደረገው ሰው ታሪክ
    - የልጅነት ፀባይ (አስተዳደግ)
    - ከቤተሰብና ጓደኛ ጋር ያለው ግንኙነት (ሁነታ)
    - ህመም / በሽታ
    - የአእምሮ መረበሽ (ድብርት ፣ተስፋቢስነት፣ የመሳሰሉት)
    - የራስና የበቴሰብ የአልኮል መጠጥ አወሳሰድ
    - ከቤተሰብ አባል ውስጥ ወይም በራስ ላይ ከዚህ በፊት የተደረገ ራስን የማጥፋት ሙከራ ካለ
    - ከዚህ ቀደም ለአእምሮ ህመም ወይም ለሌላ ህክምና አገልግሎት ተጠቅመው ያውቃሉ?

3. ራሳቸውን ለማጥፋት ሙከራ ላደረጉ ሰዎች የሚሰጥ የህክምና ዕርዳታ
    - ምን አይነት የመድሀኒትና የስነ ልቦና ዕርዳ ይሰጣል?
    - ራሳቸውን ለማጥፋት ለሞከሩ ሰዎች የሚሰጥ የምክር አገልግሎት በሆስፒታሉ ውስጥ አለ ወይ?
    - ካለ አጥጋቢ ነው ይላሉ?

4. ራሳቸውን ለማጥፋት ለሞከሩ ሰዎች የሚሰጥ የህክምና እርዳታ
    - የመድሀኒትና የስነ ልቦና ህክምና

APPENDIX G

በአዲስ አበባ ዩኒቨርሲቲ

በድህረ ምረቃ ትምህርት ቤት

የሳይኮሎጂ ትምህርት ክፍል

ለ ጤና ባለሙያዎች

የዚህ ጥናት ዋና አላማ ለጥናቱ የተመረጡ ሰዎች ለምን ራሳቸውን ለማጥፋት ሙከራ እንዳደረጉና ምን አይነት የስነልቦና ችግር እንደገጠማቸው መፈተሽ ነው። ከዚህ ጥናት የሚገኘው መረጃ ችግሩን ለመቀነስ በሚደረገው ጥረት ላይ ከፍተኛ አስተዋጽኦ ይኖረዋል። ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዝና ለጥናቱ አላማ ብቻ የሚውል ነው። የርስዎም ግልፅ የሆነ መልስ የጥናቱን አላማ ከግብ ለማድረስ ከፍተኛ ጠቀሜ አለው።

1. አጠቃላይ መረጃ
    - ዕድሜ ------
    - ፆታ ------
    - የሚሰሩበት ሙያ ---
    - በሙያው ያገለገሉበት ዕድሜ ----

2. ራሱን ለማጥፋት ስለሞከረው ሰው
    - ራሱን ለማጥፋት የሞከረበት ዋነኛ ምክንያት ምንድነው?
    - ራሱን ለማጥፋት ከሞከረ በኋላ ምን አይነት ስነልቦናዊ ችግሮች ታይተዋል?

3. ሕክምና
    - ራሱን ለማጥፋት ሙከራ ላደረገ ሰው ምን አይነት ህክምና ይሰጣል?

4. የስነልቦና ህክምና አገልግሎት በአሙኑኤል ሆስፒታል
    - ራሱን ለማጥፋት ለሞከረ ሰው የሚሰጠው የካውንስሊንግ ወይም የስነልቦና ህክምና ምን ይመስላል?
    - ሕክምናው አጥጋቢ ነው ይላሉ?

5. ሰዎች ራሳቸውን እንዳያጠፉና ለማጥፋት እንዳይሞክሩ ምን አይነት ማህበራዊ ድጋፍ ያስፈልጋቸዋል?

APPENDIX I

በአዲስ አበባ ዩኒቨርሲቲ

በድህረ ምረቃ ትምህርት ቤት

የሳይኮሎጂ ትምህርት ክፍል

ለቡድን ተወያዩች

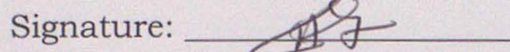
የዚህ ጥናት ዋና አላማ ለጥናቱ የተመረጡ ሰዎች ለምን ራሳቸውን ለማጥፋት ሙከራ እንዳደረጉና ምን አይነት የስነልቦና ችግር እንደገጠማቸው መፈተሽ ነው፡፡ ከዚህ ጥናት የሚገኘው መረጃ ችግሩን ለመቀነስ በሚደረገው ጥረት ላይ ከፍተኛ አስተዋጽኦ ይኖረዋል፡፡ ለጥያቄዎቹ የሚሰጡት መልስ በሚስጥር የሚያዝና ለጥናቱ አላማ ብቻ የሚውል ነው፡፡ የርስዎም ግልፅ የሆነ መልስ የጥናቱን አላማ ከግብ ለማድረስ ከፍተኛ ጠቀሜ አለው፡፡

1. አጠቃላይ መረጃ
   - እድሜ ------
   - የሚሰሩበት ሙያ ----
   - ያገለገሉበት ዕድሜ (የስራ ልምድ) -----------
2. ስለ ህመምተኛው
   - ራሱን ለማጥፋት ሙከራ ያደረገበት ምክንያት ምንድነው ይላሉ?
   - ራሱን ለማጥፋት ሙከራ ካደረገ በኋላ ምን አይነት የስነ ልቦና ችግሮች ደርሰውበታል ወይም ታይቶበታል?
3. ሕክምና
   - ራሱን ለማጥፋት ሙከራ ላደረገ ሰው ምን አይነት ህክምና ይሰጣል?
4. በሆስፖታሉ ውስጥ ስለሚሰጥ የህክምና አገልግሎት
   - ራሳቸውን ለማጥፋት ሙከራ አድርገው ለመጡ ሰዎች ሆስፒታሉ ምን አይነት ርዳታ ደርጋል?
   - በሆስፒታሉ ውሰጥ የካውንስሊንግ (የምክር አገልግሎት) ለህመምተኞችና ለቤተሰቦቻቸው ወይም ለተንከባካቢዎች ይሰጣል ?
   - አዎን ይሰጣል ካሉ አገልግሎቱ የሚሰጠው በማን ነው?
5. ሰዎች ራሳቸውን ለማጥፋት ሙከራ እንዳያደርጉ ምን አይነት ማህበራዊ ድጋፍ ያስፈልጋቸዋል?

Declaration

I the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used have been duly acknowledged.

Name: Hewan Mulugeta

Signature: 

Date: June 12 2009

This thesis has been submitted for examination with my approval as a university advisor.

Name: ______________________

Signature: ___________________

Date of Approval: _____________

ቁጥር: ክማ/168/5/372
ቀን: 8-8-01

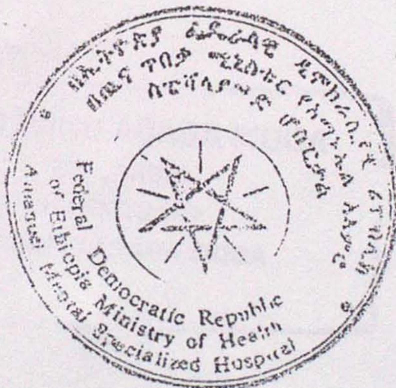
የኢትዮጵያ ፌዴራላዊ ዲሞክራሲያዊ ሪፐብሊክ
Federal Democratic Republic of Ethiopia
Ministry of Health
Amanuel Mental
Specialized Hospital

ለወ/ት ሔዋን ሙሉጌታ
አዲስ አበባ ዩኒቨርሲቲ
ሣይኮሎጂ ክፍል
አዲስ አበባ፤

በሆስፒታላችን ጥናታዊ ምርምር ለማካሄድ እንዲችሉ ማመልከትዎ ይታወሣል::

የሆስፒታሉ የጥናትና ኤትካል ኮሚቴ በ8/8/2001 ዓ.ም ተሰብስቦ ያቀረቡትን ማስረጃዎች ከመረመረ በኋላ በጥናቱ ይዘት ላይ ምንም ዓይነት የኤቲክስ ችግር አላገኘበትም::

ስለዚህ በሆስፖታሉ የመመረቂያ ጥናታዊ ምርምር እንዲያደርጉ የተፈቀደልዎ መሆኑን እገልፃለሁ::



ከሰላምታ ጋር::

ዶ/ር ተስፋል ተገኝ
የኤትካል ኮሚቴ ሰብሳቢ

ግልባጭ፤
ለኤትካል ኮሚቴ ጽ/ቤት
አማ/የአእ/ስፔ/ሆ/ል::