Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness- A Cross Sectional Study

By

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This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

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Statement of Authorship

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This thesis has not been submitted for any other degree at any other tertiary institution. All ethical issues related to this study have been strictly maintained and protected. If the findings of this research are disseminated in the future for publication, the research supervisor will be appropriately involved and acknowledged, and the thesis will be acknowledged as an undergraduate thesis.

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Dedication

I have dedicated my research to the Almighty Allah, my family members and all the teachers of BHPI who have supported me throughout my academic journey.

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List of Abbreviations

BHPI	Bangladesh Health Professions Institute
CRP	Centre for the Rehabilitation of the Paralysed
CDC	Centers for Disease Control & Prevention
CI	Confidence Interval
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
IRB	Institutional Review Board
ICD	International Classification of Diseases
NIMH	National Institute of Mental Health and Hospital
OPD	Outpatient Department
OCD	Obsessive-Compulsive Disorder
RDM	Research Data Management
SIS	Suicide Intent Scale
SPSS	Statistical Package for Social Science
SBQ-R	Suicide Behaviors Questionnaire-Revised
SD	Standard Deviation
WHO	World Health Organization

Abstract

Background: Suicide is a major public health concern worldwide and is closely related to mental illness. In Bangladesh, suicidal thoughts and attempts are common among people with psychiatric disorders. However, limited research evidence is available regarding the level of suicidal tendency and associated behavioral and situational factors among patients with mental illness. Identifying these factors is necessary to reduce suicidal risk and improve mental health services.

Aim: To determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness.

Methods: This was a quantitative cross-sectional study conducted among 130 patients with mental illness. Data were collected through face-to-face interviews using a socio-demographic and the Suicide Intent Scale (SIS). Data were analyzed in SPSS (version 20) using descriptive statistics. The Chi-square test was used to examine associations between suicidal tendency and related factors, and Fisher's exact test was used when the expected cell count was less than 5. Ordinal logistic regression was used to identify the independent factors associated with suicidal tendency.

Results: The mean age of the participants was 24.24 ± 8.72 years. The majority were female (62.3%), unmarried (54.6%), and belonged to the middle-income group (96.9%). Schizophrenia was the most common diagnosis (36.2%), followed by bipolar I disorder (15.4%) and bipolar affective disorder (13.1%). The median Suicide Intent Scale (SIS) score was 13.5 (range: 4-25). Most participants were categorized as having medium suicidal risk (66.9%), followed by low risk (20.8%) and high risk (12.3%).

Among behavioral factors, history of substance use was significantly associated with suicidal tendency (P = 0.013). In ordinal logistic regression analysis, history of substance use remained an independent predictor of higher suicidal risk (B = 1.954, P = 0.010; 95% CI: 0.473–3.435). Among situational factors, monthly family income was significantly associated with suicidal tendency in regression analysis (B = –2.258, P = 0.030; 95% CI: –4.298 to –0.219), indicating that participants from non-middle income groups were more likely to have higher suicidal risk. Other behavioral and situational variables were not statistically significant.

Conclusion: This study shows that most patients with mental illness had a moderate level of suicidal tendency. History of substance use was an important associated factor. These findings show that regular suicide risk screening and checking substance use history can help to prevent suicide among patients with mental illness.

Keywords: Suicide intent scale, Suicidal tendency, Mental illness, Substance use, Risk factors, Bangladesh.

CHAPTER I: INTRODUCTION

1.1 Background

Suicide is one of the leading causes of death worldwide and is a major public health concern. According to the WHO, the global age-standardized suicide rate in 2021 was about 8.9 per 100,000 population, showing clear regional and socio-demographic variation (World Health Organization, 2025). In the United States, suicide is the second major cause of death among individuals aged 10–34 years (Centers for Disease Control and Prevention [CDC], 2025).

Globally, psychiatric disorders contribute to the majority of suicide deaths, and mood and psychotic disorders are commonly recognized as key risk factors (Khoso et al., 2023). Conditions such as major depressive disorder, bipolar disorder, schizophrenia, and obsessive-compulsive disorder are often related to suicidal ideation and attempts in psychiatric samples (Siddique et al., 2022).

A South Asian meta-analysis reported that suicidal attempts are common in severe mental illnesses, including psychosis and bipolar disorder, indicating a particularly high burden in low- and middle-income settings (Khoso et al., 2023). Bangladesh, with a population of more than 167 million, is no exception to this crisis (Mamun et al., 2022). Rural community data from Bangladesh report that 33.1% of participants reported lifetime suicidal ideation, 5.5% reported having made a suicide plan, and 1.8% reported a lifetime suicide attempt (Mamun et al., 2022). Hospital-based research at the National Institute of Mental Health (NIMH), Dhaka, showed that suicidal attempts among psychiatric patients often involved strong intent to die and repeated attempts (Parveen et al., 2020). A Bangladeshi OCD clinic study reported a

significant proportion of patients experiencing suicidal ideation, indicating that suicidality is also relevant in anxiety-related disorders (Siddique et al., 2022). Evidence from Ethiopia also reports high level of suicidal ideation and attempts among psychiatric patients (Mohammed et al., 2024). Another Ethiopian clinical study reported a high level of suicidal behavior that was strongly associated with major depressive disorder and bipolar disorder (Dereje et al., 2024).

Socio-demographic and situational factors contribute meaningfully to suicidal tendency in clinical contexts (Roy et al., 2020). Bangladeshi studies report that young adults, women, unmarried or divorced individuals, nuclear-family backgrounds, and lower socioeconomic groups are disproportionately vulnerable (Roy et al., 2023). South Asian clinical studies similarly associate demographic and contextual pressures to suicidal tendency in psychiatric samples (Madhavan et al., 2021). Availability to harmful means such as pesticides and household medicines may increases impulsive attempts in these settings (Vincent et al., 2019).

In summary, evidence from global, regional, and Bangladeshi studies highlights that suicide is a complex phenomenon with strong psychiatric, behavioral, and situational influences (Khoso et al., 2023). Therefore, assessing the level of suicidal tendency and identifying associated factors among psychiatric patients in Bangladesh is an important step for targeted interventions and effective prevention planning (Parveen et al., 2020).

1.2 Justification of the study

In Bangladesh, suicidal tendency among patients with mental illness is becoming an important concern. However, there is still limited local evidence to properly assess the severity of suicidal tendency in psychiatric settings. Studies from hospitals in Bangladesh show that many patients who attempt suicide have underlying mental illness, which highlights the strong connection between mental illness and suicidal behavior (Roy et al., 2020). Research from NIMH also shows that suicidal thoughts, intent, and repeated attempts are common among psychiatric patients (Parveen et al., 2020). Other studies suggest that many suicide attempts are impulsive and happen due to specific life stressors (Roy et al., 2023).

During my clinical placement at NIMH as an occupational therapy student, I observed that many patients with mental illness reported suicidal thoughts or past attempts. These were often related to family problems, financial stress, and difficulties in managing daily life. I also noticed that although suicidal risk is recognized, the level of suicidal tendency is not regularly assessed in a structured way, and different related factors are not always considered together.

Although some studies have been done in Bangladesh, most of them focus on specific aspects of suicidality rather than giving a complete picture. There is still a lack of research that looks at the level of suicidal tendency along with behavioral and situational factors together (Roy et al., 2020). Because of this, mental health professionals have limited guidance in identifying whether a patient's suicidal tendency is low, medium, or high (Parveen et al., 2020).

Therefore, this study aims to assess the level of suicidal tendency among patients with mental illness and identify the related behavioral and situational factors. The findings will help improve understanding and support better assessment and

management in psychiatric care. It will also help occupational therapists develop more effective interventions to support patients in managing stress and improving daily functioning.

1.3 Operational Definition

1.3.1 Suicide

Suicide means a fatal self-injurious act carried out with the intention to end one's own life (CM et al., 2024).

1.3.2 Suicidal Tendency

Suicidal tendency refers to a continuum of suicidal thoughts and behaviors that may include suicidal ideation, suicidal planning, and suicidal attempts, assessed as lifetime or recent occurrence (Islam et al., 2019).

1.3.3 Suicide attempt

A suicide attempt is a non-fatal, self-directed injurious act carried out with at least some intent to die. The behavior does not result in death, but the individual's purpose is to end their life (Centers for Disease Control and Prevention [CDC], 2025)

1.4 Aim of the study

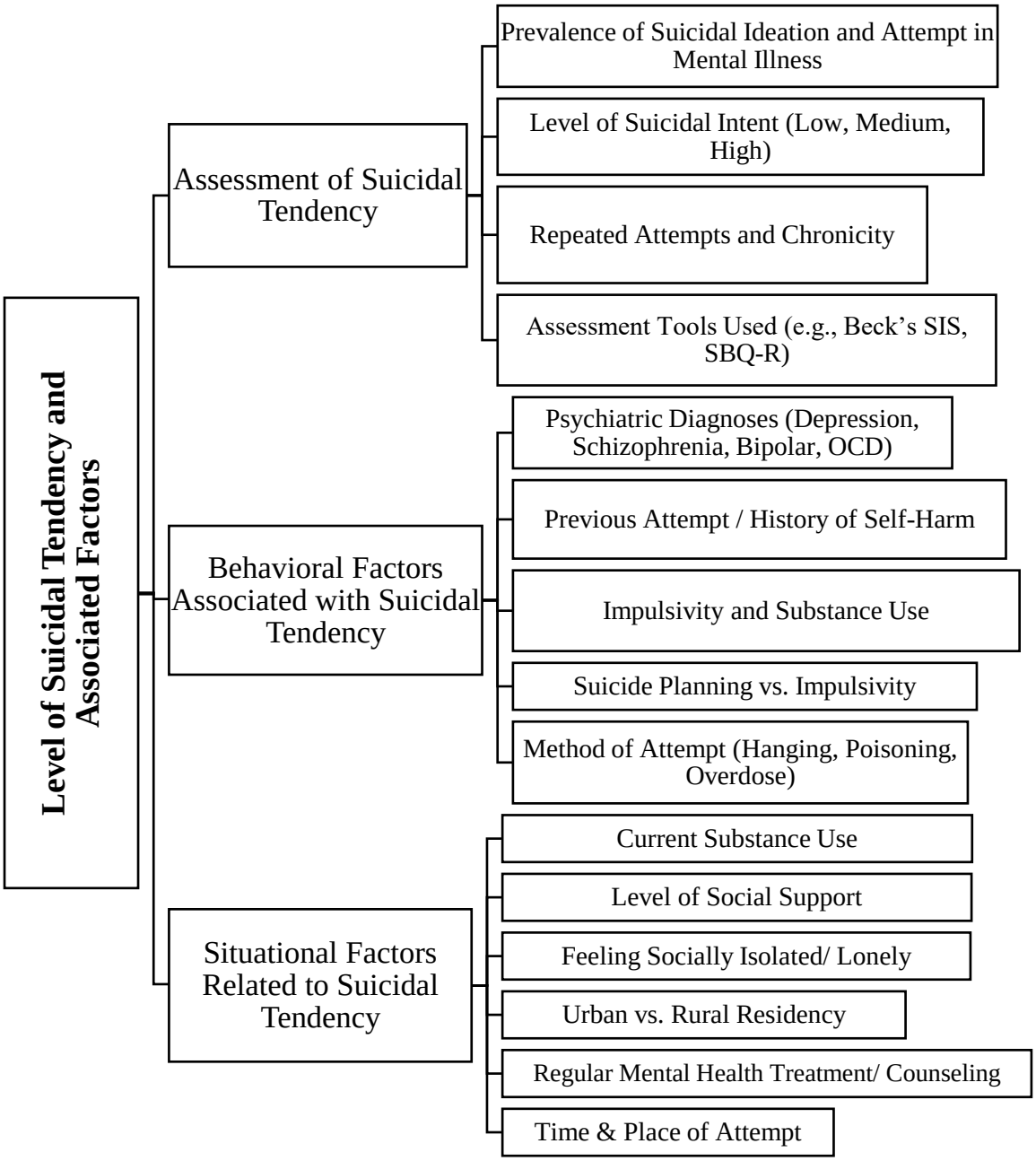
To determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness.

CHAPTER II: LITERATURE REVIEW

This chapter summarizes evidence on the level of suicidal tendency and its associated factors among patients with mental illness. It includes information about suicidal thoughts, suicide attempts, and how serious these thoughts and behaviors can be. It also explains repeated attempts and the tools used to measure suicidal behavior. The chapter describes different behavioral factors such as types of mental illness, previous history of self-harm or suicide attempts, impulsive behavior, and substance use. It also explains whether suicide attempts are planned or happen suddenly, and what methods are commonly used. In addition, this chapter looks at situational factors like current substance use, level of social support, feelings of loneliness, place of residence (urban or rural), regular mental health treatment, and the usual time and place where suicide attempts occur.

Figure 2.1

Overview of the literature findings



2.1. Assessment of Suicidal Tendency

2.1.1. Prevalence of Suicidal Ideation and Attempt in Mental Illness

Suicidal ideation and suicide attempts are most common incident among patients with mental illness. Many studies have shown that psychiatric patients often experience suicidal thoughts, and some of them even try to harm themselves. A study conducted in Ethiopia found that a notable number of psychiatric patients had suicidal behavior. About 24.4% reported having suicidal thoughts at some point in their life. Among them, 20.4% had made plans, and 16.9% had attempted suicide. This shows that suicidal thoughts can gradually develop into more serious actions (Dereje et al., 2024). Similarly, a study from Finland among patients with major depressive disorder found that 58% of the participants had suicidal thoughts during their current illness, while around 15% had attempted suicide. This indicates that depression has a strong link with suicidal behavior (Sokero et al., 2003).

Another study conducted in a psychiatric outpatient department in Addis Ababa reported that 66.2% of patients had suicidal ideation. This suggests that suicidal thoughts are very common among people who are receiving mental health care (Mohammed et al., 2024). In Bangladesh, a study conducted among psychiatric patients in a tertiary care hospital found that 32.5% of patients had lifetime suicidal ideation. The same study also reported that 14% had made suicide plans and 7.4% had attempted suicide. This finding is important as it reflects the situation in a similar clinical setting (Qusar et al., 2022).

In addition, a systematic review and meta-analysis conducted in South Asia reported that 38% of individuals with psychosis and bipolar disorder had suicidal thoughts, and 22% had attempted suicide. This shows that suicidal behavior is a significant issue in psychiatric populations across the region (Koly et al., 2024).

Overall, these studies show that suicidal ideation is quite common among people with mental illness. Although not everyone attempts suicide, a considerable number of patients move from thoughts to actions. Therefore, it is important to assess suicidal tendency among psychiatric patients, which supports the need for the present study.

2.1.2. Level of Suicidal Intent (Low, Medium, High)

Only knowing whether a person has suicidal thoughts is not enough. It is also important to understand how strong those thoughts are. This is called suicidal intent. It shows how seriously a person is thinking about suicide and how much planning is involved. Studies show that suicidal intent can be divided into different levels such as low, medium, and high. This helps to understand how serious the situation is and which patients are at higher risk.

A study conducted among young adults who had attempted suicide in a tertiary care suicide prevention clinic in Kerala measured suicidal intent using Beck's Suicidal Intent Scale. The results showed that 31.2% of patients had low intent, 44.4% had medium intent, and 24.4% had high intent. This means that a large number of patients fall into the medium to high intent group, which indicates a higher level of risk (Madhavan et al., 2021). The study also used standard score ranges of the scale to classify these levels. This shows that suicidal intent can be measured in a structured and reliable way. It also makes it easier to compare patients and identify those who need more attention.

2.1.3. Repeated Attempts and Chronicity

Repeated suicide attempts are considered an important sign of long-term or ongoing suicidal tendency. It shows that the problem is not limited to a single event but may continue over time. A study conducted in a psychiatric clinic in Ethiopia found that some patients had attempted suicide more than once. This indicates that repeated

attempts are present in a noticeable number of psychiatric patients and should be taken seriously (Dereje et al., 2024).

Similar findings have also been reported in Bangladesh. A clinical study found that the average number of suicide attempts among patients was 2.63 (±2.84). This suggests that many patients attempt suicide multiple times, and over time, this behavior can become repeated or patterned (Parveen et al., 2020). Other clinical evidence also supports this pattern. Studies on patients with depression show that suicidal thoughts often come first, and later some patients move toward actual attempts. In more severe cases, these behaviors may continue or come back again, showing a repeated cycle of suicidal tendency (Sokero et al., 2003). In addition, research focusing on patients with severe mental illness such as psychosis and bipolar disorder shows that these individuals are at higher risk of repeated suicidal behavior over time, indicating the chronic nature of suicidality in psychiatric populations (Khoso et al., 2023).

2.1.4. Assessment Tools Used

Using proper tools is very important to measure suicidal tendency correctly. Without reliable tools, it is difficult to understand whether a patient has suicidal thoughts, how serious those thoughts are, and whether there is any risk of attempt. One commonly used tool is the Suicide Behaviors Questionnaire-Revised (SBQ-R). This tool is often used in psychiatric outpatient settings to assess suicidal behavior. It includes questions about lifetime suicidal thoughts and attempts, recent frequency of suicidal thinking, communication about suicide, and future risk. For example, a study conducted among psychiatry outpatient patients in Addis Ababa used SBQ-R items to assess suicidal ideation and attempts (Mohammed et al., 2024). Another study in Ethiopia also used

SBQ-R to measure different aspects of suicidal behavior, including ideation, intent, and attempts over different time periods (Dereje et al., 2024).

For patients with depression, another tool called the Scale for Suicidal Ideation (SSI) is commonly used. This is a structured scale where the clinician evaluates the patient. It helps to measure how strong the suicidal thoughts are, including the wish to die, level of planning, and seriousness of intent. It also has specific score ranges that help identify clinically important suicidal ideation (Sokero et al., 2003).

In patients who have already attempted suicide, Beck's Suicidal Intent Scale (SIS) is widely used. This tool helps to understand how serious the suicide attempt was. Based on the score, patients can be classified into low, medium, and high intent groups. A study among suicide attempters used this scale to categorize the level of suicidal intent, which helps identify high-risk individuals (Madhavan et al., 2021).

2.2. Behavioral Factors Associated with Suicidal Tendency

2.2.1. Psychiatric Diagnoses (Depression, Schizophrenia, Bipolar Disorder, OCD)

Mental illness itself is one of the most important factors related to suicidal tendency. Different types of psychiatric disorders are linked with higher risk of suicidal thoughts and behaviors. Among these, mood disorders like depression and bipolar disorder are strongly associated with suicidality. A study conducted in a psychiatric clinic in Ethiopia found that patients with depression and bipolar disorder had a higher chance of showing suicidal behavior compared to other mental illnesses. This may be because these conditions are often linked with feelings of hopelessness, emotional instability, and loss of interest in life (Dereje et al., 2024).

Similarly, studies on major depressive disorder show that suicidal thoughts and attempts are closely related to the severity of depression. Patients who feel more

psychological pain or distress are more likely to think about or attempt suicide (Sokero et al., 2003).

Research from South Asia also shows that people with serious mental illnesses such as psychosis and bipolar disorder have a high level of suicidal ideation and a history of suicide attempts. This means that suicidal tendency is not limited to depression only, but is also common in other severe psychiatric conditions (Khoso et al., 2023).

In addition, obsessive-compulsive disorder (OCD) has also been linked with suicidal ideation. A study conducted in Bangladesh among OCD patients found that about 30% of patients had suicidal thoughts within the two days before the interview. The study also showed that female patients reported more suicidal ideation than males. This finding suggests that even disorders like OCD, which are often considered anxiety-related, can have a significant risk of suicidality (Siddique et al., 2022).

2.2.2. Previous Attempt / History of Self-Harm

A previous history of suicide attempt or self-harm is considered one of the strongest indicators of suicidal tendency. Patients who have attempted suicide before are more likely to repeat such behavior in the future. A study conducted in Bangladesh among patients admitted after a suicide attempt found that most of them were first-time attempters. However, about 18% had a history of previous attempts, and some of them had attempted more than once. This shows that repeated suicidal behavior exists in a significant number of patients and should not be ignored (Roy et al., 2020). This pattern suggests that once a person attempts suicide, it may reduce their fear or hesitation about repeating the act. As a result, the risk of future attempts becomes higher.

Similar findings have also been reported in psychiatric clinical settings. Studies show that a history of previous suicide attempts is one of the most important predictors of future suicidal behavior. It is often used by clinicians to identify patients who are at higher risk and may need closer monitoring (Dereje et al., 2024).

2.2.3. Impulsivity and Substance Use

Impulsivity is an important behavioral factor related to suicidal tendency. It means acting quickly without thinking much. People who are impulsive may take sudden decisions, especially during emotional stress, which can increase the risk of suicidal behavior. A study conducted in India found that impulsivity was common among people who attempted suicide. The study also showed an interesting finding: people with lower suicidal intent were more impulsive, meaning their attempts were more sudden and unplanned. On the other hand, those with high suicidal intent were less impulsive and their actions were more planned (Gade et al., 2018). This suggests that impulsivity can lead to quick, crisis-driven suicide attempts.

Substance use, especially alcohol, is another important factor. It can increase the risk of suicidal behavior by affecting a person's thinking and judgment. A study conducted in Ethiopia found that patients who used alcohol had a higher chance of showing suicidal behavior. Alcohol use can increase emotional instability and reduce self-control, which may lead to harmful actions (Dereje et al., 2024). Studies on depression also support this finding. Substance misuse is often linked with higher risk of suicide attempts, especially when the person is already experiencing severe depressive symptoms (Sokero et al., 2003).

2.2.4. Suicide Planning vs. Impulsivity

Studies show that suicide attempts among people with mental illness can happen in two main ways. Some attempts are impulsive, meaning they happen suddenly without much planning. Others are planned, where the person thinks about it for a longer time before taking action. A study conducted in Bangladesh among hospital patients who attempted suicide found that most attempts were impulsive. About 58% of the attempts happened suddenly, while around 26% were planned. This suggests that many people attempt suicide during moments of intense emotional stress without much preparation (Roy et al., 2020).

Another study using the Barratt Impulsiveness Scale (BIS-11) also supports this idea. It found that people with lower or medium suicidal intent were more impulsive, meaning their actions were more sudden. In contrast, people with higher suicidal intent were less impulsive and their attempts were more planned and deliberate (Gade et al., 2018). These findings suggest that there are two main pathways of suicidal behavior. One is an impulsive pathway, where a person acts quickly during a crisis without much thinking. The other is a planned pathway, where suicidal thoughts develop over time and lead to a more organized attempt.

2.2.5. Method of Attempt (Hanging, Poisoning, Overdose)

The method used in a suicide attempt can give important information about a person's behavior and situation. It often depends on what is easily available, how quickly the person acts, and how serious the intention is. A study conducted in Bangladesh among patients who attempted suicide found that poisoning was the most common method, used by about 56% of the patients. Other methods like hanging and medication overdose were also reported, but less frequently. This suggests that people often

choose methods that are easily available and can be used quickly, especially during emotional distress (Roy et al., 2020).

Similar patterns have been seen in other psychiatric settings as well. Studies show that hanging, poisoning, and overdose are commonly used methods among mental illness patients. This indicates that the choice of method is often influenced by access to means and the sudden nature of the situation (Parveen et al., 2020).

2.3. Situational Factors Related to Suicidal Tendency

2.3.1. Current Substance Use

Current use of alcohol or drugs is an important situational factor related to suicidal tendency. It can increase emotional distress and reduce a person's ability to think clearly, especially during difficult situations. A study conducted in a psychiatric clinic in Ethiopia found that patients who were currently using alcohol had a higher risk of suicidal behavior. The study showed that alcohol use can increase the chance of moving from suicidal thoughts to actual attempts (Dereje et al., 2024).

Similar findings were also reported in another study among patients with substance use disorder. It showed that people who were currently using alcohol were more likely to have suicidal thoughts. This suggests that the risk of suicide becomes higher when a person is actively using substances (Kassie et al., 2022).

Overall, current substance use plays a significant role in increasing suicidal tendency. It can make a person more vulnerable during stressful situations and increase the likelihood of acting on suicidal thoughts. Therefore, assessing substance use is important when evaluating suicidal risk in mental illness patients.

2.3.2. Level of Social Support

Social support is an important factor that can affect suicidal tendency. When a person has low social support, they may feel alone and helpless, especially during times of mental distress. A study conducted in Bangladesh found that low social support is linked with higher suicidal tendency among psychiatric patients. Patients who do not have enough support from family, friends, or others are more likely to experience suicidal thoughts and behaviors (Parveen et al., 2020).

Another psychiatric clinic study measured social support using levels such as poor, moderate, and strong. It showed that patients with poor social support had a higher risk of suicidal behavior, which makes social support an important factor to consider during assessment (Dereje et al., 2024). Studies on patients with depression also support this finding. Patients who had suicidal thoughts reported lower levels of social support compared to those who did not have such thoughts. This suggests that weak support systems can increase a person's vulnerability during illness (Sokero et al., 2003). In addition, a study conducted at NIMH outpatient department also identified poor social support as an important factor related to suicide attempts among psychiatric patients (Parveen et al., 2020).

2.3.3. Feeling Socially Isolated/ Lonely

Feeling lonely or socially isolated is an important factor related to suicidal tendency, especially among people with mental illness. When a person feels disconnected from others, they may experience more emotional pain and negative thoughts. A study among psychiatric patients found that those who had suicidal thoughts also reported higher levels of loneliness and social isolation compared to those who did not have such thoughts. This suggests that feeling alone and disconnected can directly increase suicidal thinking (Gramaglia et al., 2024). The study also showed that loneliness often

appears along with other mental health problems. This means it is not just a minor issue, but an important part of the situation that can increase the risk of self-harm.

Similar findings were reported among patients with substance use disorders. In that group, people who felt socially isolated or experienced stigma were more likely to feel lonely and unhappy in their relationships. These feelings were also linked with higher suicidal thoughts (Kassie et al., 2022). In patients with schizophrenia, social isolation is also common. Due to social anxiety and reduced interaction with others, many patients feel disconnected and hopeless. These feelings can increase the risk of suicidal behavior (Vrbova et al., 2018).

2.3.4. Urban vs. Rural Residency

Where a person lives, whether in a rural or urban area can also affect suicidal tendency. This is because living conditions, access to healthcare, and daily life stress can be different in these areas. Bangladeshi tertiary-hospital studies report that most psychiatric suicide attempters come from rural areas, suggesting that rural disadvantage, limited mental-health services, and availability of agricultural poisons may create higher-risk situational contexts (Roy et al., 2020). Similar rural predominance has also been observed in later Bangladeshi hospital samples (Roy et al., 2023).

Outpatient psychiatric studies conducted in capital-centered services show a larger urban representation among suicidal patients (Parveen et al., 2020). This suggests that urban stressors and easier access to tertiary care may shape who presents with suicidal behavior in clinical settings (Mohammed et al., 2024). Overall, these findings imply that the effect of residency is context-specific and depends on local socio-economic conditions and healthcare pathways rather than a single uniform rural-or-urban risk direction.

2.3.5. Regular Mental Health Treatment / Counseling

Regular mental health treatment and counseling play an important role in reducing suicidal tendency. When patients receive proper treatment, their symptoms can be controlled, which helps to reduce emotional distress and crisis situations. A study conducted in a psychiatric clinic found that patients who did not follow their treatment regularly had a higher risk of suicidal behavior. This means that when patients skip medication or do not attend follow-up sessions, their mental condition may worsen, increasing the chance of suicidal thoughts and actions (Dereje et al., 2024).

Another study among patients with substance use disorder showed that those who received treatment for a longer period were less likely to attempt suicide. This suggests that continuous care and counseling can help reduce suicidal risk over time (Kassie et al., 2022). Overall, regular treatment and counseling act as protective factors against suicidal tendency. They help patients manage their symptoms, reduce distress, and prevent relapse. Therefore, ensuring proper follow-up and adherence to treatment is very important in reducing suicidal risk among mental illness patients.

2.3.6. Time and Place of Attempt

The time and place of a suicide attempt are important situational factors that help us understand when and where such incidents are more likely to occur. Studies show that most suicide attempts happen at home. A study conducted in the NIMH outpatient department found that many attempts took place in the home environment and were more common during the daytime. This suggests that daily household time and private spaces can become risky periods, especially when a person is going through emotional distress (Parveen et al., 2020).

Similar findings have been reported in other studies from Bangladesh. Research among hospital patients showed that most suicide attempts occurred at home. This may be because people feel more isolated in private spaces, and harmful methods are often easily available there (Roy et al., 2020). Further evidence from later hospital-based studies also supports this pattern, showing that the home environment is a common place for suicide attempts. These findings highlight the role of domestic situations, emotional triggers, and easy access to means in shaping suicidal behavior (Roy et al., 2023). Overall, the time and place of suicide attempts provide useful information about risk situations. Since many attempts occur at home and during regular daily hours, it is important to consider the home environment when assessing suicidal tendency and planning prevention strategies.

CHAPTER III: METHODS AND MATERIALS

3.1 Study Question, Aim, Objectives

3.1.1 Study Question:

What is the level of suicidal tendency and what are the associated behavioral and situational factors among patients with mental illness?

3.1.2 Aim:

To determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness.

3.1.3 Objectives

1. To assess the level of suicidal tendency among patients with mental illness.
2. To examine the behavioral factors associated with suicidal tendency among patients with mental illness.
3. To explore the situational factors related to suicidal tendency among patients with mental illness.

3.2 Study Design

3.2.1 Study Method

This study followed a quantitative research method. Quantitative research mainly focuses on collecting data in a numerical form and presenting the findings using statistics, such as frequency, percentage, mean, and standard deviation (Creswell, 2018). This method is widely used when the researcher needs to measure the level of a condition and examine the relationship between different variables in a population (Polit & Beck, 2017).

In this research, the quantitative method was appropriate because the study aimed to assess the level of suicidal tendency among patients with mental illness

using a standardized tool (Suicide Intent Scale) and to identify the behavioral and situational factors associated with suicidal tendency. Quantitative method also helps to analyze the data objectively and summarize the results clearly, which supports better interpretation and comparison of findings (Burns & Grove, 2016).

Therefore, the quantitative research method was suitable for this study to achieve the research objectives and to provide clear evidence about suicidal tendency and its related factors among patients with mental illness.

3.2.2 Study Approach

This study followed a cross-sectional study design. A cross-sectional study is an observational study where the researcher collects data from the participants at one point in time (Creswell, 2018). This type of study design is useful to measure the current status or level of a condition in a specific population, such as the level of suicidal tendency among patients with mental illness (Mann et al., 2021).

In cross-sectional studies, information about the outcome and related factors is collected at the same time, which helps to explore possible associations between variables (Setia, 2016). In this study, suicidal tendency was the main outcome, and different behavioral and situational factors were considered as associated factors. The cross-sectional approach was suitable because it allowed the researcher to assess the level of suicidal tendency and examine its associated factors within a limited time and resources.

Therefore, the cross-sectional study design was appropriate for this research to achieve the aim and objectives by providing a clear idea of suicidal tendency and related factors among patients with mental illness.

3.3 Study Setting and Period

3.3.1 Study Setting

This study was conducting in two major government psychiatric service centers in Bangladesh: the National Institute of Mental Health and Hospital (NIMH), Dhaka, and the Mental Hospital, Pabna. The National Institute of Mental Health and Hospital, located at Sher-e-Bangla Nagar in Dhaka, is the country's central specialized psychiatric institute and a national referral facility. It provides comprehensive inpatient, outpatient, and emergency mental-health services for adult and child psychiatric disorders, and also serves as an important center for training and research in the mental-health sector of Bangladesh. For this study, participants from NIMH were recruited from the inpatient unit, where suicidal patients were available and could be assessed within a supervised clinical environment.

The second setting was the Mental Hospital, Pabna, located in Hemayetpur, Pabna district. Established in 1957, it is the oldest and largest dedicated mental hospital in Bangladesh and provides psychiatric outpatient and inpatient services to patients referred from different regions of the country. In this hospital, however, suicidal patients are not admitted to the inpatient wards as part of the institutional clinical policy. Therefore, during the study period no eligible suicidal patients were available in the inpatient unit. Following the formal direction of the hospital director and the ethical committee, participants from Pabna Mental Hospital were recruited from the Outpatient Department (OPD), where clinically diagnosed patients with suicidal thoughts or attempts were receiving care.

Together, these two settings provided an appropriate clinical platform for determining the level of suicidal tendency and identifying associated behavioral and situational factors among patients with mental illness in Bangladesh.

3.3.2 Study Period

The study period was from June 15, 2025 to December 15, 2025 and the data collection period was from 2 August, 2025 to 15 September 2025.

3.4 Study Participants

3.4.1 Study Population

In this research, the study population comprised patients with mental illness who attended psychiatric services at the National Institute of Mental Health and Hospital (NIMH), Dhaka, and the Mental Hospital, Pabna. All participants were clinically diagnosed by psychiatrists according to the DSM-5 diagnostic criteria and were receiving inpatient care at NIMH or outpatient care at Pabna Mental Hospital during the study period. The population therefore represented adults with confirmed mental disorders who were appropriate for assessing the level of suicidal tendency and its associated behavioral and situational factors within a clinical psychiatric context.

3.4.2 Sampling Technique

This study used purposive sampling to select the participants. Purposive sampling is a non-probability sampling technique where participants are selected based on specific characteristics that match the purpose of the study. In this method, the researcher chooses participants who are most suitable to provide the required information.

In this research, purposive sampling was appropriate because the study focused on patients with mental illness who met the inclusion criteria. The researcher needed participants who could provide information about suicidal tendency and the related behavioral and situational factors. Therefore, the participants were selected purposively from the selected study settings during the data collection period.

3.4.3 Inclusion Criteria

- Participants who were aged 12 to 60 years.
- Participants who had a confirmed diagnosis of mental illness according to DSM-5 criteria (Schizophrenia, Bipolar mood disorder [BMD], Borderline personality disorder [BPD], Conversion disorder, Conduct disorder, Bipolar I disorder [BID], Bipolar affective disorder [BAD], Major depressive disorder [MDD], and Obsessive–compulsive disorder [OCD]).
- Participants who were receiving psychiatric treatment from hospital.

3.4.4 Exclusion Criteria

- Patients in an acute psychiatric emergency or requiring emergency medication at the time of data collection.
- Patients with severe cognitive impairment or communication difficulty.
- Patients with major neurological illness along with mental illness.

3.4.5 Sample Size

Here,

- n = required sample size
- Z = standard normal deviate = 1.96 (for 95% Confidence Interval)
- p = 0.5 (50%) *(as the exact prevalence is unknown, 50% was taken to obtain the maximum sample size)*
- q = 1 – p = 0.5
- d = margin of error = 0.05

Required sample size, n = ?

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

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

$$= \frac{3.8416 \times 0.25}{0.0025}$$

$$= \frac{0.9604}{0.0025}$$

$$= 384.16 \approx 384$$

The calculated sample size is approximately 384.

Because of the short time, the student researcher reached 130 participants and collected data from them.

3.5 Ethical Consideration

3.5.1 Ethical Clearance

The ethical clearance received from the Institutional Review Board (IRB) through the Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI) with a brief description of the aim and objectives. The IRB number is: CRP-BHPI/IRB/07/2025/1095

Besides, permission was taken from the Head of the Department of Occupational Therapy of BHPI in order to collect data from the National Institute of Mental Health (NIMH), Dhaka & Mental Hospital, Pabna.

3.5.2 Informed Consent

The student researcher ensured that all willing participants were informed about objectives, purpose and process of the research. The student researcher provides Information Sheet, Consent Form and Withdrawal Form to the participants.

3.5.3 Unequal Relationship

The student researcher did not have any unequal or power relationship with the participants.

3.5.4 Risk and Beneficence

In this study, the investigator asked participants to share personal and sensitive information about suicidal thoughts and attempts. Discussing suicide could have been emotionally uncomfortable for some participants and might have caused temporary distress during or after the interview. Participants were clearly informed that they were not bound to answer any question they did not want to, and they could stop or withdraw from the interview at any time without any problem. If any participant became upset, the interview was paused or stopped and necessary support was ensured in the clinical setting.

There was no direct benefit for the participants, but their contribution helped to understand the level of suicidal tendency and the associated behavioral and situational factors among patients with mental illness, which may support future prevention and care planning in Bangladesh.

3.5.5 Power Relationship

The student research did not have any power relationships with any participants.

3.5.6 Confidentiality

The information provided by the participants was confidential. Their name and identity were not disclosed to anyone except for the supervisor and it was stated on the information sheet. The participants were informed that their identity will remain confidential for future uses, such as report writing, publication, conference or any other written materials and verbal discussion.

3.6 Data Collection Process

3.6.1 Participants Recruitment Process

- First, administrative permission was obtained from the concerned authorities of NIMH, Dhaka and Pabna Mental Hospital before starting participant recruitment.
- I obtained ethical clearance from the IRB of BHPI and took written permission from both hospitals for data collection.
- After getting permission, I reviewed patients' clinical records and selected participants who met the inclusion and exclusion criteria with the help of psychiatrists and occupational therapists.
- At NIMH, I recruited participants from the inpatient ward, and at Pabna Mental Hospital, I recruited eligible participants from the OPD under the Administrative guidance.
- A total of 130 participants (n = 130) who met the eligibility criteria were recruited for the study during the data collection period.
- Finally, I approached the selected participants individually, explained the purpose and procedure of the study, obtained written informed consent, and collected data through face-to-face interviews using the Suicide Intent Scale (SIS) and a socio-demographic questionnaire. If any participant became distressed, the interview was stopped and immediate support was ensured.

3.6.2 Data Collection Method

Data were collected through face-to-face interviews conducted by the student researcher using a fixed order of questions. Maintaining the sequence of the questionnaire helped to minimize bias and ensured consistency across participants (Kielhofner, 2017). This method was chosen because it allowed clear explanation of

items, immediate clarification when needed, and accurate completion of the Suicide Intent Scale (SIS) and the socio-demographic questionnaire in a clinical setting.

3.6.3 Data Collection Instruments

Two instruments were used for data collection in this study: (a) the Suicide Intent Scale (SIS) and (b) a semi-structured socio-demographic questionnaire.

a) Measurement Tool: Suicide Intent Scale (SIS): The Suicide Intent Scale (SIS), developed by Beck et al. (1974), was used to assess the severity of suicidal intent among patients with mental illness. The scale is designed for individuals who have made a suicide attempt and measures the level of intent surrounding the most recent attempt. The SIS contains 15 scored items, which were administered in a fixed order following the original instructions of the scale.

The items are divided into two sections. Part I: Objective Circumstances (Items 1–8) focused on observable features of the attempt, including the degree of isolation, timing, precautions against discovery or intervention, whether help was sought during/after the attempt, final acts in anticipation of death, active preparation, presence of a suicide note, and communication of intent. Part II: Self-Reported Intent (Items 9–15) explored the participant's subjective thoughts and expectations at the time of the attempt, such as the purpose of the act, expectations of fatality, perceived lethality of the method, seriousness of the attempt, attitude toward living/dying, perceived medical rescuability, and degree of premeditation.

Each item was rated on a 3-point scale from 0 to 2. The total SIS score was calculated by summing Items 1-15 (excluding "not applicable" codes), producing a total range of 0 to 30. Higher scores reflected a higher level of suicidal intent. Based on the scoring guideline attached to the scale, total scores were interpreted as low, medium, or high suicidal intent for descriptive reporting in this study.

b) Socio-Demographic Questionnaire: A semi-structured socio-demographic questionnaire was used to collect background and clinical information relevant to the study objectives.

3.6.4 Field Test

Before final data collection, the researcher conducted two field tests to check whether the questionnaire and the Suicide Intent Scale (SIS) were understandable and suitable for the study participants. The main purpose of the field tests was to ensure that the questions were clear, the sequence was appropriate, and the interview process could be completed easily within a short time.

3.7 Data Management and Analysis

3.7.1 Data Management

After data collection, the researcher checked each questionnaire to make sure the information was complete and readable. The collected data were handled carefully to avoid missing information or wrong entries.

Then, the researcher assigned codes to the responses and entered the data into SPSS (version 20). The data were cleaned by checking for missing values, errors, and inconsistencies. All collected information was kept confidential and used only for research purposes.

3.7.2 Data Analysis

Data were entered, cleaned, and analyzed using the Statistical Package for Social Sciences (SPSS), version 20. Descriptive statistics were used to summarize the socio-demographic, behavioral, and situational characteristics of the participants. Frequencies and percentages were calculated for categorical variables, while measures of central tendency and dispersion were used to describe continuous variables where

applicable. The Suicide Intent Scale (SIS) total scores were categorized into low, medium, and high suicidal tendency levels and presented accordingly.

To examine the association between suicidal tendency (SIS risk level) and behavioral as well as situational factors, the Chi-square (χ^2) test was applied. When the expected cell count in more than 20% of the cells was less than 5, Fisher's exact test was used to ensure the validity of the results. Variables found to be statistically significant in bivariate analysis were entered into an ordinal logistic regression model to identify independent predictors of suicidal tendency. The proportional odds model was applied since the dependent variable (SIS risk level) was ordinal in nature (low, medium, high). Adjusted estimates (β), standard errors, Wald statistics, 95% confidence intervals (CI), and p-values were reported. A p-value of less than 0.05 was considered statistically significant for all analyses.

3.8 Quality Control and Quality Assurance

Quality control and quality assurance were maintained throughout the entire study period. From the beginning, an appropriate quantitative descriptive cross-sectional design and purposive sampling technique were selected in line with the aim and objectives to ensure that the sample represented the target psychiatric population. To maintain consistency and reduce bias, participant recruitment and data collection followed the same procedure in both study settings.

The five stages of data life-cycle management were followed carefully to ensure data quality and safety. After ethical clearance and hospital permission were obtained, data were collected face to face using the Suicide Intent Scale (SIS) and the socio-demographic questionnaire. The questionnaires were administered in a fixed order, and responses were checked immediately after each interview to avoid missing

or unclear data. Data entry was done systematically and without bias, and cross-checking was performed to minimize entry errors.

All collected data were stored first in SPSS for analysis. For additional safety, the dataset was backed up in a secure Google Drive storage system that was accessible only to the student researcher and supervisors. Confidentiality was strictly maintained, and no unauthorized access occurred at any stage. The data were used responsibly in their original form, and no manipulation, alteration, or exploitation of any information was done. Overall, careful handling of recruitment, data collection, storage, and analysis ensured the reliability and integrity of the study findings.

CHAPTER IV: RESULTS

This chapter presents the findings of the study. The results are presented in tables in line with the study objectives, focusing on participants' socio-demographic profiles, the level of suicidal tendency (SIS risk level), and its associated behavioral and situational factors among patients with mental illness.

4.1 Sociodemographic characteristics

Table 4.1

Sociodemographic characteristics of the respondents (n = 130)

Variable	Category	n=130	Percentage (%)
Age	12–28 years	102	78.5
	29–44 years	24	18.5
	45–60 years	4	3.1
	Mean = 24.24 years SD (±8.72), Minimum= 13 years, Maximum=55 years		
Sex	Male	49	37.7
	Female	81	62.3
Marital status	Unmarried	71	54.6
	Married	58	44.6
	Divorced/Separated	1	0.8
Educational qualification	No formal education	10	7.7
	Primary	35	26.9
	Secondary	48	36.9
	Higher secondary	17	13.1
	Bachelor's	17	13.1
	Master's+	3	2.3
Employment status	Employed	1	0.8
	Unemployed	8	6.2
	Student	43	33.1
	Unable to work	78	60.0
Monthly family income	Low (<15000 BDT)	2	1.5
	Middle (15000–50000 BDT)	126	96.9
	High (>50000 BDT)	2	1.5

Variable	Category	n=130	Percentage(%)
Type of mental illness	Schizophrenia	47	36.2
	Bipolar mood disorder (BMD)	12	9.2
	Borderline personality disorder (BPD)	8	6.2
	Conversion disorder	6	4.6
	Conduct disorder	3	2.3
	Bipolar I disorder (BID)	20	15.4
	Bipolar affective disorder (BAD)	17	13.1
	Major depressive disorder (MDD)	11	8.5
	Obsessive–compulsive disorder (OCD)	6	4.6
Duration of illness	<0.5 years	4	3.1
	0.5–1 years	16	12.3
	1–5 years	73	56.2
	>5 years	37	28.5
Family history of mental illness	Yes	35	26.9
	No	94	72.3
	Don’t know	1	0.8
History of substance use (ever)	Yes	8	6.2
	No	122	93.8
Level of social support	Strong	2	1.5
	Moderate	94	72.3
	Weak	32	24.6
	None	2	1.5
Living arrangement	Alone	7	5.4
	With family	120	92.3
	With others	2	1.5
	Institution	1	0.8
Area of residence	Rural	71	54.6
	Urban	58	44.6
	Semi-urban	1	0.8
Type of housing	Permanent	86	66.2
	Temporary	44	33.8
Physical disability (if any)	None	130	100.0
Regular mental health treatment/counseling	Regular	122	93.8
	Occasional	8	6.2
Current substance use	Yes	3	2.3
	No	127	97.7
Feeling socially isolated/lonely	Often	110	84.6
	Sometimes	20	15.4
Significant life stress / recent event	Yes	45	34.6
	No	85	65.4

Table 4.1 summarizes the socio-demographic characteristics of the respondents included in the study (n = 130). The mean age of the participants was 24.24 years (SD ± 8.72), with ages ranging from 13 to 55 years. The majority of the respondents were aged 12–28 years (78.5%, n = 102), followed by 29–44 years (18.5%, n = 24) and 45–60 years (3.1%, n = 4).

In terms of sex distribution, females constituted 62.3% (n = 81) of the sample, while males accounted for 37.7% (n = 49). Regarding marital status, more than half of the respondents were unmarried (54.6%, n = 71), whereas 44.6% (n = 58) were married and 0.8% (n = 1) were divorced/separated.

Concerning educational qualification, secondary education was the most common level attained (36.9%, n = 48), followed by primary education (26.9%, n = 35). A smaller proportion had no formal education (7.7%, n = 10), while higher secondary and bachelor's degree holders each represented 13.1% (n = 17). Only 2.3% (n = 3) had completed a master's degree or above.

With respect to employment status, the majority were unable to work (60.0%, n = 78), and 33.1% (n = 43) were students. A small proportion were unemployed (6.2%, n = 8), and only 0.8% (n = 1) were employed. Regarding monthly family income, most respondents belonged to the middle-income group (15,000–50,000 BDT) comprising 96.9% (n = 126), while both low-income (<15,000 BDT) and high-income (>50,000 BDT) groups represented 1.5% (n = 2) each.

4.2 Clinical Characteristics of the Participants

Figure 4.1

Distribution of Participants by Type of Mental Illness (n = 130)

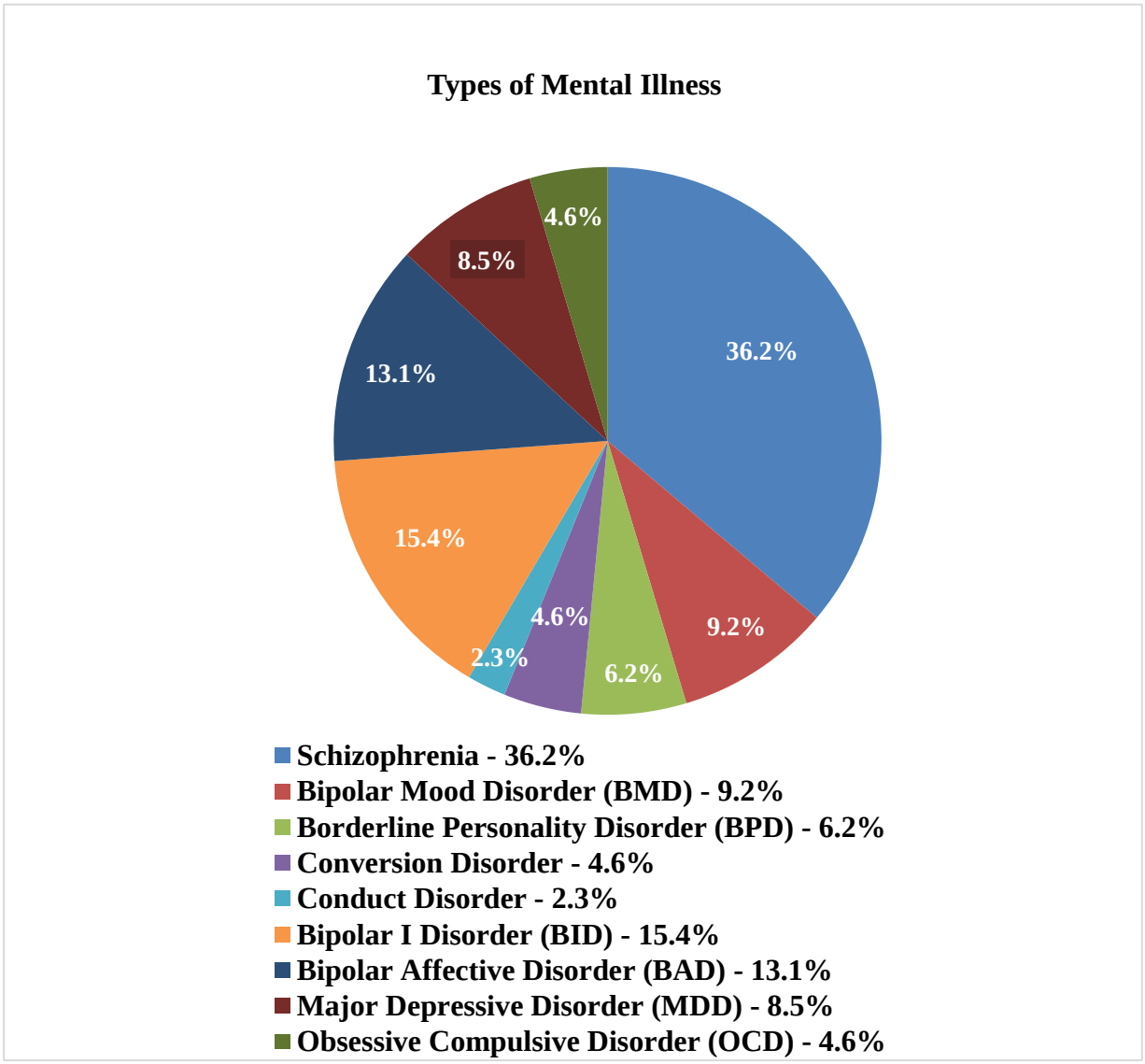


Figure 4.1 illustrates the distribution of participants according to their diagnosed type of mental illness (n = 130). The largest proportion of the respondents were diagnosed with schizophrenia (36.2%, n = 47). This was followed by bipolar I disorder (15.4%, n = 20) and bipolar affective disorder (13.1%, n = 17). Bipolar mood disorder accounted for 9.2% (n = 12) of the participants, while major depressive disorder was reported in 8.5% (n = 11). Borderline personality disorder comprised 6.2% (n = 8) of

the sample. Conversion disorder and obsessive–compulsive disorder each represented 4.6% (n = 6), and conduct disorder was the least frequent diagnosis, accounting for 2.3% (n = 3).

Overall, the figure demonstrates that schizophrenia constituted the predominant diagnostic category among the study participants, reflecting the clinical composition of the sample.

4.3 Level of Suicidal Tendency among Participants

Table 4.2

Distribution of Suicide Intent Scale (SIS) Total Scores (n = 130)

Variable	Value
Median SIS score	13.5
Minimum score	4
Maximum score	25
Possible score range	0–30

Table 4.2 presents the descriptive statistics of the Suicide Intent Scale (SIS) total scores among the participants (n = 130). As the SIS total scores were not normally distributed, the findings are summarized using the median value.

The median SIS total score was 13.5, with scores ranging from a minimum of 4 to a maximum of 25. The possible score range of the scale is 0-30. These findings indicate a moderate central tendency of suicidal intent among the study participants.

Table 4.3

Level of Suicidal Tendency among Participants (n = 130)

Level of suicidal tendency	Frequency (n)	Percentage (%)
Low risk	27	20.8
Medium risk	87	66.9
High risk	16	12.3
Total	**130**	**100.0**

Table 4.3 presents the distribution of suicidal tendency levels among the participants based on the Suicide Intent Scale (SIS) risk categorization (n = 130). Among the respondents, the majority were classified as having a medium level of suicidal tendency, accounting for 66.9% (n = 87). A smaller proportion of participants were categorized as low risk (20.8%, n = 27), while 12.3% (n = 16) were identified as having a high level of suicidal tendency.

These findings indicate that most patients with mental illness in the present study demonstrated a moderate level of suicidal intent, with a notable proportion exhibiting high suicidal risk.

Figure 4.2

Distribution of Level of Suicidal Tendency among Participants (n = 130)

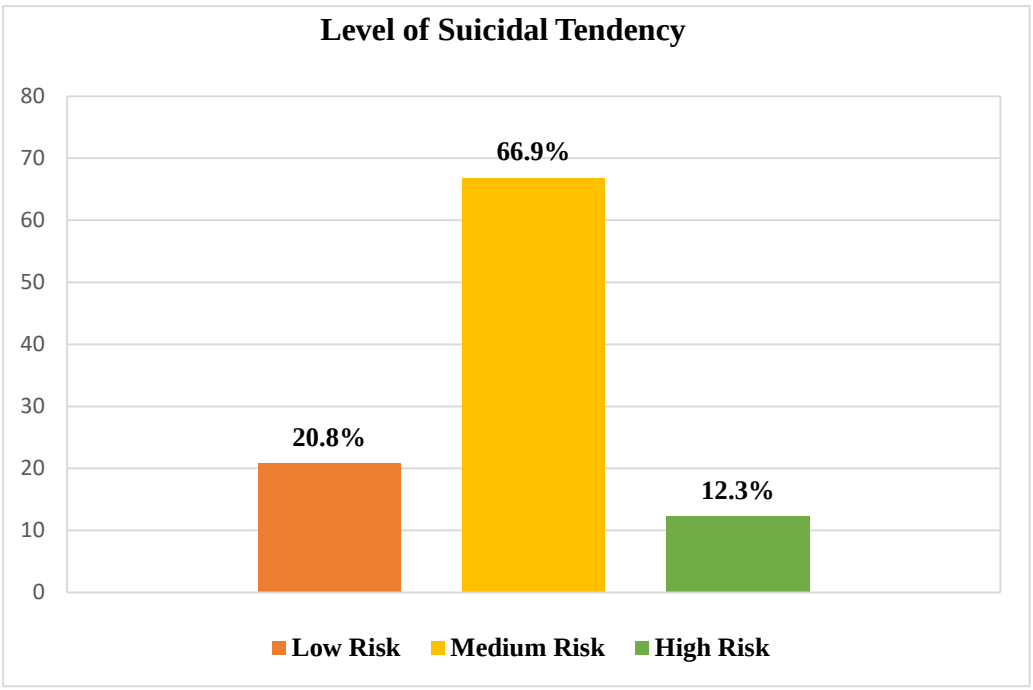


Figure 4.2 illustrates the graphical presentation of the distribution of suicidal tendency levels among the participants (n = 130). The majority of respondents were classified as having a medium level of suicidal tendency (66.9%, n = 87). Participants with low suicidal tendency accounted for 20.8% (n = 27), while 12.3% (n = 16) were categorized as having a high level of suicidal tendency. The figure visually demonstrates that a considerable proportion of patients with mental illness in the study exhibited moderate to high levels of suicidal intent.

4.4 Behavioral Factors Associated with Suicidal Tendency

Table 4.4

Distribution of Behavioral Factors among Participants (n = 130)

Behavioral Variable	Category	Frequency (n)	Percentage (%)
History of substance use	Yes	8	6.2
	No	122	93.8
Current substance use	Yes	3	2.3
	No	127	97.7
Regular mental health treatment / counseling	Regular	122	93.8
	Occasional	8	6.2
Feeling socially isolated / lonely	Often	110	84.6
	Sometimes	20	15.4
Family history of mental illness	Yes	35	26.9
	No	94	72.3
	Don’t know	1	0.8

Table 4.4 presents the distribution of behavioral factors among the participants included in the study (n = 130). Regarding history of substance use, the majority of respondents reported no history of substance use (93.8%, n = 122), while 6.2% (n = 8) reported having a history of substance use. Similarly, current substance use was reported by only 2.3% (n = 3) of the participants, whereas 97.7% (n = 127) were not currently using any substances.

In terms of mental health treatment, most of the respondents (93.8%, n = 122) reported receiving regular mental health treatment or counseling, while 6.2% (n = 8) reported receiving treatment occasionally or not at all. With regard to feelings of social isolation or loneliness, the majority of participants reported often feeling socially isolated (84.6%, n = 110), whereas 15.4% (n = 20) reported feeling socially isolated sometimes, rarely, or never. Concerning family history of mental illness, 26.9% (n = 35) of the respondents reported a positive family history, while 73.1% (n = 95) reported no known family history of mental illness.

Table 4.5

Association of Behavioral Factors with Suicidal Tendency (SIS Risk Level: Low/Medium/High) among Patients with Mental Illness (n = 130)

Variable	Category	SIS risk level			χ^2 / Fisher's exact test	*P*-value
		Low risk % (n)	Medium risk % (n)	High risk % (n)		
History of substance use	Yes	12.5% (1)	37.5% (3)	50.0% (4)	Fisher's exact test = 7.846	0.013
	No	21.3% (26)	68.9% (84)	9.8% (12)		
Current substance use	Yes	0.0% (0)	100.0% (3)	0.0% (0)	Fisher's exact test = 0.675	1.000
	No	21.3% (27)	66.1% (84)	12.6% (16)		
Regular mental health treatment / counseling	Regular	21.3% (26)	65.6% (80)	13.1% (16)	χ^2 = 1.869,	0.393
	Occasional / None	12.5% (1)	87.5% (7)	0.0% (0)		
Feeling socially isolated / lonely	Often	20.9% (23)	65.5% (72)	13.6% (15)	χ^2 = 1.263	0.532
	Sometimes / Rarely / Never	20.0% (4)	75.0% (15)	5.0% (1)		
Family history of mental illness	Yes	25.7% (9)	57.1% (20)	17.1% (6)	χ^2 = 2.158	0.340
	No (No+ Don't know)	18.9% (18)	70.5% (67)	10.5% (10)		

Table 4.5 shows the association between behavioral factors and suicidal tendency categorized as low, medium, and high risk levels based on the Suicide Intent Scale (SIS) among the participants (n = 130). A statistically significant association was found between history of substance use and suicidal tendency (Fisher's Exact Test = 7.846, *P* = 0.013). Participants with a history of substance use demonstrated a higher proportion of medium and high suicidal risk compared to those without a history of

substance use. No statistically significant association was observed between current substance use and suicidal tendency (Fisher's Exact Test, $P = 1.000$).

Similarly, regular mental health treatment or counseling was not significantly associated with SIS risk level ($\chi^2 = 1.868$, $P = 0.393$). Feeling socially isolated or lonely also did not show a statistically significant association with suicidal tendency ($\chi^2 = 1.262$, $P = 0.532$). Furthermore, family history of mental illness was not significantly associated with SIS risk level ($\chi^2 = 2.158$, $P = 0.340$). Overall, among the behavioral factors examined, only history of substance use showed a statistically significant association with suicidal tendency in this study.

Table 4.6

Ordinal Logistic Regression Analysis of Behavioral Factors Associated with SIS Risk Level (n = 130)

Predictor	Estimate (B)	Std. Error	Wald	95% CI (Lower–Upper)	*P*-value
History of substance use (Yes vs. No)	1.954	0.756	6.689	0.473 – 3.435	0.010
Regular mental health treatment (Regular vs. Occasional/None)	0.008	0.775	0.000	-1.527 – 1.510	0.992
Feeling socially isolated (Often vs. Sometimes/Rarely/Never)	1.134	0.513	3.480	-0.872 – 1.140	0.068
Family history of mental illness (Yes vs. No/Don't know)	-0.107	0.415	0.066	-0.921 – 0.707	0.797

Table 4.6 presents the results of the ordinal logistic regression analysis examining the association between behavioral factors and SIS risk level (low, medium, high) among the participants (n = 130). The overall model was not statistically significant (Model $\chi^2 = 5.634$, df = 4, $P = 0.228$). However, the test of parallel lines was not significant ($P = 0.228$), indicating that the proportional odds assumption was satisfied. The goodness-of-fit statistics (Pearson p = 0.324; Deviance p = 0.361) suggested that the model adequately fit the data.

Among the behavioral predictors, history of substance use was found to be significantly associated with SIS risk level (B = 1.954, SE = 0.756, Wald = 6.689, 95% CI: 0.473–3.435, *P* = 0.010). Participants with a history of substance use were more likely to have a higher level of suicidal tendency compared to those without such history. Regular mental health treatment (B = 0.008, *P* = 0.992), feeling socially isolated (B = 1.134, *P* = 0.068), and family history of mental illness (B = -0.107, *P* = 0.797) were not statistically significant predictors of SIS risk level. Overall, among the behavioral factors included in the regression model, only history of substance use emerged as a significant independent predictor of suicidal tendency.

4.5 Situational Characteristics of the Participants

Table 4.7

Distribution of Situational Factors among Participants (n = 130)

Situational Variable	Category	Frequency (n)	Percentage (%)
Marital Status	Unmarried	71	54.6
	Married	58	44.6
	Divorced/Separated	1	0.8
Monthly family Income	Low (<15000 BDT)	2	1.5
	Middle (15000–50000 BDT)	126	96.9
	High (>50000 BDT)	2	1.5
Living arrangement	Alone	7	5.4
	With family	120	92.3
	With others	2	1.5
	Institution	1	0.8
Level of social support	Strong	2	1.5
	Moderate	94	72.3
	Weak	32	24.6
	None	2	1.5
Significant life stress / recent event	Yes	45	34.6
	No	85	65.4
Employment status	Employed	1	0.8
	Unemployed	8	6.2
	Student	43	33.1
	Unable to work	78	60.0
Duration of mental illness	<0.5 years	4	3.1
	0.5–1 years	16	12.3

	1–5 years	73	56.2
	>5 years	37	28.5

Table 4.7 presents the distribution of situational factors among the participants included in the study (n = 130). Regarding marital status, more than half of the respondents were unmarried (54.6%, n = 71), while 45.4% (n = 59) were ever married (married/divorced/separated). In terms of living arrangement, the majority of participants were living with their family members (80.8%, n = 105), whereas 19.2% (n = 25) were living alone or with others.

Concerning level of social support, most respondents reported good social support (approximately 76.2%, n = 99), while 23.8% (n = 31) reported poor social support. With respect to significant life stress or recent adverse events, 36.9% (n = 48) of the participants reported experiencing significant life stress, whereas 63.1% (n = 82) did not report any recent significant stress.

Regarding employment status, the majority belonged to the not-working group (employed/student vs. unemployed/unable to work, as recoded), with most participants classified as not working. Finally, in relation to duration of mental illness, most participants (84.6%, n = 110) had been suffering from mental illness for more than one year, while 15.4% (n = 20) had a duration of illness of one year or less. These findings describe the situational context of the participants in the present study.

4.6 Situational Factors Associated with Suicidal Tendency

Table 4.8

Association between Situational Factors and Suicidal Tendency (SIS Risk Level) among Patients with Mental Illness (n = 130)

Situational factors	Category	SIS risk level			χ^2 / Fisher's exact test	*P*-value
		Low risk % (n)	Medium risk % (n)	High risk % (n)		
Marital Status	Unmarried	74.1% (20)	48.3% (42)	56.2% (9)	5.552	0.062
	Ever Married	25.9% (7)	51.7% (45)	43.8% (7)		
Monthly family Income	Middle income	21.4% (27)	67.5% (85)	11.1% (14)	5.798	0.055
	Non-middle income (Low+ High)	0.0% (0)	50.0% (2)	50.0% (2)		
Living arrangement	With family	21.7% (26)	66.7% (80)	11.7 % (14)	1.141	0.565
	Non- family living(Alone+ With others+ Institution)	10.0% (1)	70.0% (7)	20.0% (2)		
Level of social support	Good support (Strong + Moderate)	81.5% (22)	74.7% (65)	56.2% (9)	3.414	0.181
	Poor support (Weak + None)	18.5% (5)	25.3% (22)	43.8% (7)		
Significant life stress / recent event	Yes	22.2% (10)	60.0% (27)	17.8% (8)	2.236	0.327
	No	20.0% (17)	70.6% (60)	9.4% (8)		
Employment status	Working group (Employed + Student)	29.5% (13)	59.1% (26)	11.4% (5)	0.069	0.966
	Not working group (Unemployed + Unable to work)	25.0% (2)	62.5% (5)	12.5% (1)		
Duration of mental illness	≤1 year (<0.5 + 0.5–1 years)	20.0% (4)	75.0% (15)	5.0% (1)	1.263	0.532
	>1 year (1–5 + >5 years)	20.9% (23)	65.5% (72)	13.6% (15)		

Table 4.8 presents the association between selected situational factors and suicidal tendency categorized as low, medium, and high risk levels based on the Suicide Intent Scale (SIS) among the participants (n = 130). No statistically significant association was observed between marital status and SIS risk level ($\chi^2 = 5.558$, $P = 0.062$). Although participants who were ever married showed a comparatively higher proportion of medium and high risk levels, the association did not reach statistical significance.

Monthly family income also did not show a statistically significant association with suicidal tendency ($\chi^2 = 5.787$, $P = 0.055$). However, participants from non-middle income groups appeared to have a relatively higher proportion of elevated suicidal risk. Living arrangement was not significantly associated with SIS risk level ($\chi^2 = 1.140$, $P = 0.565$). Similarly, level of social support did not demonstrate a statistically significant relationship with suicidal tendency ($\chi^2 = 3.410$, $P = 0.181$).

Significant life stress or recent adverse events were also not significantly associated with SIS risk level ($\chi^2 = 2.238$, $P = 0.327$). Furthermore, employment status showed no statistically significant association with suicidal tendency ($\chi^2 = 0.069$, $P = 0.966$). Lastly, duration of mental illness was not significantly associated with SIS risk level ($\chi^2 = 1.263$, $P = 0.532$). Overall, none of the situational factors examined in this study demonstrated a statistically significant association with suicidal tendency at the bivariate level.

Table 4.9

Ordinal Logistic Regression Analysis of Situational Factors Associated with SIS Risk Level (n = 130)

Predictor	Estimate (B)	Std. Error	Wald	95% CI (Lower – Upper)	*P*-value
Marital status (Ever married vs. Unmarried)	-0.618	0.382	2.619	-1.366 – 0.130	0.106
Monthly family income (Non-middle vs. Middle)	-2.258	1.040	4.711	-4.298 – -0.219	0.030
Level of social support (Poor vs. Good)	-0.819	0.439	3.480	-1.679 – 0.041	0.062
Significant life stress (Yes vs. No)	0.242	0.394	0.378	-0.530 – 1.013	0.539

Table 4.9 presents the results of the ordinal logistic regression analysis examining the association between selected situational factors and SIS risk level (low, medium, high) among the participants (n = 130). The overall model was statistically significant (Model χ^2 = 10.788, df = 4, *P* = 0.029), indicating that the predictors collectively contributed to the model. The test of parallel lines was not significant (*P* = 0.189), suggesting that the proportional odds assumption was satisfied. The goodness-of-fit statistics (Pearson p = 0.626; Deviance p = 0.368) indicated an acceptable model fit.

Among the situational predictors, monthly family income was found to be significantly associated with SIS risk level (B = -2.258, SE = 1.040, Wald = 4.711, 95% CI: -4.298 to -0.219, *P* = 0.030). Participants from non-middle income groups were more likely to have a higher level of suicidal tendency compared to those from the middle-income group. Marital status (B = -0.618, *P* = 0.106), level of social support (B = -0.819, *P* = 0.062), and significant life stress (B = 0.242, *P* = 0.539) were not statistically significant predictors of SIS risk level. Overall, among the situational factors included in the regression model, only monthly family income emerged as a significant independent predictor of suicidal tendency.

CHAPTER V: DISCUSSION

The study aimed to determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness. The findings of this study provide important insights into the magnitude of suicidal tendency and its related determinants in a clinical psychiatric population.

In this study, the median Suicide Intent Scale (SIS) score was 13.5, with scores ranging from 4 to 25 out of a possible range of 0-30. The distribution of suicidal tendency revealed that the majority of participants were categorized as having a medium level of suicidal tendency (66.9%), followed by low risk (20.8%) and high risk (12.3%). These findings suggest that a substantial proportion of patients with mental illness experience moderate to high levels of suicidal intent. This pattern is consistent with previous clinical studies that reported a predominance of medium to high suicidal intent among psychiatric patients assessed using standardized tools such as Beck's Suicidal Intent Scale (Madhavan et al., 2021). Similarly, psychiatric outpatient studies have demonstrated high rates of suicidal ideation and attempts among individuals with mental illness, reinforcing the clinical relevance of systematic risk assessment (Dereje et al., 2024).

Regarding behavioral factors, a statistically significant association was found between history of substance use and suicidal tendency at the bivariate level. Participants with a history of substance use demonstrated a higher proportion of medium and high suicidal risk compared to those without such history. Furthermore, ordinal logistic regression analysis revealed that history of substance use was an independent predictor of higher SIS risk level. This finding aligns with previous literature indicating that substance use increases suicidal behavior through emotional

dysregulation, impaired judgment, and impulsivity (Sokero et al., 2003). Substance involvement may reduce inhibition and increase the likelihood of acting on suicidal thoughts, thereby elevating overall suicidal risk.

In contrast, current substance use, regular mental health treatment, feeling socially isolated, and family history of mental illness were not statistically significant predictors in the multivariable model. Although loneliness and family psychiatric history are commonly identified as risk indicators in previous studies (Gramaglia et al., 2024; Dereje et al., 2024), their lack of significance in the present study may be attributed to the high proportion of participants receiving regular treatment and the relatively homogeneous clinical setting.

With respect to situational factors, monthly family income was found to be significantly associated with suicidal tendency in the ordinal logistic regression model. Participants from non-middle income groups (low or high income) were more likely to demonstrate higher levels of suicidal tendency compared to those from middle-income families. Economic instability and financial stress are well-documented contextual stressors that can intensify psychological distress and hopelessness among psychiatric patients. Previous studies have similarly reported that socio-economic adversity contributes to increased suicidal behavior in mentally ill populations (Parveen et al., 2020).

Other situational factors including marital status, level of social support, significant life stress, employment status, living arrangement, and duration of mental illness did not show statistically significant associations with SIS risk level in this study. Although prior literature suggests that poor social support and recent stressors may elevate suicidal risk (Sokero et al., 2003; Kassie et al., 2022), these variables did not emerge as independent predictors in the present sample. This discrepancy may be

due to contextual variations, sample characteristics, or overlapping effects among predictors.

Overall, the findings of this study highlight that suicidal tendency among patients with mental illness is influenced by both behavioral and situational dimensions. Among the factors examined, history of substance use and monthly family income emerged as significant independent predictors of suicidal risk. These results underscore the importance of integrating substance-use assessment and socio-economic evaluation into routine suicide risk screening in psychiatric settings.

The study contributes to the growing body of evidence emphasizing that suicidal tendency in mental illness is multifactorial. Early identification of high-risk patients particularly those with substance use history and economic vulnerability may support timely intervention, targeted counseling, and preventive strategies within mental health services.

CHAPTER VI: CONCLUSION

6.1 Strength and Limitation

6.1.1 Strengths

- Conducted in two major government psychiatric hospitals (NIMH, Dhaka and Mental Hospital, Pabna), enhancing clinical relevance.
- Included clinically diagnosed patients according to DSM-5 criteria, ensuring diagnostic validity.
- Used a standardized tool (Suicide Intent Scale - SIS) to measure suicidal tendency severity in a structured manner.
- Applied ordinal logistic regression to identify independent predictors of suicidal tendency.
- Maintained strong ethical procedures, including IRB approval, informed consent, confidentiality, and distress management during interviews.
- Data checking and data entry were done carefully; responses were reviewed after interviews and the dataset was cross-checked to reduce entry errors and missing information.

6.1.2 Limitations

There are some limitations of the study. They are,

- The cross-sectional design limits causal interpretation between associated factors and suicidal tendency.
- Purposive sampling may limit generalizability to all patients with mental illness in Bangladesh.
- The participants were recruited from only two government facilities (NIMH inpatient and Pabna OPD), which may reduce representativeness.
- Some variables were based on self-report (e.g., substance use history, social support, and recent life events), creating potential recall or social desirability bias.
- Patients in acute psychiatric crisis were excluded, which may underestimate suicidal risk among the most severe cases.
- The data were collected within a limited period, which may reduce the generalizability of the findings across different times and settings.

6.2 Practice Implication

6.2.1 Recommendation for Future Practice

- Routine suicide risk screening (using SIS) should be included in regular psychiatric assessment in both inpatient and outpatient settings.
- Substance use history should be assessed early and managed with integrated psychiatric and counseling support.
- Clinicians should assess key behavioral warning signs (e.g., isolation, intent, planning) for proper safety planning.
- Family psychoeducation and psychosocial support should be strengthened to reduce suicide risk.
- Crisis response planning and regular follow-up should be ensured for moderate and high-risk patients.

6.2.2 Recommendation for Future Research

- Conduct longitudinal studies to explore causal relationships between associated factors and suicidal tendency.
- Conduct multicenter studies with larger samples to improve generalizability across Bangladesh.
- Explore diagnosis-specific suicidal tendency patterns among different mental illnesses.
- Conduct qualitative studies to understand patients' lived experiences of suicidal intent.
- Evaluate integrated interventions (psychiatric care + substance-use management + family support) for reducing suicide risk.

6.3 Conclusion

The primary objective of this research was to determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness. The study revealed that most participants were classified as having a medium level of suicidal risk, while a clinically important proportion were identified as high risk. The findings further indicated that a history of substance use was an important factor associated with higher suicidal tendency. Several intent-related behavioral features such as isolation during the attempt, limited help-seeking behavior, stronger purpose/intent, and higher perceived lethality of the method were more prominent among individuals with higher suicidal risk. In contrast, some situational characteristics, including living arrangement and level of social support, did not show a clear statistical relationship with suicidal tendency in this sample. Overall, the study suggests that suicidal tendency among patients with mental illness is closely linked with attempt-related behavioral indicators and substance use history; therefore, a comprehensive approach that integrates routine suicide risk screening, substance use assessment, and targeted psychosocial interventions is essential to reduce suicidal risk and improve patient safety.

CHAPTER VII: LIST OF REFERENCE

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APPENDICES

Appendix A: Approval letter from IRB & Permission Letter

Approval letter

বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref: CRP-BHPI/IRB/07/2025/1095 Date: 21.07.2025

To
Md Mehedi Hasan Shimul
4th Year, B.Sc. in Occupational Therapy
Session: 2020-2021, **Student ID: 122200409**
BHPI, CRP, Savar, Dhaka-1343

Subject: Approval of the thesis proposal **Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness: A Cross-sectional Study** by ethics committee.

Dear Mehedi Hasan Shimul,
Congratulations.

The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above-mentioned dissertation, with yourself as the principal investigator and Nayan Kumer Chanda, Assistant Professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	Suicide Intent Scale (SIS)
3	Information sheet & consent form.

The purpose of the study is to determine the level of suicidal tendency and identify the behavioral and situational factors among patients with mental illness. The study involves the use of the Suicide Intent Scale (SIS), which will take approximately 15 to 20 minutes to complete. There is no likelihood of any harm to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June 2025 at BHPI (50th IRB Meeting).

The Institutional Ethics Committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol, and patient information or informed consent, and asks to be provided a copy of the final report. This Ethics Committee is working according to the Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013, and other applicable regulations.

Best regards,

Muhammad Millat Hossain
Associate Professor, Project & Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
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E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Permission Letter

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালক ও অধ্যাপকের কার্যালয়
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট ও হাসপাতাল
শের-ই-বাংলা নগর, ঢাকা- ১২০৭

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ ২৫৯২ তারিখঃ ২৪/৮/২৫

বরাবর

এসকে মনিরুজ্জামান
অধ্যাপক এন্ড প্রধান
অকুপেশনাল থেরাপি বিভাগ
পক্ষাঘাতগ্রস্তদের পুনর্বাসন কেন্দ্র (সিআরপি)
চাপাইন, সাভার, ঢাকা।

বিষয় : গবেষনা সংক্রান্ত তথ্য (ডাটা) সংগ্রহের অনুমতি প্রদান প্রসঙ্গে।

উপরোক্ত বিষয়ের আলোকে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), ঢাকা এর বিএসসি চতুর্থ বর্ষের শিক্ষার্থী কে জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, শেরে বাংলা নগর, ঢাকায় "Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness - A Cross Sectional Study" বিষয়ক গবেষনা সংক্রান্ত থিসিসের তথ্য উপাত্ত (ডাটা) সংগ্রহের জন্য অনুমতি প্রদান করা হলো।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা।

স্মারক নং-এনআইএমএইচ/একাডেমিক/২০২৫/ তারিখঃ
অনুলিপি অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য প্রেরন করা হলো ঃ-

১। সহযোগী অধ্যাপক, চাইল্ড, এডলোসেন্ট এন্ড ফ্যামিলি সাইকিয়াট্রি বিভাগ, এনআইএমএইচ, ঢাকা।।
২। সহযোগী অধ্যাপক, জেরিয়াট্রিক এন্ড অর্গানিক সাইকিয়াট্রি, এনআইএমএইচ, ঢাকা।
৩। ড. মোঃ জহির উদ্দিন, সহকারী অধ্যাপক, ক্লিনিক্যাল সাইকোলজি, এনআইএমএইচ, ঢাকা।
৪। মোঃ জামাল হোসেন, সাইকিয়াট্রিক সোসাল ওয়ার্কার, এনআইএমএইচ, ঢাকা।
৫। রেসিডেন্ট সাইকিয়াট্রিস্ট, এনআইএমএইচ, ঢাকা।
৬। প্রশাসনিক কর্মকর্তা, এনআইএমএইচ, ঢাকা।
৭। পরিচালক মহোদয়ের ব্যক্তিগত সহকারী, জাতীয় মানসিক স্বাস্থ্য ইনষ্টিটিউট, ঢাকা।
৮। সহকারী লাইব্রেরিয়ান, এনআইএমএইচ, ঢাকা।
৯। অফিস কপি।

(অধ্যাপক ডা. মোঃ মাহবুবুর রহমান)
পরিচালক (ভারপ্রাপ্ত) ও
অধ্যাপক (চলতি দায়িত্ব), সাইকিয়াট্রি
জাতীয় মানসিক স্বাস্থ্য ইনস্টিটিউট, ঢাকা

Student Office Order-282

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিচালকের কার্যালয়
মানসিক হাসপাতাল, পাবনা।
e-mail:pmh@hospi.dghs.gov.bd

স্মারক নং-মাহাপা/কমিটি/২০২৫/ তারিখ:

অফিস আদেশ

অত্র কার্যালয়ের বহি: পত্র নিবন্ধন নং-২০৩২ তারিখ: ২৫/০৮/২০২৫ খ্রি. মোতাবেক বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই) ঢাকা এর Md. Mehedi Hasan Shimul, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200409, BHPI, CRP, Savar, Dhaka) কর্তৃক মানসিক হাসপাতাল, পাবনায় "Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness" শিরোনামে ডাটা কালেকশনের জন্য আবেদন করায় এবং অত্র কার্যালয়ের Ethical Committee এর সুপারিশ ক্রমে উক্ত বিষয়ে গবেষনা করার অনুমতি প্রদান করা হলো।

(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।

স্মারক নং-মাহাপা/কমিটি/২০২৫/ ১২২৯/৮(১৫) তারিখ: ২৫/০৮/2025

অনুলিপি সদয় অবগতি/অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য:

১। সিনিয়র সচিব, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
২। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা। দৃষ্টি আকর্ষণঃ সহকারী পরিচালক (সমন্বয়)।
৩। মহাপরিচালক, স্বাস্থ্য শিক্ষা অধিদপ্তর, মহাখালী, ঢাকা।
৪। ডা: এহিয়া কামাল, চিকিৎসা তত্ত্বাবধায়ক,মানসিক হাসপাতাল, পাবনা।
৫। ডা: আহসান আজিজ সরকার, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৬। ডা: মো: রাজিবুর রহমান, সহকারী অধ্যাপক (সাইকিয়াট্রি), সংযুক্ত: মানসিক হাসপাতাল, পাবনা।
৭। ডা: এ কে এম শফিউল আযম আবাসিক সাইকিয়াট্রিষ্ট (ভারপ্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
৮। ডা: মো: রুহিদ হোসেন, জুনিয়র কনসালটেন্ট, জেনারেল হাসপাতাল, পাবনা।
৯। বোরহান উদ্দিন হায়দার, সাইকিয়াট্রিক সোসাল ওয়ার্কার (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১০। মো: মজাহার আলী, সাইকিয়াট্রিক সোসাল ওয়ার্কার, মানসিক হাসপাতাল, পাবনা।
১১। মো: জাকির হোসেন, সমাজসেবা কর্মকর্তা (অবসর প্রাপ্ত), মানসিক হাসপাতাল, পাবনা।
১২। মো: আলমগীর হোসেন, সমন্বয়কারী, বাংলাদেশ লিগ্যাল এইড এন্ড সার্ভিসেস ট্রাস্ট (BLAST), পাবনা ইউনিট।
১৩। Prof.SK Moniruzzaman, Professor & Head, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka.
১৪। Md. Mehedi Hasan Shimul, (4th Year, B.Sc.in Occupational Therapy, Student ID-122200409, BHPI, CRP, Savar, Dhaka)
১৫। প্রধান সহকারী/পিএ/পরিসংখ্যান বিভাগ, মানসিক হাসপাতাল, পাবনা।
১৬। অফিস নথি।

২৫/৮/২০২৫
(ডা: শাফ্‌কাত ওয়াহিদ)
পরিচালক
মানসিক হাসপাতাল, পাবনা।
ফোন: ০২৫৮৮৮০-৫২১২
২৫/০৮/২০২৫

Permission Letter for Suicide Intent Scale (SIS)

Gmail **Mehedi Hasan Shimul <mehedi.savar.shimul55@gmail.com>**

RE: Request for Permission and Guidance on Using the Suicide Intent Scale (For Attempters) [thread::SsNexFS_dbuySQaFSId7bRU::]
1 message

Beck Institute <help@beckinstitute.org> 30 January 2025 at 09:13
To: "mehedi.savar.shimul55@gmail.com" <mehedi.savar.shimul55@gmail.com>

Dear Mehedi,

Thank you for writing to us.

You have our permission to use the **Suicide Intent Scale** for the designated purpose that you described in your email. There is no charge for this permission.

The **Suicide Intent Scale** and related literature can be downloaded from our website.

However, we would appreciate it if you could send us a copy of your results once you have completed your study. Any reports, reprints, or publications you prepare in which the scale is used or referenced would also be greatly appreciated, as these are catalogued as a resource for other researchers and clinicians.

We are pleased to hear that you are working with this material in your research. We would like to direct your attention to the following resources that might interest you:

- Tools and resources for clinicians, researchers and students
- Robust training programs in Cognitive Behavior Therapy for individuals and organizations
- Training and resources for organizations and individuals in Recovery-Oriented Cognitive Therapy.
- The newest edition of Dr. Judith Beck's leading CBT textbook: Cognitive Behavior Therapy, Basics and Beyond
- Best-in-class CBT certification through Beck Institute

Warm Regards,
Heather Lenoir

Heather Lenoir
Customer Service Representative
Pronouns: she/her
Beck Institute for Cognitive Behavior Therapy
One Belmont Avenue, Suite 503
Bala Cynwyd, PA 19004
Email: hlenoir@beckinstitute.org

Appendix B: Information Sheet, Consent Form & Withdrawal Form (English Version)

Information Sheet (English version)

Information Sheet

Research Title: "Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness – A Cross Sectional Study."

Name of the Researcher: Mehedi Hasan Shimul, 4th Year, Department of Occupational Therapy, Roll No: 09

Supervisor: Nayan Kumer Chanda, Assistant Professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343

Invitation to Participate in Research

I, Mehedi Hasan Shimul, kindly invite you to participate in my research. Before you decide whether or not to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take a few moments to read the following information carefully. If you have any questions or need further clarification, feel free to ask.

Background and Aim of the Study

I am a final-year undergraduate student pursuing a B.Sc. in Occupational Therapy at the Bangladesh Health Professions Institute (BHPI), affiliated with the Faculty of Medicine, University of Dhaka, and an academic institute of the Centre for the Rehabilitation of the Paralysed (CRP). As part of my academic requirement, I am

conducting a research project under the supervision of Nayan Kumer Chanda, Assistant Professor, Department of Occupational Therapy. The title of my research is: "Level of Suicidal Tendency and Associated Factors Among Patients with Mental Illness – A Cross Sectional Study." The aim of this study is: To determine the level of suicidal tendency and identify the associated behavioral and situational factors among patients with mental illness. Your participation in this study is voluntary and will contribute significantly to understanding the risk factors of suicidal behavior and help develop future mental health support strategies.

What is the purpose of this research?

The purpose of this research is to investigate the level and associated factors of suicidal tendencies among individuals diagnosed with mental illnesses. The study aims to identify key risk factors contributing to suicidal behavior, examine behavioral and situational factors related to suicidal tendency, and provide evidence to support the development of comprehensive mental health interventions and suicide prevention strategies targeted at high-risk populations.

What does the research involve?

Participants will be given a structured questionnaire containing the Suicide Intent Scale (SIS) in order to measure the severity of suicidal intent. The procedure will require about 15-20 minutes and confidentiality will be maintained throughout the session in a clinical or rehabilitation setting. For further details or inquiries, you can contact the researcher via the provided phone number or email.

Why were you chosen for this research?

You have been selected because you have a history of suicide attempts and are receiving mental health care. Your insights will help in identifying patterns of suicidal behavior and its underlying causes.

Source of funding

This research is being conducted on a self-funded basis.

Consenting to participate in the project and withdrawing from the research

- Your participation requires written informed consent before the interview.
- Participation is optional, and there is no obligation to contribute.
- You may withdraw at any time before data analysis without any negative consequences.
- You have the right to refuse to answer specific questions if they cause distress.

Possible benefits and risks to participants

- There are no direct personal benefits, but your participation will contribute to improving mental health support and suicide prevention strategies.
- The study poses minimal risk, but discussing past suicide attempts may cause emotional discomfort.
- If distress occurs, the researcher will:
    - ✓ Remind you that participation is voluntary, and you may withdraw at any time.
    - ✓ Offer breaks during the interview if you feel overwhelmed.
    - ✓ Allow rescheduling of the interview if needed.

- ✓ Provide mental health support resources after the session.

Confidentiality

- All information will remain strictly confidential.
- Your name will not appear in any reports or publications.
- A unique code will be assigned to anonymize data after collection.
- Only the research team will have access to interview transcripts and personal data.

Storage of data

- Digital data will be stored in a password-protected system.
- Physical documents will be kept in locked cabinets at the research facility.
- Data will be securely retained for five years before being permanently deleted.

Results

Findings from this research will be analyzed and compiled into a comprehensive report. Key results may be published in academic journals and conferences. Participants may request a summary of the findings by contacting the researcher.

Complaints & Ethical Concerns

If you have any concerns regarding the research process, you are encouraged to contact the supervisor:

Nayan Kumer Chanda

Assistant Professor,

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI), CRP

Savar, Dhaka-1343

Call: 01735296444

Email: **nayanchanda2020@gmail.com**

Thank you,

Mehedi Hasan Shimul

Student ID No.- 122200409

Session: 2020-21

4th year, B.Sc. in Occupational Therapy

Bangladesh Health Professions Institute (BHPI), CRP

Consent Form (English)

Consent Form

(For Interview Participants)

Assalamu Alaikum. I am Mehedi Hasan Shimul, a 4th-year student of B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI), affiliated with the Faculty of Medicine, University of Dhaka. As part of my B.Sc. degree requirements, I am conducting a research project titled **"Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness."** The aim of this study is to determine the level of suicidal tendency among patients with mental illness and to identify the behavioral and situational factors related to suicidal tendency. To complete this research, I will collect some information from you through a face-to-face brief interview that will take approximately 15–20 minutes.

Please be assured that this study is purely academic, and all information collected will be used solely for research purposes. Your information will be kept confidential and used only for this study. Participation is completely voluntary, and you may withdraw your consent at any time within one week after data collection begins. After one week, withdrawal will no longer be possible.

If you have any questions about this research, you may contact me, Mehedi Hasan Shimul, or my supervisor, Mr. Nayan Kumar Chanda.

Do you have any questions before we begin?

- ☐ Yes
- ☐ No

May I have your consent to conduct the interview?

- ☐ Yes
- ☐ No

Participant’s Signature and Date: _____

Data Collector’s Signature and Date: _____

Withdrawal Form (English)

Participant's Withdrawal Form

(Applicable only for voluntary withdrawal)

Participant's Name: ……

Reason for withdrawal:

……

……

……

Signature and Date of Participant:

……

Appendix B: Information Sheet, Consent Form & Withdrawal Form (Bangla Version)

Information Sheet (Bangla)

তথ্যপত্র

গবেষণার শিরোনাম: "মানসিক রোগে আক্রান্ত ব্যক্তিদের মধ্যে আত্মহত্যার প্রবণতার স্তর এবং সংশ্লিষ্ট কারণসমূহ"

গবেষকের নাম: মেহেদী হাসান শিমুল, চতুর্থ বর্ষ, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা: ১৩৪৩

তত্ত্বাবধায়ক: নয়ন কুমার চন্দ, সহকারী অধ্যাপক, অকুপেশনাল থেরাপি বিভাগ, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

গবেষণায় অংশগ্রহণের আমন্ত্রণ

আমি, মেহেদী হাসান শিমুল, আপনাকে আমার গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানাচ্ছি। অংশগ্রহণ করার সিদ্ধান্ত নেওয়ার আগে গবেষণার উদ্দেশ্য ও এতে আপনার ভূমিকা সম্পর্কে জানা গুরুত্বপূর্ণ। অনুগ্রহ করে নিচের তথ্যগুলো মনোযোগ দিয়ে পড়ুন। কোনো প্রশ্ন থাকলে বা আরও ব্যাখ্যার প্রয়োজন হলে নির্দ্বিধায় জিজ্ঞাসা করুন।

গবেষণার পটভূমি ও উদ্দেশ্য

আমি ঢাকা বিশ্ববিদ্যালয়ের অধিভুক্ত ও সিআরপি-র একটি একাডেমিক প্রতিষ্ঠান, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (BHPI)-এর অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের শিক্ষার্থী। এটি আমার একাডেমিক গবেষণা প্রকল্প যা নয়ন কুমার চন্দ স্যারের তত্ত্বাবধানে পরিচালিত হচ্ছে। এ গবেষণার উদ্দেশ্য **হচ্ছে** মানসিক রোগে আক্রান্ত ব্যক্তিদের আত্মহত্যার প্রবণতার মাত্রা নির্ণয় এবং সংশ্লিষ্ট আচরণগত ও পরিস্থিতিগত কারণসমূহ চিহ্নিত করা। এই গবেষণাটি আত্মহত্যার ঝুঁকি বিশ্লেষণে সহায়তা করবে এবং ভবিষ্যতের মানসিক স্বাস্থ্য সহায়তা কর্মসূচি গঠনে অবদান রাখবে।

এই গবেষণার উদ্দেশ্য কী?

এই গবেষণার উদ্দেশ্য হলো মানসিক রোগে আক্রান্ত ব্যক্তিদের মধ্যে আত্মহত্যার প্রবণতা এবং এর পেছনে বিদ্যমান কারণসমূহ (যেমন: আচরণগত ও সামাজিক পরিস্থিতি) নির্ণয় করা। এতে প্রাপ্ত তথ্য আত্মহত্যা প্রতিরোধমূলক পদক্ষেপ গ্রহণে সহায়ক হবে।

গবেষণায় কী করতে হবে?

আপনাকে একটি প্রশ্নাবলী পূরণ করতে হবে, যার মধ্যে থাকবে Suicide Intent Scale (SIS), যার মাধ্যমে আত্মহত্যার প্রবণতার মাত্রা মাপা হবে। এটি সম্পূর্ণ করতে ১৫-২০ মিনিট সময় লাগবে। তথ্য সংগ্রহ একটি নিরিবিলি ক্লিনিক বা পুনর্বাসন পরিবেশে গোপনীয়ভাবে করা হবে।

আপনাকে কেন নির্বাচিত করা হয়েছে?

আপনি মানসিক স্বাস্থ্যসেবা গ্রহণ করছেন এবং পূর্বে আত্মহত্যার চেষ্টা করেছেন – এ কারণেই আপনি এই গবেষণার জন্য উপযুক্ত অংশগ্রহণকারী হিসেবে বিবেচিত হয়েছেন। আপনার অভিজ্ঞতা আমাদের আত্মহত্যামূলক আচরণ ও এর কারণগুলো বুঝতে সহায়তা করবে।

তহবিলের উৎস

এই গবেষণা সম্পূর্ণভাবে নিজস্ব খরচে পরিচালিত হচ্ছে।

অংশগ্রহণের সম্মতি ও গবেষণা থেকে প্রত্যাহার

- অংশগ্রহণের আগে আপনার লিখিত সম্মতি নেওয়া হবে।
- অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাসেবামূলক।
- আপনি যেকোনো সময়, ডেটা বিশ্লেষণের আগে, কোনো কারণ ছাড়াই গবেষণা থেকে সরে যেতে পারবেন।
- আপনি কোনো প্রশ্নে উত্তর দিতে অস্বীকৃতি জানাতে পারেন, যদি তা আপনাকে মানসিকভাবে কষ্ট দেয়।

সম্ভাব্য সুবিধা ও ঝুঁকি

- গবেষণায় অংশগ্রহণের মাধ্যমে ব্যক্তিগতভাবে সরাসরি কোনো উপকার না হলেও, এটি ভবিষ্যতের মানসিক স্বাস্থ্যসেবায় গুরুত্বপূর্ণ ভূমিকা রাখতে পারে।
- কিছু প্রশ্ন মানসিক অস্বস্তির সৃষ্টি করতে পারে, বিশেষ করে আত্মহত্যার অভিজ্ঞতা নিয়ে আলোচনা করার সময়।
- অস্বস্তি হলে গবেষক আপনাকে—
    - ✓ স্মরণ করিয়ে দেবেন যে আপনি যেকোনো সময় অংশগ্রহণ বাতিল করতে পারেন,
    - ✓ প্রয়োজনে বিরতি দিতে পারবেন,
    - ✓ সাক্ষাৎকার পরবর্তীতে চালিয়ে যেতে চাইলে সময় নির্ধারণ করা যাবে,
    - ✓ মানসিক স্বাস্থ্য সহায়তার তথ্য দেওয়া হবে।

গোপনীয়তা

- আপনার সব তথ্য কঠোরভাবে গোপন রাখা হবে।
- আপনার নাম বা পরিচয় কোনো প্রতিবেদনে প্রকাশ করা হবে না।
- প্রতিটি অংশগ্রহণকারীর জন্য একটি ইউনিক কোড ব্যবহার করে তথ্য গোপন রাখা হবে।
- শুধুমাত্র গবেষক দল তথ্য অ্যাক্সেস করতে পারবে।

তথ্য সংরক্ষণ

- ডিজিটাল ডেটা পাসওয়ার্ড-সংরক্ষিত সিস্টেমে রাখা হবে।
- মুদ্রিত কাগজপত্র তালাবদ্ধ আলমারিতে সংরক্ষিত থাকবে।
- তথ্য ৫ বছর সংরক্ষণ করার পর স্থায়ীভাবে মুছে ফেলা হবে।

গবেষণার ফলাফল

এই গবেষণার ফলাফল বিশ্লেষণ করে একটি পূর্ণাঙ্গ প্রতিবেদন তৈরি করা হবে। গুরুত্বপূর্ণ ফলাফল গবেষণা জার্নাল ও সম্মেলনে প্রকাশিত হতে পারে। আপনি চাইলে গবেষণার সারাংশ গবেষকের কাছ থেকে সংগ্রহ করতে পারবেন।

অভিযোগ ও নৈতিক উদ্বেগ

যদি গবেষণার প্রক্রিয়া নিয়ে কোনো অভিযোগ বা উদ্বেগ থাকে, তাহলে আপনি গবেষণা তত্ত্বাবধায়কের সাথে যোগাযোগ করতে পারেন:

নয়ন কুমার চন্দ

সহকারী অধ্যাপক,

অকুপেশনাল থেরাপি বিভাগ,

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএচপিআই), সিআরপি

সাভার, ঢাকা-১৩৪৩

ফোন: ০১৭৩৫২৯৬৪৪৪

ইমেইল: nayanchanda2020@gmail.com

ধন্যবাদান্তে,

মেহেদী হাসান শিমুল

আইডি নং: ১২২২০০৪০৯

সেশন: ২০২০-২০২১

৪র্থ বর্ষ, বি.এসসি. ইন অকুপেশনাল থেরাপি

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা: ১৩৪৩

Consent Form (Bangla)

সম্মতিপত্র

(যারা ইন্টারভিউতে অংশ নিচ্ছেন তাদের জন্য)

আসসালামু আলাইকুম। আমি মেহেদী হাসান শিমুল, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা অনুষদের অধীনে বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউটে বিএসসি ইন অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্র হিসেবে ২০২০-২০২১ সেশনে অধ্যয়নরত আছি। আমার বিএসসি ডিগ্রী সম্পন্ন করতে, আমাকে একটি গবেষণা প্রকল্প পরিচালনা করতে হবে এবং এটি আমার অধ্যয়নের একটি অংশ। আমার গবেষণার শিরোনাম: **"মানসিক রোগে আক্রান্ত ব্যক্তিদের মধ্যে আত্মহত্যার প্রবণতার স্তর এবং সংশ্লিষ্ট কারণসমূহ বের করার জন্য একটি ক্রস - সেকশনাল স্টাডি"।** আমার গবেষণার লক্ষ্য হলো — মানসিক রোগে আক্রান্ত ব্যক্তিদের মধ্যে আত্মহত্যার প্রবণতার স্তর নির্ধারণ করা এবং আত্মহত্যার সাথে সম্পর্কিত আচরণগত ও পরিস্থিতিগত কারণসমূহ চিহ্নিত করা। আমার গবেষণার প্রকল্পটি পূরণ করতে, ডেটা সংগ্রহ করার জন্য আমার আপনার কাছ থেকে কিছু তথ্য দরকার। সুতরাং, আপনি এই গবেষণার একজন সম্মানিত অংশগ্রহণকারী হতে পারেন। সামনা সামনি কথা বলার মাধ্যমে তথ্যগুলো সংগ্রহ করা হবে এবং কথোপকথনের সময় হবে ১৫-২০ মিনিট।

আমি আপনাকে জানাতে চাই যে, এটি একটি সম্পূর্ণরূপে একাডেমিক অধ্যয়ন এবং অন্য কোনো উদ্দেশ্যে ব্যবহার করা হবে না। আমি আশ্বাস দিচ্ছি যে, সমস্ত তথ্য গোপন রাখা হবে। আপনার অংশগ্রহণ সেচ্ছায় হবে। তথ্য সংগ্রহের এক সপ্তাহের মধ্যে যে কোনো সময় আপনার সম্মতি প্রত্যাহার করার অধিকার থাকবে। তবে তথ্য সংগ্রহের এক সপ্তাহ পরে প্রত্যাহার করতে পারবেন না।

এই গবেষণা সম্পর্কে আপনার কোন প্রশ্ন থাকলে, আপনি গবেষক মেহেদী হাসান শিমুল অথবা আমার সুপারভাইজার নয়ন কুমার চন্দ (সহকারী অধ্যাপক, অকুপেশনাল থেরাপি বিভাগ, বিএইচপিআই, সিআরপি, সাভার, ঢাকা) এর সাথে যোগাযোগ করতে পারেন।

তথ্য প্রদান শুরু করার আগে আপনার কোন প্রশ্ন আছে?

- ☐ হ্যাঁ
- ☐ না

তাহলে, ইন্টারভিউ নেওয়ার জন্য আমি কি আপনার সম্মতি পেতে পারি?

- □ হ্যাঁ
- □ না

অংশগ্রহণকারীর স্বাক্ষর এবং তারিখ : ----------

তথ্য সংগ্রহকারীর স্বাক্ষর এবং তারিখ : ----------

Withdrawal Form (Bangla)

অংশগ্রহণকারীর প্রত্যাহার পত্র

(শুধু মাত্র স্বেচ্ছায় প্রত্যাহারকারীর জন্য প্রযোজ্য)

অংশগ্রহণকারীর নাম : ----------

প্রত্যাহার করার কারণ :

অংশগ্রহণকারীর স্বাক্ষর ও তারিখ :

Appendix C: Questionnaire

Socio-demographic Questionnaire (English Version)

Socio-Demographic Questionnaire

Participant's Name: _____
Mobile Number: _____ Date: _____

No.	Question	Options / Response
1	Age	_____ years
2	Gender	☐ Male ☐ Female ☐ Other / Prefer not to say
3	Marital Status	☐ Unmarried ☐ Married ☐ Divorced / Separated ☐ Widow / Widower
4	Educational Qualification	☐ No formal education ☐ Primary ☐ Secondary ☐ Higher secondary ☐ Bachelor's ☐ Master's+
5	Employment Status	☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Unable to work due to illness/disability
6	Monthly Family Income (BDT)	☐ Low (<15,000) ☐ Middle (15,000–50,000) ☐ High (>50,000)
7	Type of Mental Illness (if diagnosed)	
8	Duration of Mental Illness	☐ <6 months ☐ 6 months–1 year ☐ 1–5 years ☐ >5 years
9	History of Suicide Attempt	☐ Yes ☐ No
10	Family History of Mental Illness	☐ Yes ☐ No ☐ Don't know
11	History of Substance Use	☐ Yes, specify: _____ ☐ No

12	Level of Social Support	☐ Strong ☐ Moderate ☐ Weak ☐ None
13	Living Arrangement	☐ Alone ☐ With family ☐ With others ☐ Institution
14	Area of Residence	☐ Rural ☐ Urban ☐ Semi-urban
15	Type of Housing	☐ Permanent ☐ Temporary ☐ Other: _____
16	Physical Disability	☐ None ☐ Mobility ☐ Visual ☐ Hearing ☐ Amputation ☐ Other: _____
17	Mental health treatment / counseling	☐ Regularly ☐ Occasionally ☐ Do not receive ☐ Not aware
18	Current substance use	☐ Yes ☐ No
19	Social isolation / loneliness	☐ Often ☐ Sometimes ☐ Rarely ☐ Never
20	Recent life stress / event	☐ Yes, specify: _____ ☐ No

Socio-demographic Questionnaire (Bangla Version)

সামাজিক ও জনসংখ্যাতাত্ত্বিক প্রশ্নাবলী

অংশগ্রহণকারীর নাম: _____

মোবাইল নম্বর: _____ **তারিখ:** _____

ক্র.নং	প্রশ্ন	উত্তর বিকল্প / স্থান
১	**আপনার বয়স কত?**	_____ বছর
২	**আপনার লিঙ্গ কি?**	☐ পুরুষ ☐ মহিলা ☐ অন্যান্য / বলতে ইচ্ছুক না
৩	**আপনার বৈবাহিক অবস্থা কী?**	☐ অবিবাহিত ☐ বিবাহিত ☐ বিচ্ছিন্ন/বিভক্ত ☐ বিধবা/বিধুর
৪	**আপনার সর্বোচ্চ শিক্ষা কী?**	☐ কোনো শিক্ষাগত যোগ্যতা নেই ☐ প্রাথমিক শিক্ষা ☐ মাধ্যমিক শিক্ষা ☐ উচ্চ মাধ্যমিক ☐ স্নাতক ☐ স্নাতকোত্তর বা তদূর্ধ্ব
৫	**আপনার কর্মসংস্থানের অবস্থা কী?**	☐ কর্মরত ☐ বেকার ☐ ছাত্র/ছাত্রী ☐ অবসরপ্রাপ্ত ☐ অসুস্থতার কারণে কাজ করতে অক্ষম
৬	**আপনার পরিবারের মাসিক আয় কত?**	☐ কম আয় (১৫,০০০ টাকার নিচে) ☐ মধ্যম আয় (১৫,০০০–৫০,০০০ টাকা) ☐ উচ্চ আয় (৫০,০০০ টাকার ওপরে)
৭	**আপনার মানসিক রোগের ধরণ কী? (যদি নির্ণীত হয়ে থাকে)**	
৮	**মানসিক রোগে আক্রান্ত হওয়ার সময়কাল কত?**	☐ ৬ মাসের কম ☐ ৬ মাস থেকে ১ বছর ☐ ১ থেকে ৫ বছর ☐ ৫ বছরের বেশি
৯	**কি আপনি আগেই কখনো আত্মহত্যার চেষ্টা করেছেন?**	☐ হ্যাঁ ☐ না
১০	**আপনার পরিবারের কারো কি মানসিক রোগ বা আত্মহত্যার ইতিহাস আছে?**	☐ হ্যাঁ ☐ না ☐ জানি না

১১	**আপনি কি কখনো মাদক বা অ্যালকোহল ব্যবহার করেছেন?**	☐ হ্যাঁ, উল্লেখ করুন: _____ ☐ না
১২	**আপনার সামাজিক সহায়তার স্তর কেমন?**	☐ শক্তিশালী ☐ মাঝারি ☐ দুর্বল ☐ নেই
১৩	**আপনি কার সাথে বাস করেন?**	☐ একা বাস করি ☐ পরিবারের সঙ্গে বাস করি ☐ পরিবারের বাইরে অন্য কারো সঙ্গে বাস করি ☐ কোনও প্রতিষ্ঠানে (যেমন হোস্টেল, আশ্রম) থাকি
১৪	**আপনার বসবাসের এলাকা কোথায়?**	☐ গ্রামীন ☐ শহুরে ☐ আধা-শহুরে
১৫	**আপনার বাড়ির ধরণ কী?**	☐ স্থায়ী বাড়ি ☐ অস্থায়ী বাড়ি ☐ অন্যান্য: _____
১৬	**আপনার কি কোনো শারীরিক প্রতিবন্ধকতা আছে?**	☐ নেই ☐ চলাফেরায় সমস্যা ☐ দৃষ্টিশক্তি সমস্যায় ভুগছি ☐ শ্রবণশক্তি কমে গেছে ☐ অঙ্গচ্ছেদ হয়েছে ☐ অন্যান্য: _____
১৭	**আপনি কি নিয়মিত মানসিক স্বাস্থ্য চিকিৎসা বা পরামর্শ নিচ্ছেন?**	☐ নিয়মিত নিচ্ছি ☐ মাঝে মাঝে নিচ্ছি ☐ নিচ্ছি না ☐ এই ধরনের সেবার ব্যাপারে জানি না
১৮	**আপনি কি বর্তমানে কোনো ধরনের মাদক/তামাক/অ্যালকোহল ব্যবহার করেন?**	☐ হ্যাঁ ☐ না
১৯	**আপনি কি একাকীত্ব বা সামাজিক বিচ্ছিন্নতার অনুভূতি করেন?**	☐ প্রায়ই ☐ মাঝে মাঝে ☐ কখনো না
২০	**সাম্প্রতিক সময়ে আপনার জীবনে কোনো বড় মানসিক বা সামাজিক চাপের ঘটনা ঘটেছে? (যেমন চাকরি হারানো, প্রিয়জনের মৃত্যু, পারিবারিক সমস্যা)**	☐ হ্যাঁ, যদি হ্যাঁ হয়, উল্লেখ করুন: _____ ☐ না

Suicide Intent Scale (SIS) - English Version

Suicide Intent Scale (SIS)

(For Attempters)

Instructions: Interview the patient about his/her most recent suicide attempt to enable a reliable coding of the objective circumstances of the attempt, and the patient's perceptions of the attempt. The total score is computed by summing items 1-15. If an item is "Not applicable" code it "-8." Do not include "-8's" when calculating the total score.

Total Score:

I. Objective Circumstances Related to Suicide Attempt

Item	Statements	Score
1. Isolation	0. Somebody present 1. Somebody nearby, or in visual or vocal contact 2. No one nearby or in visual or vocal contact	☐ 0 ☐ 1 ☐ 2
2. Timing	0. Intervention is probable 1. Intervention is not likely 2. Intervention is highly unlikely	☐ 0 ☐ 1 ☐ 2
3. Precautions against Discovery/Intervention	0. No precautions 1. Passive precautions (e.g. alone in room with unlocked door) 2. Active precautions (e.g. locked door)	☐ 0 ☐ 1 ☐ 2
4. Acting to Get Help During/After Attempt	0. Notified potential helper regarding attempt 1. Contacted but didn't specify 2. Didn't contact or notify anyone	☐ 0 ☐ 1 ☐ 2
5. Final Acts in Anticipation of Death	0. None 1. Thought about or made some arrangements 2. Made definite plans or completed arrangements	☐ 0 ☐ 1 ☐ 2
6. Active Preparation for Attempt	0. None 1. Minimal to moderate 2. Extensive	☐ 0 ☐ 1 ☐ 2
7. Suicide Note	0. Absence of note 1. Note written, but torn up; note thought about 2. Presence of note	☐ 0 ☐ 1 ☐ 2
8. Overt Communication of Intent Before the Attempt	0. None 1. Equivocal communication 2. Unequivocal communication	☐ 0 ☐ 1 ☐ 2

II. Self Report

Item	Statements	Score
9. Alleged Purpose of Attempt	0. To manipulate environment, get attention, revenge 1. Components of "0" and "2" 2. To escape, surcease, solve problems	☐ 0 ☐ 1 ☐ 2
10. Expectations of Fatality	0. Thought that death was unlikely 1. Thought that death was possible but not probable 2. Thought that death was probable or certain	☐ 0 ☐ 1 ☐ 2
11. Conception of Method's Lethality	0. Did less to self than he thought would be lethal 1. Wasn't sure if what he did would be lethal 2. Equaled or exceeded what he thought would be lethal	☐ 0 ☐ 1 ☐ 2
12. Seriousness of Attempt	0. Did not seriously attempt to end life 1. Uncertain about seriousness to end life 2. Seriously attempted to end life	☐ 0 ☐ 1 ☐ 2
13. Attitude Toward Living/Dying	0. Did not want to die 1. Components of "0" and "2" 2. Wanted to die	☐ 0 ☐ 1 ☐ 2
14. Conception of Medical Rescuability	0. Thought that death would be unlikely if he received medical attention 1. Was uncertain whether death could be averted by medical attention 2. Was certain of death even if he received medical attention	☐ 0 ☐ 1 ☐ 2
15. Degree of Premeditation	0. None; Impulsive 1. Suicide contemplated for three hours or less prior to attempt 2. Suicide contemplated for more than three hours prior to attempt	☐ 0 ☐ 1 ☐ 2

III. Other Aspects (Not Included in Total Score)

Item	Statements	Score
16. Reaction to Attempt	0. Sorry about attempt; feels foolish, ashamed (circle which one) 1. Accepts both attempt and its failure 2. Regrets failure of attempt	☐ 0 ☐ 1 ☐ 2
17. Visualization of Death	0. Life-after-death, reunion with decedents 1. Never ending sleep, darkness, end-of-things 2. No conceptions of, or thoughts about death	☐ 0 ☐ 1 ☐ 2
18. Number of Previous Attempts	0. None 1. One or two 2. Three or more	☐ 0 ☐ 1 ☐ 2

19. Relationship between Alcohol Intake and Attempt	0. Some alcohol intake prior to but not related to attempt, reportedly not enough to impair judgment, reality testing 1. Enough alcohol intake to impair judgment, reality testing and diminish responsibility/impulse control 2. Intentional intake of alcohol in order to facilitate implementation of suicide attempt	☐ 0 ☐ 1 ☐ 2
20. Relationship between Drug Intake and Attempt *(narcotics, hallucinogens, etc. drug is not the method used to suicide)*	0. Some drug intake prior to but not related to attempt, reportedly not enough to impair judgment, reality testing 1. Enough drug intake to impair judgment, identity testing and diminish responsibility/impulse control 2. Intentional drug intake in order to facilitate implementation of suicide attempt	☐ 0 ☐ 1 ☐ 2

Scoring & Recommendations

Total Score (Items 1–15)	Risk Level	Recommended Action
0–10	Low Risk	Send home with advice to follow up with GP or Community Mental Health Team.
11–19	Medium Risk	Recommend assessment by Mental Health Team or Psychiatrist. Arrange follow-up if treatment refused. Admission may be needed if patient lives alone or has previous attempts.
20–30	High Risk	Immediate psychiatric evaluation is needed. Admission is strongly advised. Involuntary admission may be necessary.

Suicide Intent Scale (SIS) - Bangla Version

Suicide Intent Scale (SIS) (For Attempters)

(যারা আত্মহত্যার চেষ্টা করেছেন, তাদের জন্য)

নির্দেশনা: রোগীর সর্বশেষ আত্মহত্যার চেষ্টার সময় কী হয়েছিল আর কী ভেবেছিলেন, তা বুঝতে নিচের প্রশ্নগুলো করুন। ১ থেকে ১৫ নম্বর প্রশ্ন পর্যন্ত স্কোর যোগ করে মোট স্কোর বের করুন। যেসব প্রশ্ন প্রযোজ্য নয়, সেখানে "৮" ব্যবহার করতে পারবেন (এই স্কোর মোট স্কোরের সঙ্গে যোগ হবে না)।

মোট স্কোর: _____

I. যখন আত্মহত্যার চেষ্টা করেছিলেন, তখন কী পরিস্থিতি ছিল

ক্রম	প্রশ্ন	স্কোর
১	**আপনি যখন আত্মহত্যার চেষ্টা করেছিলেন, তখন পাশে কেউ ছিল?** • ০ – হ্যাঁ, কেউ ছিল • ১ – আশেপাশে কেউ ছিল বা ডাকলে শুনতে পারত • ২ – একদম একা ছিলাম	☐ ০ ☐ ১ ☐ ২
২	**আপনি এমন সময় চেষ্টা করেছিলেন, যাতে কেউ আপনাকে বাঁচাতে পারত?** • ০ – হ্যাঁ, পারত • ১ – পারার সম্ভাবনা কম ছিল • ২ – একদমই পারত না	☐ ০ ☐ ১ ☐ ২
৩	**আপনি এমন কিছু করেছিলেন যাতে কেউ বুঝতে না পারে?** • ০ – না, কিছু করিনি • ১ – দরজা খোলা ছিল • ২ – দরজা বন্ধ করে দিয়েছিলাম	☐ ০ ☐ ১ ☐ ২
৪	**চেষ্টা করার সময় বা পরে কাউকে জানানোর চেষ্টা করেছিলেন?** • ০ – হ্যাঁ, বলে দিয়েছিলাম • ১ – ইশারায় কিছু বলেছিলাম • ২ – কাউকে কিছুই বলিনি	☐ ০ ☐ ১ ☐ ২
৫	**মৃত্যুর আগে কিছু গুছিয়ে রেখেছিলেন (যেমন উইল বা কিছু উপহার)?** • ০ – কিছুই করিনি • ১ – ভেবেছিলাম বা সামান্য কিছু করেছি • ২ – অনেক কিছু গুছিয়ে রেখেছিলাম	☐ ০ ☐ ১ ☐ ২
৬	**আপনি আত্মহত্যার জন্য পরিকল্পনা করেছিলেন?** • ০ – না • ১ – একটু পরিকল্পনা করেছিলাম • ২ – ভালোভাবে পরিকল্পনা করেছিলাম	☐ ০ ☐ ১ ☐ ২

৭	**আপনি কি কোনো চিঠি লিখেছিলেন?** • ০ – না • ১ – লিখেছিলাম কিন্তু ছিঁড়ে ফেলেছিলাম • ২ – হ্যাঁ, লিখেছিলাম	☐ ০ ☐ ১ ☐ ২
৮	**আপনি কি আগে কাউকে ইঙ্গিত দিয়েছিলেন যে আপনি এমন কিছু করতে যাচ্ছেন?** • ০ – না • ১ – ঘুরিয়ে-পেঁচিয়ে কিছু বলেছিলাম • ২ – সরাসরি বলেছিলাম	☐ ০ ☐ ১ ☐ ২

II. **নিজের অনুভব ও ইচ্ছা**

ক্রম	প্রশ্ন	স্কোর
৯	**আপনি কেন আত্মহত্যার চেষ্টা করেছিলেন বলে মনে হয়?** • ০ – মনোযোগ পাওয়ার জন্য, কাউকে দোষ দেওয়া বা শাস্তি দিতে • ১ – এই রকম আর কষ্ট থেকে মুক্তির জন্য দুই কারণই • ২ – কষ্ট বা সমস্যার থেকে মুক্তি পেতে	☐ ০ ☐ ১ ☐ ২
১০	**আপনি কি ভেবেছিলেন এতে আপনার মৃত্যু হবে?** • ০ – না • ১ – হতে পারে ভেবেছিলাম • ২ – হ্যাঁ, নিশ্চিত ছিলাম	☐ ০ ☐ ১ ☐ ২
১১	**আপনি যা করেছিলেন, তাতে সত্যিই মারা যেতে পারেন বলে মনে হয়েছিল?** • ০ – না, খুব একটা না • ১ – বুঝে উঠতে পারছিলাম না • ২ – হ্যাঁ, সম্ভব ছিল	☐ ০ ☐ ১ ☐ ২
১২	**আপনি কি সত্যিই মরতে চেয়েছিলেন?** • ০ – না • ১ – একটু দ্বিধায় ছিলাম • ২ – হ্যাঁ, মরতেই চেয়েছিলাম	☐ ০ ☐ ১ ☐ ২
১৩	**আপনি কি বাঁচতে চেয়েছিলেন, না মরতে?** • ০ – বাঁচতে চেয়েছিলাম • ১ – দুই মনের মধ্যে ছিলাম • ২ – মরতেই চেয়েছিলাম	☐ ০ ☐ ১ ☐ ২
১৪	**আপনি কি ভেবেছিলেন চিকিৎসা পেলে বেঁচে যাবেন?** • ০ – হ্যাঁ • ১ – বুঝতে পারছিলাম না • ২ – না, মরবই ভেবেছিলাম	☐ ০ ☐ ১ ☐ ২

১৫	**কত আগেই আপনি এই কাজ করার কথা ভেবেছিলেন?** • ০ – হঠাৎ করে • ১ – ৩ ঘণ্টার মধ্যে • ২ – ৩ ঘণ্টার বেশি আগে	☐ ০ ☐ ১ ☐ ২

III. অন্যান্য প্রশ্ন (স্কোরে যোগ হবে না)

ক্রম	প্রশ্ন	স্কোর
১৬	**চেষ্টা করার পর কেমন অনুভব হয়েছিল?** • ০ – অনুতপ্ত বা লজ্জিত • ১ – যেটা হয়েছে মেনে নিয়েছি • ২ – চেষ্টা করে ব্যর্থ হওয়ায় খারাপ লেগেছে	☐ ০ ☐ ১ ☐ ২
১৭	**মৃত্যুর পর কী হবে বলে আপনি ভেবেছিলেন?** • ০ – প্রিয়জনদের সঙ্গে দেখা হবে • ১ – ঘুম, অন্ধকার বা কিছুই থাকবে না • ২ – কিছু ভাবিনি	☐ ০ ☐ ১ ☐ ২
১৮	**আগেও কখনো এমন চেষ্টা করেছিলেন?** • ০ – না • ১ – এক–দুই বার • ২ – তিন বার বা তার বেশি	☐ ০ ☐ ১ ☐ ২
১৯	**চেষ্টা করার সময় আপনি অ্যালকোহল/মদ খেয়েছিলেন?** • ০ – অল্প, তেমন প্রভাব পড়েনি • ১ – অনেক খেয়েছিলাম, চিন্তায় প্রভাব ফেলেছিল • ২ – ইচ্ছা করেই খেয়েছিলাম	☐ ০ ☐ ১ ☐ ২
২০	**চেষ্টা করার সময় আপনি মাদক (ড্রাগ) নিয়েছিলেন?** • ০ – অল্প, তেমন প্রভাব পড়েনি • ১ – নিয়েছিলাম, নিয়ন্ত্রণ হারিয়েছিলাম • ২ – ইচ্ছা করেই নিয়েছিলাম	☐ ০ ☐ ১ ☐ ২

স্কোর মূল্যায়ন ও করণীয়

মোট স্কোর (১–১৫ নম্বর পর্যন্ত)	ঝুঁকির মাত্রা	প্রস্তাবিত পদক্ষেপ
০–১০	কম ঝুঁকি	বাসায় পাঠানো যেতে পারে। পরামর্শ: মানসিক স্বাস্থ্য বিশেষজ্ঞ বা চিকিৎসকের সঙ্গে যোগাযোগ করতে বলা।
১১–১৯	মাঝারি ঝুঁকি	মানসিক স্বাস্থ্য টিম বা মনোরোগ বিশেষজ্ঞের মাধ্যমে মূল্যায়ন জরুরি। চিকিৎসা না চাইলে ফলোআপ ব্যবস্থা নিতে হবে। একা থাকা বা আগের প্রচেষ্টা থাকলে ভর্তি বিবেচনা করা উচিত।
২০–৩০	উচ্চ ঝুঁকি	জরুরি ভিত্তিতে মনোরোগ বিশেষজ্ঞ বা কমিউনিটি মেন্টাল হেলথ টিম দ্বারা মূল্যায়ন দরকার। হাসপাতালে ভর্তি (প্রয়োজনে জোরপূর্বক) হতে পারে।

Appendix D: Supervisor Contact Sheet

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: Level of Suicidal Tendency and Associated Factors among Patients with Mental Illness – A cross sectional study

Name of student: Md. Mehedi Hasan Shimul, 4th year, B.Sc. in occupational Therapy.

Name and designation of thesis supervisor: Nayan Kumer Chanda, Assistant professor
Department of occupational Therapy
Bangladesh Health Professions Institute, BHPI, CRP, Savar

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	25/05/25	BHPI Teachers room	finalization of research title, aim and objectives	1 hours	Title and objectives clarified	Shimul	Nayan
2	27/05/2025	BHPI Teachers room	Review of literature outline and variable selection	1 hr 30 min	Guidance taken on behavioral and psychosocial factors	Shimul	Nayan
3	31/05/2025	BHPI Teachers room	Study design and cross-sectional approach	1 hr	Design finalized	Shimul	Nayan

4	16/06/2025	BHPI Teachers room	Tool selection (Suicide Intent Scale - SIS)	1hr 30 min	Measurement tool confirmed	Shimul	
5	18/06/2025	BHPI Teachers room	Operational definition and variables	1hr	Definitions refined	Shimul	
6	22/06/2025	BHPI Teachers room	Sampling technique and inclusion and exclusion criteria	1hr	criteria finalized	Shimul	
7	23/06/2025	BHPI Teacher's room	Ethical issues and consent procedure	1hr 30min	Ethical section prepared	Shimul	
8	25/06/2025	BHPI Teacher's room	Questionnaire review and modification	1hr	Questionnaire finalized	Shimul	
9	30/06/2025	BHPI Teacher's room	IRB application guidance	1hr	IRB process clarified	Shimul	
10	02/07/2025	BHPI Teacher's room	Data collection plan and field preparation	1hr 30min	field plan approved	Shimul	
11	07/07/2025	BHPI Teacher's room	pilot testing discussion	1hr	pilot test guidance	Shimul	
12	10/07/2025	BHPI Teacher's room	Data collection troubleshooting	1hr	Issues discussed	Shimul	
13	12/07/2025	BHPI Teacher's room	Data coding and spss preparation	1hr 30 min	coding method learned	Shimul	
14	15/07/2025	BHPI Teacher's room	Data entry checking	1hr	Accuracy ensured	Shimul	

15	29/07/2025	BHPI Teacher's room	Descriptive statistics guidance	1 hr	Analysis approach clarified	Shimul	
16	30/07/2025	BHPI Teacher's room	Association tests (Chi-square/fisher)	1 hr 30 min	statistical test selection	Shimul	
17	03/08/2025	BHPI Teacher's room	Regression analysis discussion	1 hr	logistic regression explained	Shimul	
18	06/08/2025	BHPI Teacher's room	results interpretation	1 hr	findings clarified	Shimul	
19	12/09/2025	BHPI Teacher's room	chapter – IV (Results) review	1 hr 30 min	connections noted	Shimul	
20	23/09/2025	BHPI Teacher's room	Discussion chapter structure	1 hr	Discussion outline improved	Shimul	

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.

21	12/11/2025	BHPI Teachers room	linking results with literature	1 hr 30 min	Interpretation refined	Shimul	
22	18/11/2025	BHPI Teachers room	limitation and strengths	1 hr	Section finalized	Shimul	
23	02/12/2025	BHPI Teachers room	conclusion and recommendations	1 hr	conclusion finalized	Shimul	
24	08/12/2025	BHPI Teachers room	final thesis formatting	1 hr	formatting corrected	Shimul	
25	09/12/2025	BHPI Teachers room	final proofreading	1 hr	Minor errors corrected	Shimul	
26	03/01/2026	BHPI Teachers room	Supervisor final review	1 hr 30 min	final feedback received	Shimul	
27	10/01/2026	BHPI Teachers room	corrections after review	1 hr	corrections done	Shimul	
28	14/01/2026	BHPI Teachers room	pre-submission checking	1 hr	ready for submission	Shimul	
29	03/02/2026	BHPI Teachers room	Submission guidance	1 hr	Submission confirmed	Shimul	
30	09/02/2026	BHPI Teachers room	final supervisor consultation	1 hr	Thesis approved	Shimul	