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Faculty of Graduate Studies

Palestinian Women Attempted Suicide, Risks beyond the Experience A Descriptive Phenomenological Study

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This Thesis is Submitted in Partial Fulfillment of the Requirements For the Degree of Masters of Community Mental Health Nursing, Faculty of Graduate Studies, An-Najah National University, Nablus, Palestine.

2014

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الاهداء

بسم الله المستعان رب الاكوان

إلهي لا يطيب العمل الا برضاك و شكرك .. احمدك واشكر فضلك حمدا كثيرا طيبا مباركا فيه

.. إلى نبي الرحمة ونور العالمين .. الى سيدي وحبيبي سيد الخلق اجمعين

سيدنا محمد صلى الله عليه وسلم

إلى من كلله الله بالهيبة والوقار .. إلى من علمني العطاء بدون انتظار .. إلى من أحمل أسمه بكل افتخار .. أرجو من الله أن يمد في عمرك

والدي العزيز

إلى ملاكي في الحياة .. إلى معنى الحب وإلى معنى الحنان والتفاني .. إلى بسمةالحياة وسر الوجود

إلى من كان دعائها سر نجاحي وحنانها بلسم جراحي إلى أغلى الحبايب

أمي الحبيبة

إلى توأم روحي ورفقاء دربي .. إلى اصحاب القلوب الطيبة والنوايا الصادقة

اخوتي واخواتي الاحباء

..إلى شعلة الذكاء والنور إلى من أرى التفاؤل بعينها .. والسعادة في ضحكتها

إلى الوجه المفعم بالبراءة

ابنتي الحبيبة

الى رياحين هذه الحياة وبسمتها

ابناء وبنات اخواني

الى اخوات لم تلدهن امي

صديقاتي الغاليات وزوجات اخوتي

إلى كل من مد لي يد العون لأخطو في طريق العلم اهدي هذا البحث

الشكر والتقدير

الشكر لله أولاً وأخيراً الذي كان عوناً لي في إتمام بحثي هذا وإخراجه بصورته النهائية .

كما أتقدم بخالص شكري وعرفاني إلي أستاذتي المشرفتان على بحثي الدكتورة / عائدة القيسي والدكتورة سابرينا روسو

اللواتي أشرفن وتابعن معي في البحث عن المعلومة والوصول إلي النتيجـــة،لهن كل الشكر والتقدير على الجهد المتواصل والدعمم الكبير الذي قدمنه لي.

الى كل الأساتذة الأفاضل في الصرح العلمي الكبير(كلية التمريض في جامعة النجاح)

الى زملائي في الدراسة على دعمهم المتواصل

كما أتقدم بالشكر للوزارات والمؤسسات الحكومية وغير الحكومية على دعمها ومساعدتي في الوصول للمعلومات اللازمة.

شكر خاص لقسم الصحة النفسية المجتمعية في محافظة طولكرم على دعمهم واهتمامهم.

والذين ساعدوني في الحصول على المعلومة اللازمة لإتمام هذا البحث.

الشكر الجزيل للسيدات اللواتي تحملن الالم ولم يبخلن بالحديث عن تجاربهن وكن النواة الاهم لاتمام هذا البحث. لكل امرأة شاركت بتجربتها كل الشكر والمحبة.

إقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

Palestinian Women Attempted Suicide, Risks beyond the Experience A Descriptive Phenomenological Study

اقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشـــارة إليه حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

The work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's name: **اسم الطالب:**

Signature: **التوقيع:**

Date: **التاريخ:**

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Abstract

Introduction: suicide is a major public health problem all over the world. It described as "intentional, self-destructive, and self-inflicted acts.

Aim: The aim of this study is to explore the risks beyond the experience of attempting suicide among a group of Palestinian women.

Design: The study used a qualitative descriptive phenomenological method to explore the experiences of Palestinian women attempted suicide, to capture as much as possible the way in which the phenomenon is experienced, and the risks lays beyond the experience.

Data collection: Face to face, in-depth, semi-structured interviews were conducted with participants – the women who previously attempted suicide.

Sample: Purposive sampling was used; 20 women attempted suicide at least once.

Setting: Interviews were conducted in a private place agreed for with the women.

Data Analysis: The data was analyzed by using Giorgi's phenomenological psychology method (1985).

Results: From the interviews, Five themes and eighteen sub-themes emerged: violence (Sexual violence, domestic violence, collective violence, witnessing abuse, and child maltreatment); Losses (loss of parents, loss of cultural identity, loss of relation, and loss of security) ; psychological risk factors (Low self efficacy, Low Self esteem, Negative Self image, and Maladaptive coping mechanism); and Socio cultural factors (poverty, stigma, and dysfunctional family); Lack of support system (Non professional, and professional).

Conclusion and Recommendation: The findings of the study demonstrate the importance of understanding the experience of the women attempted suicide, the risk beyond their experience, and the phenomena of suicide within the Palestinian community. It reflect the need for national prevention programs which include the implementation of national programs for mental health, recognizing the rights of females, tackling illiteracy among both males and females, prohibiting forced child marriage, providing economic and social support especially for young females, and promoting Islamic values rather than traditional customs.

Key words: Attempted suicide, experience, risk, descriptive phenomenology.

Definitions of Concepts:

- **Violence:** is the intentional use of physical force or power, threatened or actual, against a person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. This definition associate intentionality with the committing of the act itself, irrespective of the outcome it produces (WHO, 2005).
- **Sexual violence:** any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work(WHO, 2005).
- **Rape**: Physically forced or otherwise coerced penetration even if slight – of the vulva or anus, using a penis, other body parts or an object(WHO, 2005).
- **Domestic violence:** refers to a behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviors (WHO, 2005).
- **Physical abuse:** is an act of another party involving contact intended to cause feelings of physical pain, injury, or other physical suffering or bodily harm (WHO, 2005).

- **Verbal violence:** is persistent behavior using words and/or "mind games" to instill self-doubt in the victim and to build the abuser's sense of dominance and control (WHO, 2005).

- **Children maltreatment:** Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (WHO, 2005).

- **Sexual violence of child:** Sexual abuse is defined as those acts where a caregiver uses a child for sexual gratification (WHO, 2005).

- **Physical violence of child:** Physical abuse of a child is defined as those acts of commission by a caregiver that cause actual physical harm or have the potential for harm (WHO, 2005).

- **Emotional ill treatment:** Emotional abuse includes the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child. Such acts include restricting a child's moments, denigration, ridicule, threats and intimidation, discrimination, rejection and other non- physical forms of hostile treatment (WHO, 2005).

- **Negligence**: Neglect refers to the failure of a parent to provide for the development of the child – where the parent is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. Neglect is thus distinguished from circumstances of poverty in that neglect can occur only

in cases where reasonable resources are available to the family or caregiver (WHO, 2005).

- Self-efficacy: Is a person's belief in their ability to accomplish some specific goal or task. It generally corresponds to the level of competence an individual feels (Ormrod, 2006).
- Self-esteem: It is a judgment of oneself as well as an attitude toward the self (Hewitt, 2009)
- Self-image: The self-concept is a factual description of how you perceive yourself (Ormrod, 2006).

Chapter One

Introduction

1.1 Introduction

Suicide, as a public issue, has engaged the attention of organizations, communities, tribes, and countries around the world (Kinder, et al. 2009; Gau et al., 2008). Research suggests that changes in socioeconomic, political, and environmental conditions exacerbate various public problems such as suicide and childhood abuse (Boothroyd, et al. 2001; Ferry, 1999; Lu et al., 2007; Mann, et al.2008; Johnson et al., 2008).

Suicide carries a social and a moral meaning in all societies. Unsurprisingly, suicide was one of the first social phenomena to be studied in the history of the discipline of sociology.

At both the individual and population levels, suicide has long been understood to correlate with cultural, social, political, and economic forces (Giddens, 1964). As such, understanding suicide and its causes requires an understanding of how it varies and relates to social context.

The World Health Organization (WHO) established a “global suicide rate”, at about 16 per 100,000 people. According to the World Health Organization, in the last 45 years worldwide suicide rates have increased dramatically; suicide is now among the three leading causes of death among those aged 15-44 years old for both sexes (WHO, 2008). According to WHO, based on current trends, they estimate that approximately 1.53 million people will die from suicide, and people will attempt suicide 10-20

times more worldwide. This would result, on average, one death every twenty seconds and one attempt every 1–2 seconds (WHO, 2010).

Despite the fact that suicide is viewed as a global public health issue, it has nonetheless remained under-studied and under-researched in Arab countries. In Palestine, a mere two studies on subject have been conducted. One of which was in English and carried out by DR. Nadia Taysir Dabbagh in 2005, entitled, "Suicide in Palestine: Narrative of Despair" and the other in Arabic, by AMMAN Center for Social Studies (2003), which discusses the causes of suicide in Palestine. Some statistics were obtained from the Police Research Unit in Palestine. The hard data for the study was collected through personal visits from the researcher to the Police Research Unit. The study shows an increase in suicide and suicide-attempt rates in the last five years. In 2008, 360 cases of attempted suicide were reported, with twelve reported dead as a result of suicide. In 2009 there were a reported 308 cases of attempted suicide, with 14 resulting in death. In 2010, 340 cases were reported with one death. In 2011, 350 cases of attempted suicide and in 2012, a total of 363 cases were reported with a total of 13 deaths. 60.6% of those who attempt suicide in Palestine (West Bank and Gaza Strip) are women. Suicide rates are said to be underestimated due to the social stigma behind the subject, as well as most cases not admitting suicide attempts. These incidents are recorded as accidents (Police Research Unit, 2013).

The statistical picture of suicide in Palestine was explained by Dabbagh (2005) in her study. Statistics were built up from data gathered from hospitals, clinics, individual doctors and legal records. The epidemiology turned out to be very similar to that found in the West, with a variance of characteristics in terms of attempted suicide and actual suicide. Attempted suicide was more common than completed suicide, largely carried out by young people, mainly women, and often using 'soft' methods such as drugs. Fatal suicide appeared to be generally committed by older age groups, and more often by men using more violent methods. In Western countries, such as the UK and France, noted the most common type of suicidal behaviour was through drug overdose, especially for young women.

In addition, as part of the data collection process in her study, Dabbagh (2005) spent a year following every cases of self-harm in Ramallah Government Hospital (Ramallah, West Bank, Palestine). In her study, she discusses the manner in which the statistics were shaped and collected. As suicide and attempted suicide are regarded as crimes, all incidents were meant to be reported to the police. This appeared to be a mainly bureaucratic exercise, as the suicidal action was recorded but no further action was taken. It was noticed that single men who were brought in without family members were much more likely to be reported than women who came in with a close male family member. The latter were

almost never reported. These decisions made by health care workers influenced the accuracy of statistical data.

It is well known that more men than women actually commit suicide, while women make more suicide attempts. This indicates that women are at a significantly higher lifetime risk of attempting suicide than are men (Cooperman et al. 2005; Oquendo et al., 2007).

Suicide is the fourth leading cause of death for women between the ages of 15 and 44 years of age, exceeding the number of deaths due to homicide, HIV, cerebrovascular disease (CVD), and diabetes (CDC, 2009). Although women have lower rates of suicide mortality than men, the fatality rates have not decreased in recent years. In 1999, the suicide rate among women aged 15–44 was 4.8 deaths per 100,000 people; in 2006, it was 5.0 deaths per 100,000 people (CDC, 2009).

Stressful situations such as unemployment, poverty, familial death, and divorce can increase the risk of suicide (Werneck, et al. 2006). Suicide in women is more related to cultural and social contexts. Social norms and values are often more oppressive for women, putting them at greater risk (Rudmin, et al.2003). Factors associated with psychiatric morbidity and suicidal behavior in women of low-income countries includes early age at marriage, lack of autonomy, coercion to have children, and economic dependence on men (Khan, 2005).

Durkheim (1952) and Erkki, et al. (1994) argue that suicide should not be viewed only as individual biological, psychological, or psychiatric phenomena, but also as a social phenomenon. Following Durkheim and colleagues, researchers investigated social factors related to suicide. Many scholars (Blakely et al. 2003; Platt, 1994; Schutt et al.1994; Stack, 2000) state that social, cultural, and economic factors have an impact on suicide. Kim et al. (2006) reported that Korean people in lower social classes have higher rates of suicide.

Studies in Islamic countries showed that familial conflict (Syed & Khan, 2008) and other social problems such as education and economic factors are the main social contributors to suicide (Al Ansari, et al. 2007; Cosar, et al. 1997).

Some researchers reported lower suicide rates in Islamic countries such as Kuwait, Bahrain, Jordan, and Egypt compared with the Western societies (Lester, 2006). This is due to the fact that suicide is considered a great sin in Islam; however, many cases are not reported. Islam notes the sanctity of life and the at the highest priority. Allah says:

“and taken no life which Allah made sacred, except by way of justice and law.”(al_An’am: 151)

“and kills (or destroy) not yourselves; verily, Allah is most merciful to you.”(al_Nisa’,29).

1.2 The Palestinian context

Palestinian society is patriarchal, and as a society it is tightly knit and conservative, often advocating for segregation of genders. Generally, women marry early in life, and therefore, also bear and raise children fairly early. In 2012 about five percent of women aged 15-49 were married before the age of 15; 16% beared children before the age of 17 (Palestinian Central Bureau of Statistics, 2012).

Religion is a central feature in the lives of the majority of Palestinians in the West Bank; prominent religions are Islam, Christianity and Judaism. According to a recent census, 92% of Palestinian in the West Bank reported to be Sunni Muslim (Palestinian Central Bureau of Statistics, 2012).

Palestinian society is broadly divided between people from towns (madaniyeen), villages (peasants or falaheen) and camps (refugees or lajieen) each with stereotypes attached (Palestinian Central Bureau of Statistics, 2012).

As in most Muslim-dominated countries, the religious culturerules by which a strong masculine role determines social order (Rubin & Yasien-Esmael, 2004). Women are not legally allowed to pass on their family name, and are also considered potentially precarious of their family's honor, therefore, society uses these pressures and regulations to justify gender-based (Douki et al., 2003).

There is a high likelihood that arranged and forced child marriage (along with domestic violence against women) originates from this view toward females (Kulwicki, 2002).. In addition, there is also another unique cultural pattern of violence against young females originating from this view called “honor killing,” Honor killing is a crime committed against a female by one of her male family members because the women had supposedly dishonored the status of their family (Hadidi, Kulwicki, & Jahshan2001; Kulwicki, 2002).

1.3 Aim of the study

Using a qualitative approach, we will explore the risks beyond the experience of attempting suicide among a group of Palestinian women. Suicide poses a challenge for the health of women in Palestine, and it is influenced by a set of complex and interactive psychological, social, cultural, and economic factors.

A lack of research in the subject makes it difficult to understand the phenomena in relation to the special cultural and social aspects in Palestine. Understanding these factors is critical in provision of effective and culturally appropriate care.

1.4 Problem Statements

The purpose of phenomenological research is to describe specific phenomena of interest as they are lived and experienced by individuals. The focus on phenomenological studies is in order to understand the impact

of experience within the context of people's lives. This is referred to as capturing the lived experience (Hirst, 2010).

This purpose of this study is to investigate factors and risks that influence women to attempt suicide in Palestine. An increased rate of suicidal behavior has been reported within Palestine; 60 % of which are women (Palestinian Central Bureau of Statistics, 2010). As aforementioned, there exists sufficient evidence to support the different reasons, motives and manifestations of suicidal behavior in most countries of the world. It is therefore needed and imperative to know and explore the nature and phenomenon of suicide attempts in Palestine. The demand of this study is particularly urgent in Palestine, as requested by many health care professionals whom have faced cases of suicide attempt. There exists no prior work in this field, before especially focused on women.

Women in Palestine find their situation particularly challenging and sometimes disillusioning. While some women have been able to push through the forces that suppress them, others have been caught in them and silenced. In the midst of the chaotic reality of Palestine, specifically the oppression faced in the Israeli occupation, societal patriarchy, and legal inequality effects on women's rights, movements have been limited. Amnesty International describes the situation of Palestinian women as a triple challenge: (1) as Palestinians under Israeli military occupation which controls every aspect of their lives (2) as women in a society governed by

patriarchal customs, (3) as unequal members of society subject to discriminatory laws.

All these stressors exist alongside other environmental, social and economical challenges, which women face on a daily basis. Evidently, this level of unhealthy stress may cause frustration and aggression toward themselves, resulting in attempted suicide more frequently than any time before (Amnesty, 2005).

The multiple effect of violence on Palestinian women, simultaneously coming from outside their culture (the occupation) and inside their culture, constitutes a "spirit injury" to women, and thus on the entire culture. Spirit injury is a term which contemplates the psychological, spiritual, and cultural effects of multiple assaults toward women. Spirit injury "leads to the slow death of the psyche, of the soul, and of the identity of the individual". Women come to believe in their own inferiority, and that there is justification for the violence against them, because a fundamental part of ourselves and our dignity is dependent upon the uncontrollable, powerful, external observer who constitutes society.

If society places a low value on certain members, they, in turn, will perceive themselves as having a lesser worth in society. Due to being devalued by both the external society of the oppressor and the internal society consisting of their own culture, as well as by their nuclear family, women are forced to be profoundly silenced and experience the loss of self actualization. Palestinian women have been living under occupation for

centuries since the Ottoman Empire throughout the ongoing Israeli occupation. In addition to constant occupation, studies show critical rates of violence, primarily consisting of domestic violence toward Palestinian women, illustrating a strong link to suicide rates (Wing, 1997).

Suicide among women is an unspoken plague within Palestinian society. The society has consistently avoided facing the reality that members of society find life so painful that they consciously take their own lives. It is therefore important to know the factors, which lead them toward suicide.

1.5 Significance of the Study

In line with the recommendations of several suicidology scholars (Cutcliffe, 2005; Cutcliffe et al, 2004; Hawton, 2001: Leenaars, 2002a, 2002b; Michel et al., 2002; Shneidman, 1993), this study will explore the phenomenological experience of women who have attempted and survived suicide. As such, it can complement and enhance the voluminous quantitative research on the central topic. Studying the subject in this way may also open new pathways toward understanding suicide attempts and clinical intervention. It will help to move the individual from a less empowered position to one in which their own experiences and words become the point of expertise and generative force to underline the practitioner's understanding of this phenomenon.

Suicide and suicide attempts are results of behavior that have become known as a major global public and mental health issue. According to WHO, suicide is a major preventable cause of premature death. To identify the risk of suicide is the first step in developing a national prevention strategy for suicide. In Palestine the only study describing and discussing the issue of suicidal behaviors was carried out by Dabbagh (2005). Therefore, it is clear we lack the research evidence and the data to understand the phenomena of suicide within the Palestinian community, and to what extent it affects health and life of Palestinians.

1.6 Background

1.6.1 Definition of Suicide

There is a wide variety of the definition of suicide. Durkheim (1951) in his important contribution to the taxonomy of suicide, defined suicide and attempting suicide as follows:

"All cases of death resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this result, whereas an attempt is an act thus defined but falling short of the actual death."

Suicide attempt was defined as "a situation in which a person has performed an actually or seemingly life-threatening behavior with the intent of jeopardizing his life, or to give the appearance of such intent, but which has not resulted in death" (Beck et al. 1972).

Many other scholars have offered definitions of suicide. Valente and Saunders (2002) described it as “intentional, self-destructive, and self-inflicted acts. Whitehead and Abufarha (2008) described suicide from a political perspective, seeing it as a form of resistance and self-sacrifice for certain causes. Silverton, et al. (2008) described suicide as a medical illness. Other theorists also have emphasized suicide as a medical or mental health issue, as opposed to a social one (Duffy & MacLeod, 2003; Georgiades, 2009; Pridmore, 2000). WHO (2008) defined suicide simply as “the act of deliberately killing oneself”. MacNeil (2008) described WHO’s definition as a “broadly accepted definition which excludes accidental deaths and deaths that result from natural causes”.

While attempted suicide is defined by the WHO in the Tenth Revision of the International Classification of Disease (i.e., ICD-10) as “an act with a nonfatal outcome, in which an individual deliberately initiates a non-habitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desires via the actual or expected physical consequences” (Bille-Brahe et al., 1995).

1.6.2 Gender and suicide

Males are successful in suicide attempts at about four times the rate of females, despite the fact that females attempt suicide two to three times more frequently (CDC, 2007). Suicides completed by males account for

78.8% of all suicides within the United States. Suicide was the 8th leading cause of death for males and the 16th leading cause of death for females in 2004, the most recent year for which data is currently available (CDC, 2007).

Men over the age of 75 have the highest rate of suicide, at 37.4 suicides per every 100,000 deaths. Approximately 56% of males commit suicide using firearms, making it the most highly used method among males. For females, those between the ages of 40 and 50 have the highest suicide rates, at about 8.0 per 100,000 deaths. Self-poisoning is the most common chosen means of suicide among females, accounting for 37.8% of all female suicides (WHO, 2010).

1.6.3 Age and suicide

Suicide is most prevalent among the elderly. Elderly suicides account for nearly 20% of all successful suicide attempts in the United States (Hoyert et al., as cited in Goldsmith et al., 2002). There is a greater incidence of death following a suicide attempt in the elderly population than in other populations (CDC, 2005). Suicide also affects the young. In USA it is the third leading cause of death among those aged 15-24, and the second leading cause of death in those 25-34 (CDC, 2007). The rate of adolescent suicide (15-19) nearly doubled from 1970 to 1990, and has tripled since the mid 1950's (Goldsmith et al., 2002).

1.6.4 Marital Status and Suicide

Marital status is strongly related to suicide, as suicide has been shown to be higher for those that are divorced and widowed than for single people.

Specifically, rates of suicide as high 660 per 100,000 populations have been reported among widows, which are up to 50 times higher than the average suicide rate for the general population (Platt, et al. 1988; Smith, et al.1988).

The strong association between divorce and suicide can also be observed at the societal level. In particular, American states with higher divorce rates have also found to have higher suicide rates. (Hassan 1995).

1.6.5 Risk and Protective Factors

Outlined below are demographic, social, psychological, and additional factors that have been associated with increased lifetime risk for suicide. None of these factors, either individually or together, are predictive of suicide. A thorough assessment of the presence or absence of these factors can help identify individuals who are at higher risk of attempting or completing suicide. However, this is fundamentally different than a prediction of who will or will not attempt or complete suicide.

Some individuals with relatively few risk factors complete suicide while others with very many do not. Alvarez's comment serves to remind

us that each act of suicide, while sharing commonalities with others, is also at its essence a multi-determined and highly personal act (Alvarez, 2006).

1.6.6 Social factors

Jacobs et al. (1999) outlines the major social factors that are associated with the increased risk of suicide. For adults, those who are single (or live alone), divorced, or widowed are at an increased risk for suicide. This differs from adolescence, where marriage is associated with increased risk. Those with little or no social support, or who are socially isolated, are at increased risk for suicide. Lacking a guiding belief system, or a way of making sense of the world and one's purpose in it, also increases an individual's risk for suicide. Unemployment, recent job loss, or recent or pending financial ruin is associated with increased risk, as is the fear of humiliation.

The recent loss of a loved one or family member, especially in the elderly, increases the risk for suicide. A history of trauma, particularly of childhood abuse, is associated with increased risk. In adolescence, being pregnant and unwed increases a young woman's risk for suicide, and parental absence or abuse by parents, for both males and females, increases risk. Academic or disciplinary problems are also associated with increased risk for suicide among teenagers, as is having a history of perinatal distress (i.e., difficulties during their mother's pregnancy and delivery) associated with increased risk (Jacobs et al., 1999).

1.6.7 Psychological factors

An increased risk for suicide is associated in particular with Axis I and Axis II diagnoses. The affective disorders, particularly major depression and bipolar I disorder, as well as schizophrenia, substance abuse, borderline, antisocial, and narcissistic personality disorders are associated with increased risk for suicide (Jacobs et al., 1999). Kay Redfield Jamison (1999) writes, "No illness or event causes suicide; and certainly no one knows all, or perhaps even most, of the motivations behind the killing of the self. But psychopathology is almost always there, and its deadliness is fierce". Psychological autopsy studies suggest that affective disorder diagnoses are the ones most frequently associated with completed suicides (Jacobs et al., 1999). Studies have documented the presence of a major depression diagnosis in 50% to 70% of completed suicides (Barraclough et al., 1974; Murphy, 1984). Moderate to severe depressive episodes are more highly associated with increased risk for suicide than are mild depressive episodes. Himmelhoch (1987) found that increased suicidality tends to occur at the beginning phases of a depressive episode for unipolar depression, and can often get worse as the symptoms of the depression continue to intensify. A similar pattern is noted in Bipolar I (Balderessarini & Tondo, 1999). Increased risk for suicide among those with affective diagnosis also occurs during the early phases of recovery, as well as following release from inpatient hospitalization (Jamison, 1999).

Those diagnosed with schizophrenia have a 10% lifetime risk for suicide (Miles, 1977). Some have made distinctions between the type of schizophrenia and the lifetime suicide risk. In one study, it was found that those diagnosed with paranoid schizophrenia (i.e., both positive and negative symptomology) had a higher lifetime risk than those who experienced largely only the negative symptoms of schizophrenia (Fenton & McGlashan, 1991). Westermeyer et al., (1991) note that similar to the suicide risk patterns in bipolar and other affective disorders, those with schizophrenia are at a higher risk for suicide during critical periods such as early in recovery from a relapse, or when depressive symptoms are dominant (as contrasted with more psychotic symptoms). A 1986 study found that of those diagnosed with schizophrenia that go on to commit suicide, only 20% are experiencing psychotic symptoms at the time of their death (Robins, 1986).

The use or abuse of alcohol is associated with higher risk for suicide. Of all suicides, about 25% met criteria for an alcohol use disorder (Murphy, Wetzel, Robins, & McEvoy, 1992).

As many as 50% of those who commit suicide were drinking at or immediately before the time of their death (Frances, et al.1987). In addition, having a co-morbid depressive episode places one at much higher risk for suicide than does having a diagnosis of a depressive episode or alcoholism alone (Fawcett, Clark, & Busch, 1993).

Borderline, narcissistic, and antisocial personality diagnoses have been associated with increased risk for suicide (Perry et al., 1987). Reports from psychological autopsies find that approximately one-third of those who commit suicide met the criteria for a personality disorder at the time of their death (Bronisch, 1996).

Several other factors have also been associated with an increased risk for suicide. Some association between panic attacks and an increased risk for suicide has been made, especially when the panic occurs co-morbidly with another Axis I or an Axis II disorder (Jacobs et al., 1999). In addition, physical illness, access to firearms, fear of humiliation, hopelessness, impulsivity, and either a personal or familial history of suicide attempts have been associated with increased risk for suicide. There are also issues related to what has been referred to as a suicidal lifestyle or passive suicide (Gladstone, 2004). These are situations in which a person acts in such a way as to place him or herself at higher risk for dying by suicide without making a defined suicide attempt, a life of alcoholism or substance abuse that results in ones death, for example, or failing to take prescribed medications for a life-threatening illness (Gladstone, 2004). This also includes a general sense of carelessness or recklessness with one's life (i.e., driving erratically, deliberate self-exposure to AIDS, withholding food as in eating disorders, etc.). This can also include accidental deaths (i.e., the individual who dies while experimenting with suffocation) (Gladstone, 2004).

1.6.8 Neurobiology

While there is no "gene" for suicide, neurobiological research centers have linked various neurotransmitters and their receptors (and their genetic counterparts) with some association with either suicide, or mental health diagnosis associated with suicide. Some of this research involves the serotonergic system, as serotonin has been indicated in the pathophysiology of depression, and thus possibly suicide (Stockmeier et al., 2009). Serotonin is also known to play a role in various elements of a person's temperament (Serretti et al., 2008), which can also influence both mental health diagnosis and suicide. Research results are many and varied, with many methodological complications, including both the sensitivity of the technology as well as the normal changes in the serotonergic system that occur postmortem (Mann & Arango, 1999). Research has also focused on the noradrenergic system (Mann & Arango, 1999), as well as the cholinergic and gamma-aminobutyric acid [GABA] systems.

1.6.9 Prevention

Suicide prevention primarily consists of public policies aimed at community-level interventions. It is housed generally within public health literature. These include national prevention strategies such as suicide research centers, national institutes for suicide prevention, national policies and strategies to improve mental health within communities (WHO, 2010).

1.6.10 Risk Management

The risk management literature is concerned mainly with two aspects of treating suicidal clients: (a) development and implementation of standards of care regarding assessment of suicidal risk and treatment of the suicidal client, and (b) effective, comprehensive documentation. Literature dedicated to standards of care revolves generally around two issues: (a) forseeability and (b) causation (Bongar et al., 1998). Forseeability refers to a clinician's ability to reasonably anticipate a suicide attempt; causation refers to any situation in which a therapist's actions may have contributed to a client's suicide attempt. This includes events like failing to complete a thorough risk assessment or failing to take adequate measures to protect a client in the event that the client was judged to be at risk of suicide. Documentation literature guides practitioners regarding the content of their documentation, including process notes, decisions to hospitalize a client, decisions to refrain from hospitalizing a client, follow-up care, and consultation with peers. The focus is to both assure adequate care, as well as the prevention and minimization of legal repercussions (Bongar et al., 1998).

1.6.11 Theoretical framework

Scholars agree that Durkheim is one of the most influential theorists in the field of suicide studies (Allett, 1991; Norstrom, 1995; Selkin, 2005).

Durkheim (1951) distinguished four motives for suicide:

1. Egoistic: Egoistic suicide occurs as a result of an individual's weak tie to a group or community. The person becomes isolated and withdrawn from others, which can lead to depression and a fixation of his or her own problems. Durkheim (1951) stated that egoistic suicides "vary inversely with social integration involving religious, domestic and political societies".

2. Altruistic: Durkheim (1951) described altruistic suicide as the opposite of egoistic suicide because the individual is extremely attached and loyal to a group. Such an attachment can cause the loss of a sense of personal identity. According to Durkheim, "An individual tends to commit suicide easily when he/she is isolated from the social group, but also when that individual is too integrated in it" (Cajvaneanu, 2004).

3. Anomic: Durkheim (1951) saw anomic suicide as a reflection of particular historical circumstances. For Allett (1991), anomic suicide occurs as a result of the erosion of social or community norms, values, and traditions. Cajvaneanu (2004) described anomic suicide as "specific to modern societies and characterized by a weakening of the links between the group and the individual and by a lack of precise social norms".

4. Fatalistic: For Durkheim, fatalistic suicide is characterized by "the existence of extremely rigid social regulations as present in authoritarian and totalitarian regimes which create hopelessness in people" (as cited in Cajvaneanu, 2004). In fatalistic suicide, one sees oneself as helpless, with nothing to strive for or look forward to.

Interpersonal-psychological theory

Joiner (2005) recently proposed an interpersonal-psychological theory of suicide that can be applied to risk assessment and treatment. The theory hypothesizes that three components must exist for an individual to die by suicide: (1) the acquired capability to enact lethal self-injury, (2) the sense that one is a burden on loved ones or society (burdensomeness), and (3) the sense that one does not belong to or feel connected with a valued group or relationship (thwarted belongingness). The theory asserts that all three components are necessary for completed suicide. Thus, for example, even if one desires death by suicide (e.g., feels disconnected or a burden on others), the risk of serious attempt or completion should be moderate unless acquired capability to enact lethal self injury is in place. These components suggest points of emphasis for both assessment and therapy in that, if they are addressed, an individual's trajectory toward greater frequency and intensity of suicidal behavior can be curtailed.

1.7 Research Questions

1. What is the experience of women living in the Palestinian community who attempt suicide?
2. What risks lay beyond the experience of attempting suicide?
3. Why do women attempt suicide and what factors are subjected (liable) to this act of self-annihilation in Palestine?
4. What are the protective factors of suicide?

Chapter Two

Literature review

A review of studies from 35 countries carried out prior to 1999 indicated that between 10% and 52% of women reported being physically abused by an intimate partner at some point in their lives, and between 10% and 30% reported they had experienced sexual violence by an intimate partner. Between 10% and 27% of women and girls reported having been sexually abused, either as children or adults (Krug EG et al.2002& Heise L, 1999).

Several recent international studies, including the World Mental Health Surveys (Borges et al., 2007; Gureje et al., 2007; Joe, Stein, Seedat, Herman, & Williams, 2008; Nock et al., 2008), WHO Suicide Prevention Multisite Intervention Study on Suicidal behaviours (SUPRE-MISS) (Bertolote et al., 2005; Tran Thi Thanh et al., 2006), along with various in-country secondary school-based adolescent health surveys (Blum et al., 2003; & Siziya, 2007; & Siziya, 2007; & TwaeTwa, 2007) and other studies (Agoub, Moussaoui, & Kadri, 2006; Alem, Kebede, Jacobsson, & Kullgren, 2007b; Kebede & Alem, 2007), have found the reported prevalence of attempted suicide among women and girls to be approximately 18%.

Unfortunately, most of these studies report only on the role of socio-demographic characteristics and/or mental disorders as risk factors for suicidal behavior (Bertolote et al., 2005; Nock et al., 2008). Although there is evidence from North America and Europe, and recently from India, confirming that adverse childhood experiences (Dube et al., 2001;

Fergusson, Boden, & Horwood, 2008) and partner violence (Ellsberg et al., 2008) are associated with suicidal behavior, only a limited number of studies from low and middle income countries have explored the role of these risk factors (Ahmed et al., 2004; Alem, Kebede et al., 2007b; Blum et al., 2003; Borges et al., 2008; Maselko & Patel, 2008; Naved & Akhtar, 2008; Pillai, Andrews, & Patel, 2008; Vizcarra et al., 2004). Early exposure to violence and/or trauma may increase subsequent feelings of depression and affect ability to cope with life stressors, and thus be related to suicidal outcomes (Brodsky & Stanley, 2008; Fergusson et al., 2008).

Devries et al. (2011) in their study about the relation between violence against women and suicide confirm the important and consistent relationship between women's suicide attempts and violence across a range of low and middle-income countries.

The literature on psychological risk factors for suicide suggests that hopelessness is strongly related with suicidal thoughts and behaviors (Conner et al., 2001; Hawton and van Heeringen, 2009). In an investigation of the associations between levels of hopelessness, suicidal behavior, and PTSD that recruited African American women who attended hospital after a suicide attempt, found that hopelessness remained a strong predictor of suicide attempts after controlling the effects of PTSD (Kaslow et al., 2000).

Longitudinal studies in high income settings have also found strong relationships between childhood sexual abuse and subsequent suicidal behaviour in both men and women (Dube et al., 2001; Fergusson et al.,

2008), and in a 2004 comparative risk assessment of the global burden of disease study, child sexual abuse was estimated to account for 11% of all suicide attempts in women (Andrews, Corry, Slade, Issakidis, & Swanston, 2004, chap. 23).

Non-partner physical violence against adult women and its relationship with suicidality has not been widely discussed in the literature and is absent from reviews of suicide risk factors in developing countries (Khan, 2005; Vijayakumar et al., 2005), although there is some evidence on the role of physical abuse by family members in suicides in Asian settings (Ahmed et al., 2004; Kumar, 2003). This form of physical violence was perpetrated mainly by male family members. In our study, as well as other studies, physical, sexual and emotional partner violence was highly correlated with suicide risk (Yoshihama et al., 2009). The work of Joiner (Joiner, Sachs-Ericsson,Wingate, Brown, Anestis, & Selby, 2007) suggests that physical violence and physically violent sexual assault may be more strongly associated with suicide. He hypothesizes that habituation to physical pain is a necessary precursor to future suicide attempts (Joiner et al., 2007). In our study, physical and/or sexually intimate partner violence generally remains a stronger risk for attempting suicide.

Maria et al., (2006) in their work reveals that women exposed to physical/psychological and intimate partner violence had a higher incidence and severity of depressive and anxiety symptoms, post traumatic stress disorder, and thoughts of suicide than women in the control group,

with no differences between the two abused groups. The concomitance of sexual violence was associated with a higher severity of depressive symptoms in both abused groups and a higher incidence of suicide attempts in the physically/psychologically abused group.

With regards to battering, the prevalence of suicide attempts and the occurrence of domestic abuse were documented in a sample of women seeking emergency care in Sweden (Bergman & Brismar, 1991). Those women who were classified as battered wives had an eight times higher incidence of suicide attempts than women who were classified as nonbattered. Furthermore, conflict with the husband was the most common triggering factor for the suicide attempt. Love affairs and domestic disputes are also two of the main precipitating causes for suicide in Sri Lanka (Hettiarachchi & Kodituwakku, 1989). The high suicide rates of young women immigrants from the Indian subcontinent (India, Pakistan, Bangladesh, Sri Lanka) have also been attributed to family conflict and domestic violence, rather than mental illness per se (Patel & Gaw, 1996). In another study of the association between female suicidality and the battering of women, Stark and Flitcraft (1995) conclude, "battering may be the single most important cause of female suicidality, particularly among black and pregnant women" (page 43). These authors highlight the necessity of considering the gender and societal context in which suicidality occurs. For women, in particular, suicidality may emerge when there is an absence of options to a partner's coercive control and isolating

tactics, in conjunction with economic hardship and culturally accepted female inequality (Stark & Flitcraft, 1995).

Dabbagh (2005) in her book on “Suicide in Palestine” stresses that suicide is seen as a “Western Phenomenon” among Palestinians and goes against religious beliefs, but in her narrative analysis on stories of men and women who attempted suicide, she points to the feelings of women as feeling controlled by others, many having experienced physical and/or sexual abuse (often by family members) and feeling powerless in their family life. These narratives seem to give support for the finding of the critical role of family in the suicidal behavior of Arab women in the study. Douki, Ben Zineb, Nacef, and Halbreich (2007) in their study of women’s mental health in the Muslim world, stress the role of family related variables (such as family honor, virginity, unmarried pregnancy and abuse) in suicidal tendencies of women. Results of the study are also in keeping with Abu-Hijleh (1998), who, in his study on stressful life events and suicidal behavior in Jordanian adolescents, notes that conflict with families, scholastic failure and breaks with close friends are the most frequent events which precipitate suicidal behavior in adolescents.

Most studies report an association between self-injury and alcohol and drug use or abuse. Borowsky's study (2001) found that the use of alcohol and, marijuana predicts an increased risk of attempted suicide across both sexes and all race/ethnicities involved in the study.

Hall, Platt, and Hall (2009) found that victims of intimate partner violence who were experiencing verbal aggression, and those who reported physical aggression, reported significant degrees of sadness. As they explain sadness is a good screening tool for identifying patients at greater risk of suicide. They found that feelings of self-dislike and worthlessness were also predictive of suicide attempts in their study sample. Hall, Platt, and Hall (2009) reported that feelings of worthlessness were a risk factor for severe suicide attempts in managed care patients. A study conducted at Duke University found that feelings of worthlessness were found more commonly in their patients with psychotic depression than in patients with non psychotic depression (Thakur, Hays, & Krishnan, 2009). These feelings of worthlessness and self-dislike could perhaps be correlated with other psychopathology or personality disorders; however, they do appear to be predictive of suicide attempts in certain patient populations.

A broken home environment (Angst et al., 2002) and divorced/separated parents (Wichstrom, 2000) significantly increase the risk for attempting suicide. Family histories of offending and drug abuse (Fergusson and Lynskey, 2005) and chronic psychiatric disorders of the parent (Angst et al., 2002) are also associated with risk of attempted suicide as discussed in the literature.

Borowsky (2001) reports that positive aspects of the community (such as adult caring and school connectedness), family (particularly parent-family connectedness), and individual characteristics like emotional well-

being are significant protective factors against attempting suicide for some of the subjects. Similarly, Wichstrom observes that global feelings of self-worth (Wichstrom, 2000) and family cohesion (McKeown et al., 1998) decrease the odds of attempted suicide.

The complex relationship between gender, body image and suicide is reflected in the study of Figueroa (2009); a disproportionate number of women are seeking cosmetic surgery compared to men. Women who are depressed and suffer from severe body image dissatisfaction may seek to rectify their perceived imperfections through cosmetic and surgical procedures. It has been found that 10 to 16 percent of patients at dermatology and cosmetic surgery clinics suffer from body dimorphic disorder. This condition is a severe body image dissatisfaction that is linked to depression and suicide. It has also been found that there is a higher suicide rate among women who have undergone breast augmentation.

According to the WHO, stressful situations such as unemployment, poverty, family death, and divorce can increase the risk of suicide (Werneck, et al. 2006). Gender and social factors have great importance in suicidal behavior. The gender-based inequality in many low-income countries results from a social system where women are expected to be subordinate to men (Ahmed et al., 2004). In Matlab, Bangladesh, it was reported that female suicide rates were higher than in European countries, while the opposite was found for male suicide (Ahmed et al., 2004). In

South India, suicide rates amongst young women were reported to be 148/100,000, the highest in the world.

In an analysis of attempted suicide, it was suggested that attempts are the result of a multiple process of functional neglect (Burman, Chantler, & Batsleer, 2002). Suicide in women is more related to cultural and social contexts than is suicide among men. Social norms and values are more oppressive for women, causing them more suffering (Rudmin, Ferrada-Noli, & Skolbekken, 2003). Factors associated with psychiatric morbidity and suicidal behavior in women living in low-income countries includes early age of marriage, lack of autonomy, coercion to have children, and economic dependence on men (Khan, 2005).

Oquendo, et al. (2007) found that16% of women who attempted suicide had 8 years or less of formal education, and an additional 12.9% only finished high school.

Women with limited education or without occupation are more vulnerable to suicide and more subject to adverse life circumstances (Souza et al., 2002).

Women with less education, limited occupational skills, and living in poverty are at risk for domestic violence (Werneck et al., 2006; Souza et al., 2002).

Marital status is also a universal differentiating variable in assessing those at risk of suicide or attempted suicide. A major portion of suicide

victims are single, divorced, or widowed (Oquendo et al., 2007; Souza et al., 2002). This, by itself, is not highly significant. Loneliness and lack of emotional support are identified as factors associated with attempted suicide or committing suicide (Souza et al., 2002). Among women, however, the protective effect against suicide within marriage has been attributed to the effect of having children (Oquendo et al.2007).

Khan (2005) found that in many low-income countries, childbearing is a significant source of stress for married women and that the act of marriage is not protective against attempting suicide.

Cultural meanings and acceptability of suicidal behaviour vary across settings, and suicidal behaviours are often highly stigmatized (Alem et al., 2007; Bertolote et al., 2005). Observed differences in prevalence may result in part from variations in women's willingness to disclose information. In rural Ethiopia, a qualitative study showed residents felt that those who committed suicide were condemned sinners, should be feared, and were cruel (Alem, Jacobsson et al., 2007).

In a comparative study of social behavior between groups of people who have attempted suicide, people who have completed suicide and people dying of natural causes, Maris (2009) found that those who completed suicide had participated less in social organization, were often without friends and had shown a progressive decline in interpersonal relationships leading to a state of total social isolation. Psychological

autopsy studies show that social withdrawal frequently precedes the suicidal act (Maris, 2009).

This was also brought out in a study by Negron et al. (2010), who found that people who attempted suicide were more likely to isolate themselves during an acute suicidal phase than those with suicidal ideation. Wenz (2001) identified anomie – the feeling of alienation from society caused by the perceived absence of a supporting social framework – as one factor in the suicidal behaviour of widows, along with actual and expected social isolation. A study of suicide attempts among 195 adolescents under the age of 16 who had been referred to a general hospital found that the most frequent problems underlying such behaviour were relationship difficulties with parents, problems with friends, and social isolation (2004).

Kraut and Walld (2003) carried out a cross-sectional study to compare the relationships of unemployment, part-time work, non-labour force participation, and full-time work with attempted suicide among residents of Manitoba, Canada aged 15-64 who made use of health services. Unemployment was associated with a higher likelihood of attempted suicide and those who worked part-time (1-15 weeks, 26-51 weeks) and those not working at all had an elevated likelihood of attempted suicide when compared to those working 52 weeks (that is, full time). These findings suggest that full-time employment is protective against suicide attempts.

Another review explored suicidality in patients with eating disorders, obesity and weight concern (Pompili et al, 2006).

For instance, one study of suicide in bulimia found that 20% of those who had attempted suicide had a major depressive disorder and 11% were drug and alcohol misuses'. The authors concluded that, although there is an assumption that death from exhaustion and lack of food is the major cause of death in eating disorders, their results illustrate that compared to the general population, people with eating disorders have a higher risk of suicide (Pompili et al, 2006).

One review Rehkopf and Buka, (2006) explored the association between local area level of suicide rates and socioeconomic advantage/disadvantage. The authors conducted a meta-analysis on 86 studies from a range of countries in Europe and beyond. Total numbers of participants included within the review were not stated. They found that the level of aggregation had an important effect on results. Analyses conducted at the community level were significantly more likely to demonstrate lower rates of suicide among higher socio-economic areas than studies using larger areas of aggregation. Seventy per cent of the significant results showed an inverse relationship between higher socio-economic status and suicide, i.e. higher socioeconomic status was associated with lower suicide rates.

Median income was least likely to be inversely associated with suicide rates.

However, study results did not vary significantly by gender or by study design.

The authors reveal the importance of taking account poverty or deprivation and its relation with increased suicide rates.

The relation of negative self image and risk of attempted suicide which was explained with one study among Korean adolescents as the exception (Kim and Lee, 2010), almost all obtained a significant or borderline significant association between an elevated risk of attempted suicides and an increased BMI among girls (Falkner et al., 2001; Whetstone et al., 2007; Swahn et al., 2009) and women (Frank and Dingle 1999; Carpenter et al., 2000; Brunner et al., 2006; Dong et al., 2006; Mather et al., 2009). In contrast, an inverse association between BMI and the risk of attempted suicide was observed among adult men (Carpenter et al., 2000; Osler et al., 2008; Batty et al., 2010). The gender- dependent association was also discovered by the study including both men and women (Carpenter et al., 2000). It is important to note that the largest cross-sectional study (Carpenter et al., 2000) and the cohort studies (Osler et al., 2008; Batty et al., 2010), the only two using attempted suicide as the endpoint, reached a similar conclusion, i.e., BMI was inversely associated with the risk of attempted suicides among men with a clear gradient in risk between the highest and the lowest BMI levels. The studies that observed an increased BMI associated with an elevated risk were cross-sectional

with a relatively small number of depressed patients (Brunner et al., 2006), or participants with extremely high BMIs (Dong et al., 2006).

A lot of cultural and social factors hinders the progress in research on suicide and suicide attempts in the Palestinian community. Dabbagh (2005) in her book on “Suicide in Palestine”, mentions that suicide is such an emotive act and often subject to a cultural and religious taboo, these powerful social influences shape suicide all over the world. Palestinian society is in a state of denial that the phenomenon of suicide exists within it. To date, there is no national documentation or data showing the number of cases where suicide and Para suicide acts have been committed. The only cases which have been documented are those which were recorded through police centers for the cases that were diagnosed in hospitals. This data has not been published. It primarily consists of demographic data. Hence the importance of this research is to uncover a simple subset of the risk factors for suicide among Palestinian women in particular.

Chapter Three

Methodology

Methodology

The epistemological position taken by the researcher for this study is phenomenological because it is the belief of the researcher that the specific data regarding the experience of risks beyond attempting suicide are contained within the persons who actually attempt suicide (Palestinian women). Those women know best how to describe such an experience. The researcher has therefore chosen phenomenology as a theoretical basis for this study.

3.1 Design

The design used was qualitative phenomenological descriptive design. This design used to study the experience of the people by describing the aspects of the experiences by focusing on what exists. This design does not focus on interpretation for the experience, which will act as an indicator for people's thoughts and feelings (Wilson & Buttery Worth, 2000). Semi-structured interviews were conducted with Palestinian women who attempted suicide.

Our chosen design is primarily based on a descriptive approach where our primary goal was to provide some explanation about the risks beyond the experience of attempting suicide among the Palestinian women.

3.1.1 Giorgi – Phenomenological Psychology

The method used is a descriptive phenomenological human science, which was found by Giorgi (1985). The aim of phenomenological psychology following Giorgi (1971) is to produce accurate descriptions of human experience. For this reason, phenomenologists operating within this tradition mainly utilise descriptions provided by others, usually obtained through interviews (Giorgi, 1985).

The purpose of Giorgi's phenomenological research is to capture as closely as possible the way in which the phenomenon is experienced (Giorgi & Giorgi, 2003b; Robinson & Englander, 2007) In Giorgi's work, phenomenology is used to look for the psychological meanings that constitute the phenomenon in the participants' life world. The idea is to study how individuals live, that is, how they behave and experience situations (Giorgi, 1985). Their descriptions are based on their experiences within the context in which the experience is taking place.

Central to this research is the lived context of the individual. The meaning of the phenomenon such as the experience of Palestinian women that attempt suicide in its totality and its relationships with its particulars and therefore essences can only be seen in every constituent of the meaning. The role of the phenomenological analysis is to discern the psychological essence of the phenomenon (Giorgi, 1985; 1989).

The process of research in phenomenology starts with the description of a situation as experienced in daily life (Giorgi, 1985). Striving to obtain these descriptions, a researcher sets aside any prior thoughts or judgment about the phenomenon under study. In so doing, the researcher brackets the phenomenon. The bracketing or the epoch is primarily undertaken in order to reveal the personal reality of the individual for whom the phenomenon under the study appears (Ashworth, 1999). What needs to be bracketed are those presuppositions that have to do with claims made from objective science or other authoritative sources (Giorgi, 1986; Ashworth, 1999). Phenomenology attempts to offer insightful descriptions of the way the world is experienced perfectively rather than the way it is conceptualized, categorized or reflected on (Van Manen, 1990). In this context, attempt suicide is at the center of the inquiry.

3.2 Study Participants

Phenomenology captures the phenomenon as it appears in daily life (Cosser, 2005). The participants sample consists of Palestinian women that have survived a suicide attempt.

Participants were recruited from national, non-governmental organizations involved in mental health activities and human rights issues in the West Bank. Cases from the Palestinian Center for Democracy and Conflict Resolution, Family Defense Society, Women Center for Legal Aid and Counseling, Palestinian Counseling Center, as well as governmental

ministries, such as the Ministry of Social Welfare, and the Ministry of Women's Affairs. Cases from some private hospitals were selected.

3.3 Sample Size

The sample for this study is a purposive sampling (Polit, 2006). Purposive sampling refers to precisely what the name suggests in that the sample is chosen with a purpose in mind (Ritchie et al, 2003). The researcher chooses participants due to their particular features that will enable the understanding of the phenomenon under study (Ritchie et al, 2003). Through contacts and acquaintances we found 20 female participants who can gave their consent to participate in the study and participate in semi-structured interviews. According to the Giorgi method, three interviews are sufficient to achieve the purpose of the study (Giorgi, 1985).

3.4 Inclusion & exclusion Criteria

3.4.1 Inclusion Criteria

- Adult Palestinian women who have survived at least one suicide attempt.
- Never diagnosed with mental illness.

3.4.2 Exclusion Criteria

- Females that diagnosed with mental illness.

3.5 Setting

The setting of data collection was the home of some participants or the centers they attended for therapy.

3.6 Selection of the Study Instruments

The interview process followed a semi-structured interview guide with different themes and underlying issues, from the research purpose and question. The interview guide acted as a support for those important issues. It also served as a designator of the order in which different themes were to be addressed. We used the interview guide as a checklist to ensure that all the themes were brought up instead of letting the interviewer guide the conversation. This contributed to the relaxed and natural aspect of the interviews, as opposed to a form of hearing.

3.7 Data Collection

Interview subjects consisted of women who had attempted suicide. The interviews were conducted in an isolated room in the centers or at the home of the client.

The informants we interviewed received a consent form, which we retained, and an information form, which they were given to keep.

Collection was performed through recorded interviews with 20 women. Each interview was between 60-90 min, due to an occasional lengthier description, which in this study is that the interview began with a question about which the informant was allowed to speak freely. We used as few questions as possible in order not to project the interviewer's own assumptions. Follow-up questions were asked only to get a more detailed and in-depth description (Robinson & Englander, 2007).

Sound quality was excellent on all recorded interviews which allowed for easy transcription. The interviews were transcribed verbatim and all identifying features were excluded to ensure anonymity. All interviews were first listened through, printed and then similarities were recorded in a meaningful merger operation. Some quotes were saved in their original form.

Trustworthiness of the data was ensured through appropriate sample selection to ensure credibility, showing the logic flow of the data collection and analysis, and by verifying the findings with the informants to demonstrate fittingness, or transferability of the findings (De Laine, 1997; Holloway & Wheeler, 2002).

The semi-structured interviews with women reflected the experience of the women leading to suicide attempts. The interview focused on information about the events took place in her life directly before the attempt of suicide that led to suicide attempt; previous history of stressful events in woman's life and the coping mechanism followed to decrease

stress; history of other suicidal attempts, childhood details and experiences; support system available both professional and nonprofessional; at the end debriefing session done to decrease the stress provoked from recalling the experience of attempt suicide.

The initial question to each participant was: What was happening in your life at the time you attempted suicide?

3.8 Data Analysis

Phenomenological psychologists analyse the data utilising a systematic and rigorous process. Data analysis consists of four consecutive steps where each step is a prerequisite for the next (Robinson & Englander, 2007; Giorgi, 1985b, 1997). Prior to the analysis, each interview was transcribed verbatim. All steps in the analysis must be performed within the phenomenological reduction (Robinson & Englander 2007; Giorgi, 1997). Phenomenological reduction is used in descriptive phenomenological analysis and requires bracketing as a first step (Kleiman, 2004). According to Giorgi, bracketing/epoch imply not taking a stand for or against but allowing the phenomenon to emerge (Groenewald, 2004).

Phenomenological reduction also requires withholding any existential claims and presenting data as it presents itself rather than making one's own conclusions about what is presented (Kleiman, 2004).

For essay writing, we continuously address theory, method and purpose of the essay and the question as coherent and not as separate parts.

The analysis of the material was already in progress from the time we started the collection of material. The thought of how we will analyze the collected material had been with us from the beginning of the choice of qualitative method. Designing the interview guide is a breakdown of the various themes in addition to background information.

Step 1: Getting the sense of the whole statement by reading the entire description

The entire interview protocol was read several times in order to get a sense of the whole experience. The idea was to obtain a description, not to explain or construct (Giorgi, 1989). Wertz (1985) suggests that readers should see raw data as well as processed data.

The first reading, done in the natural attitude (i.e. the everyday attitude) told the researcher to more actively identify and critically examine his/her own interests, creditors learned, theories, hypotheses and existential assumptions about the phenomenon and then set them in brackets (Giorgi, 2005).

If certain passages of the collected material are unclear, it is important that the author does not pad them with their own interpretation, but instead goes back to the interviewee and asks for clarification on descriptions. If the author is unable to collect further information about them, he/she will be later forced to describe the uncertainties that exist in the data. Ambiguities and contradictions in the data may not be reduced or declared

the basis of possible interpretations, but must always be described as such (Robinson & Englander 2007; Giorgi, 1985, 1997).

Step 2: Discriminating meaning units within a psychological perspective

After going through the first step, Giorgi (1986) suggests that the whole description should be broken into several parts to determine the meaning of the experience and these are expressed by the slashes in the texts (Giorgi, 1985) or by numbering of lines (Wertz,1985). Parts that were relevant to the phenomenon that is being studied were then identified. The process of delineating parts is referred to as meaning units, they express the participant's own meaning of the experience, and they only become meaningful when they relate to the structure of all units (Ratner, 2001). A word, a sentence or several sentences may constitute a meaning unit.

Each meaning unit is constituent and therefore focuses on the context of the text (Giorgi, 1985). The meaning units are correlated with the researcher's perspective and therefore two researchers may not have identical meaning units (Giorgi & Giorgi, 2003). This process takes place within what is called reduction. It is important in phenomenological psychology to withhold the existential judgment about the experience of the participant.

Step 3: Transforming the subject's every day expressions into psychological language

The researcher returns to all of the meaning units and questions them on what they reveal about the phenomenon of interest. Once the researcher grasps the relevance of the subject's own words for the phenomenon, the researcher expresses this relevance in as direct a manner as possible. This is called the transformation of the subject's lived experience into direct psychological expression. This step adds clarity through the description of the intrinsic meaning in the material. Furthermore, the researcher must make clear the implicit meaning of meanings which the text points to, i.e. make explicit what is implicitly given. For that, transformation must be kept at a descriptive level. It is essential; however, that it does not go beyond what is directly given in the data (Giorgi, 2003).

Step 4: Synthesising transformed meaning units into a consistent statement of the structure of the phenomenon.

This step is to make meaning units coherent and synthesized by relating them to each other to have meaning statements. Specific statements are written for individual participants and a process of analysis is used whereby common themes across these statements are elicited and then form a general structural description, which becomes the outcome of the research. (Robinson & Englander 2007; Giorgi 1985, 1997).

Sentence structure consists of the elements identified in the previous step and are understood through their relationships and the way in which they are related to each other. Sentence structure is achieved by the researcher similar to step three, making use of imaginary variations to arrive at the final sentence structure that cannot vary. All data must be considered and the researcher must also adhere to a purely descriptive language. If there are contradictions or ambiguities in the material, this shall be described but not explained or understood in terms of interpretations, theories, hypotheses or other existential assumptions. If the context and other contextual factors are relevant to the phenomenon, this must also be described. There are three levels at which the structure can be described. The first level is the individual structure that is based on a description from an informant. The second level is the general structure that can be achieved by having multiple descriptions (usually three). At the third level we find the universal structure, which is located on a philosophical level. To find the general structure is always desirable when it can be generalized to other people experiencing the same type of phenomenon.

Once the description of the psychological structure of each individual had been identified, the researcher looks at statements that can be taken as true in most cases.

3.9 Pilot study

The aforementioned method was tested in the pilot study. The pilot study involved one informant. We were able to recruit the pilot participant from the Democracy and Conflict Resolution Center. We contacted the Center through written request to meet the pilot participant in their vicinities. The Center's psychologist responsible for women introduced the researcher to the participant. The participant signed a written consent and was informed of the study orally and submitted in writing information for research (Annex 1). The agreement was available at interview. The interview was conducted in an isolated room within the Center. The interview was taped and the text was treated in accordance with the above analysis. This pilot interview is included in the study sample.

3.10 Trustworthiness

The trustworthiness of the study focuses on methods to ensure that the researcher has performed the research process accurately (Sparkes, 1998). Trustworthiness criteria include credibility, transferability, dependability and confirmability (Sparkes, 1998).

3.11Credibility and dependability

Matters relating to the implementation of interviews and analysis illustrate the survey's reliability. Prior to conducting interviews, the authors noted their expectations of the survey, in order to be conscious of how their

backgrounds may color the survey. The authors could thus limit their expectations by bracketing their previous knowledge (Robson, 2002).

The author may, by making themselves aware of their own attitudes, become better listeners who try to put themselves aside and focus on the dialogue. All interviews were recorded and transcribed verbatim. This made the survey more credible than if the authors had only taken notes during the interview (Robson, 2002).

Credibility refers to the trustworthiness of the data collection, analysis and conclusion (Sparkes 1998). To ensure credibility, the researcher therefore relied on the supervisor as a critic (Cosser, 2005). Furthermore, the participants were informed through the consent form that they would receive written feedback on the research report should they so wish. Credibility of the data may also be related to whether respondents tell the researcher the truth (Malterud, 2003). In this study we were looking for women who attempted suicide to document their experience and analyse risks beyond the experience itself.

We followed the analysis model of Giorgi (1985) as described and tried to be true to the stories of the women. We selected the phenomenological approached to the theme, which gave us more aspects to the findings. Using a developed analytical model gave us the opportunity to test the analysis that was done (Robson, 2002).

The author discussed interpretations and reflections with her supervisors and another specialist in clinical psychology at the transcription and interpretation of material, which increased the reliability of the survey (Kvale, 1997). The author has also tried to ensure reliability by clearly defining a purpose and clear questions. Reporting methodology, selection criteria and implementation of interviews and analysis of the collected material is likely to increase the reliability of the survey.

Having ensured credibility, which is more concerned about the validity of the study, it is not necessary to demonstrate dependability separately (Babbie & Mouton, 2001). Where credibility exists, dependability is also ensured. Dependability encompasses the reliability of the findings. For findings to be dependable, they must be predictable and stable (Lincoln & Guba, 1985).

3.12 Evaluating the quality of phenomenological research

When presenting phenomenological research, its value was established through honoring concrete individual instances and demonstrating some fidelity to the phenomenon (Wertz, 2005). Research reports may, for example, contain raw data such as participants' quotations providing an opportunity for readers to judge the soundness of the researcher's analysis.

The quality of any phenomenological study can be judged in its relative power to draw the reader into the researcher's discoveries, allowing

the reader to see the world of other people through innovative, in-depth manners. Polkinghorne (1983) offers four qualities to help the reader evaluate the power and trustworthiness of phenomenological accounts: vividness, accuracy, richness and elegance.

- Is the research vivid in the sense that it generates a sense of reality and draws the reader in?
- Are readers able to recognize the phenomenon from their own experience or from imagining the situation vicariously?
- In terms of richness, can readers enter the account emotionally?
- Has the phenomenon been described in a graceful, clear, poignant way?

Ethical consideration:

A procedure for the protection of the human subjects through the researcher's university subjects was followed in the study, which was approved by An-Najah National University's Research Ethics Boards. Additional ethical review processes were necessary due to the nature and location of the study. As discussed before, suicide is a very sensitive and stigmatized issue in the Palestinian community and much more stigmatized for women, thus challenging to approach. Approval was received from the Ministry of Health, the Ministry of Social Affairs and the Police Center, as well as all the NGO's from where participants were recruited.

The informants who met the selection criteria, after expressing desire to be part of the study, were approved either via telephone from the

researcher or by the referral person/institution. Information about the study and it is purpose was briefly explained. The participants signed a consent formed and received further information from the interviewer, both verbally and in writing (Annex I) for the purpose of the interview and study. Simultaneously, an agreement was made at the time of the interview.

The interview was conducted in a private room with only the participant and the interviewer present. The interview was recorded through a tape recorder and no individuals could be identified after the text processing. Information on all bands and prints were confidential and the text was stored, abiding by present regulations, in locked cabinets.

The data was stored until the investigation was completed. Upon completion of the study, all interview material was destroyed. The voluntary nature of the study was explained carefully. Participants were informed that their participation was voluntary and that at any time they would be able to withdraw from the study and that their choice would not affect them in any way. Also, they were free to maintain an anonymous identity.

Debate related to suicide research takes place in many countries around the world and many scientists suggest that research on suicidal behavior may carry many benefits, risks, or harm to participants.

Benefits include an increased understanding of suicide as an experience, which is considered by many to be a means to improving

recognition, screening, and treatment of illnesses and, ultimately, the prevention of suicide. Also, being involved in research could be directly beneficial to participants directly. People who identified as suicidal via the research would be assessed and referred for treatment or would gain self-understanding and seek counseling or other help.

There are different ways that the process of research could be directly therapeutic: by providing the opportunity for participants to exercise altruism (a sense of contributing to the greater good and helping others), by conveying hope (the researcher demonstrating caring and concern), by gaining personal insight (into own psychology and the individual's situation), by gaining a sense of universality (that they are not alone and others suffer similarly), and by being listened to (having the opportunity to talk and be heard).

Risk of harm for participants is a dominant theme in ethical issues related to suicide. Scientists suggested that suicidality might be exacerbated or "reinforced" by bringing attention to suicidal thoughts and feelings, revisiting or bringing up distressing material, inadvertently confirming the insolubility of problems, normalizing and advertising methods of suicide, and raising hope for assistance but not being able to provide any. Not having access to the right kind of support to assist participants was mentioned by many people as being potentially problematic (Lakeman and FitzGerald, 2009).

Others pointed out that this was a vulnerable population and could readily be coerced or manipulated into participating in research or treatment. Further kinds of potential for harm which were cited included the potential stigma of been labeled mentally ill, and the intrusion that the research might entail (Lakeman and FitzGerald, 2009).

These considerations are based on the Helsinki Agreement (World Medical Association Helsinki Declaration, 2008) on ethical guidelines for nursing research on volunteerism, to withdraw from the project, potential risks or discomfort, anonymity, confidentiality and contacts for any information needed.

Phenomenological studies are always retrospective (Hedelin, 2001). To construct the stories seem to be a natural human process that assist individuals in understanding the experiences and themselves (Pennebaker, 2000). How can it be a health effect for informants to participate in the survey? There is a significant, positive, consistent and identifiable relationship between talking about emotional difficult experiences and health. To construct their own history is a type of knowledge that helps to organize the emotional effects of experience as well as experience in itself. Audio recording, for example, might be perceived as unpleasant for some people and therefore we always asked permission. Being able to discuss their history can be classified as healing in itself. At the same time, it might give some benefits for other women in the same situation as a whole.

The informants' identities were fully protected. No names or other information that may reveal informants' identities were reported. Our intention has been to maintain a moral researcher behavior, which means not just ethical knowledge but also our personality, sensitivity and commitment to moral issues and actions.

Chapter Four

Results

Results

The purpose of this study is to use a qualitative approach; we will explore the risks beyond the experience of attempting suicide among a group of Palestinian women. Suicide poses a challenge for the health of women in Palestine, and it is influenced by a set of complex and interactive individual, social, cultural, and economic factors.

The selected sample was comprised of 20 adult women whom previously attempted suicide. Their ages were between18-42 and were not diagnosed with a mental illness before. We conducted 20 interviews, for about 60-90 minutes each.

4. Interviews results:

In total, 20 interviews were conducted. Participants were aged between 18 and 42 years old. On average, they had between one and four episodes of attempted suicide. Six participants were married, 2 were engaged, ten were single and two were divorced. Eight participants lived in major cities; the other nine women lived in villages, while just two of the participants were from camps.

The analysis of the data was based on the Giorgi method in phenomenological qualitative research.

Table (1): demographic data of all women at the time they attempt suicide.

#	Age of the women	Marital status	Age of the husband	Education Of the women	Education Of the husband	Work of the women	Work of the husband	Number of children	Place of residency
1.	37	married	54	7th class	4th class	Not working	carpenter	5	city
2.	35	Married	38	Lawyer	Lawyer	Not working	Lawyer	4	village
3.	21	single	-	Failed Tawjihi	-	prostitution	-	-	camp
4.	44	married	48	Tawjihi	Diploma	Not working	Not working	6	village
5.	23	single	-	university student	-	Not working	-	-	city
6.	20	single	_	Diploma of nursing student	-	Not working	_	_	village
7.	22	engaged	26	university student	Bachelor in science	Not working	Teacher	non	village
8.	18	single	-	11th class	-	Not working	-	-	village
9.	21	single	-	Tawjihi	-	Not working	-	-	village
10.	21	single	-	university student	-	Not working	-	-	city

11.	23	married	27	university student	10th class	Not working	Not working	2	camp
12.	25	Divorced	40	10th class	6th class	Not working	Merchant	3	camp
13.	21	engaged	26	Diploma of nursing	Bachelor in engineering	Nurse in hospital	Engineer	non	city
14.	19	single	-	university student	-	Not working	-	-	city
15.	27	married	32	university student	Bachelor English language	Not working	Teacher	non	city
16.	26	single	-	Bachelor Arabic language	-	Not working	-	-	village
17.	27	married	45	Tawjihi	Tawjihi	Not working	Merchant	non	city
18.	18	single	-	Failed Tawjihi	-	Not working	-	-	city
19.	18	single	-	Failed Tawjihi	-	Not working	-	-	village
20.	42	divorced	-	10th class		servant		9	village

From the interviews, five themes and eighteen sub-themes emerged; violence (Sexual violence, domestic violence, witnessing abuse, and child maltreatment); Losses (Loss of parents, Loss of cultural identity, loss of relation, Loss of security); psychological risk factors (Low self efficacy, Low Self esteem, Negative Self image, and Maladaptive coping mechanism); and Socio cultural factors (poverty, stigma, and dysfunctional family); Lack of support system (Non professional, and professional) The themes and sub themes are presented in Table (2).

Table (2) Themes and subthemes that emerged from women's interviews.

Themes	Subthemes
I. violence	1. Sexual violence 2. Domestic violence 3. Collective violence 4. Witnessing abuse 5. Child maltreatment
II. losses	1. Loss of parents 2. Loss of cultural identity 3. loss of relation 4. Loss of security
III. psychological risk factors	5. Low self efficacy 6. Low self esteem 7. Negative self image 8. Maladaptive coping mechanism
IV. Socio cultural factors	1. Poverty 2. Stigma 3. Dysfunctional family
V. Lack of support system	1. Non professional 2. Professional

Violence (The first theme)

Violence was the primary and most common experience expressed by women in all its types (sexual violence, domestic violence, witnessing abuse, child maltreatment).

Participants expressed the theme of violence as follows:

"My husband tries to suffocate me and he wants to kill me." C1

"When I refused to have sex with my husband he raped me." C4

I.1 Sexual violence

Sexual violence creates a sense of external control and a loss of rights, freedom and humanity. Its effects vary in relation to different circumstances which may continue for long period of time. Sexual violence is not just a physical experience but also a psychological trauma which may leave lifelong psychological distress, fear, anger, sadness and a feeling of guilt.

A 37 year old woman reflected on her experiences of sexual abuse as follows:

"When I refused to have anal sex with my husband he pushed me down and held my hands and made me have anal sex against my will. He raped me. That feeling was unbearable". C1

Rape is an atrocious crime. It is a violation of humanity and human rights. Following a rape, the survivor will experience a very wide range of emotional reactions which result from being faced with a life-threatening, life-altering situation. Shock, dismay, and disbelief are fairly common. Victims feel fearful, anxious, and irritable. They may feel angry, depressed, embarrassed, ashamed and guilty, often wondering whether they may have done something to provoke the rape or could have done something to avoid it. It is not uncommon for self-blame to be expressed or an act of self harm to occur.

A 19 year old single lady who was raped by her father expressed her experience:

"It was horrible the moment when my father entered my room and started to take of my clothes and touch my genitals. I started shivering with a state of fear and terror. I was like someone paralyzed. I wanted to scream, to cry, and to stop him. He shut my mouth, and with his huge hands restrained my body. He looked like a monster". C14

Prostitution has a very negative effect, both on the prostitutes themselves and on society as a whole, as it reinforces stereotypical views about women, who are seen as sex objects which can be used and abused by men. Prostitution is not a conscious and calculated choice. Many women who become prostitutes do so because they were forced or coerced by a pimp or by human trafficking, or, when it is an independent decision, it is generally the result of extreme poverty and lack of opportunity, or of

serious underlying problems, such as drug addiction, past trauma (such as child sexual abuse) and other unfortunate circumstances. In Islamic culture it is extremely forbidden and a shameful act. In Palestine for a woman to be a prostitute, she will carry the shame with her family throughout her life.

One of the participants was a 21 year old girl who were pushed to be engaged in prostitution reflected her feelings of shame and pain as follows:

"I don't deserve life, not even food or water, I feel myself like dirty animal, anyone know what I do will feel disgusted from an animal like me, I was selling myself to bring money to my family so they may accept me, humans will never accept a dirty disgusting animal to be with them, I hope I will die soon".C3

Sexual harassment is not about attraction or sexuality, it has nothing to do with sexual orientation; it's about making others feel small in order to feel powerful.

If you feel uncomfortable about the way someone is acting towards you it is not your fault you have the right to feel comfortable and safe. Harassment leaves deep effects inside your soul of humiliation and guilt. For example, a 21 year old participant reflected upon her experience with harassment as follows:

When I was 11 years old my cousin harassed me. Every time I visited their house he touched my genitals and pushed me to do the same to him.

Ten years have passed, but I still feel afraid when I enter their house" C10

I.2 Domestic violence

Women face different types of domestic violence within the family; all types of violence were experienced (physical violence, verbal violence, economical, emotional, controlling life behavior).

There were many cases with different scenarios. One 27 year old woman was pushed to marry a man 20 years older than her, drinking alcohol, and had extramarital relations explained her experience of domestic abuse:

"In my dream marriage and intimate relation was the real meaning of reassurance, safety and love. After I married, my husband violated me in all ways he could: physically, emotionally, sexually, and verbally. No longer did I have hope for a better life, so to die is much better". C17

Beside the injuries, wounds, burns and bruises resulted from physical abuse it also leaves long lasting deep effect on victims lives and their psychological well-being. Symptoms such as fear, depression, anger, self blame, isolation, and among others are common.

This participant was empowered, and began to face the violence of her husband. When we met her, she discussed her experience of abuse while she crying and shivering:

"***Almost every day my husband hit me. He pushed me on the floor and put his foot over my head, my neck and my face. He tried to suffocate me, kill me. I was admitted to the hospital many times, most of the times my children watched what happened." C4***

Verbal violence is the most common type of violence; verbal abuse may not cause physical damage, but it does cause emotional pain and scarring. It can also lead to physical violence if the relationship continues on the unhealthy path it's on.

Sometimes verbal abuse is so bad that you actually start believing what abuser says. You begin to think you're stupid, ugly or fat. You agree that nobody else would ever want to be in with you. Constantly being criticized and told you aren't good enough causes you to lose confidence and lower your self esteem. As a result, you may start to blame yourself for your partner's abusive behavior.

All participants described experiences with verbal violence, but some didn't consider these bad words as type of violence. A 35 year old participant felt guilty because of she is overweight and believes her shape is the reason for the abuse. She said:

"Every time my husband sees my face, he starts shouting, cursing, and insulting me with very bad words. I keep asking myself what do I do to provoke him in such a bad way. I look like a stupid panda; very fat, ugly, and snoring while I sleep". C2

By denying the victim access to money, such as forbidding the victim from home expenses, she is totally financially dependent upon the abuser for shelter, food, clothing and other necessities. In some cases the abuser may withhold those necessities, also including medicine and personal needs. The abuser will neglect his victim's basic needs and let her feel hopeless, helpless and useless.

18 out of 20 participants were not working and totally dependent on others like their husband or father. A married participant, whose husband works as a carpenter, punishes her by withholding money, she explained:

"My husband locks me with my children at home for two weeks, no money or food. I feel neglected, humiliated, disabled, and helpless. It was a difficult time". C1

Someone controlling your life, your behavior, and your choices deprives you to your freedom of choice; even if this person is your husband or your father. The feeling of helplessness, useless, or to feel like slave is very common.

A 27 year old who ingested organ phosphorus to suicide, spent two weeks in intensive care unit. She wanted to die because her father discovered her being sexual on the internet.

She described her life as being in prison. She said:

"When I finish my study at the university, I didn't find job. My father and brothers controlled each movement I made. They kept me at home working like a servant. The internet was my friend. I spent most of the time chatting and talking to people whom I am not allowed to meet in real life."C16

Their control over her became worse after they found her talking to a man:

"They (my father and brother) kept me in my room. They locked the door. They took my computer and my mobile. Thy forbid me to go outside my room. That was really a prison." C16

Also the husbands think that they can control the life of their wives out of their masculine role. Our first interview was with a lady who was abused and controlled by her husband. She ingests large amount of medication in trail to kill herself after friction with her husband. She reflects her experience:

"My husband locked me at home. He didn't allow me to go outside for any reason. He took my mobile and stopped the internet and telephone. He try to control me." C1

I.3 Witnessing Abuse

To witness abuse is most likely the same as being abused yourself, it carries inside pain and despair, especially when we witness the abuse of someone we care for.

An 18 year old girl attempted suicide the day after her lover committed suicide and died. She explains her childhood experiences of witnessing abuse, which foster the feeling of fear and unsafe inside her soul:

I never felt that we have a family or a home. My father was abusing my mother in all ways; hitting her, pushing her out. He divorced her two times. I felt afraid and unsafe. Life without a mother for small children is very frightening." C8

I.4 Child maltreatment

Childhood experiences are totally different from adult experiences, bad childhood experiences which we address as maltreatment (physical abuse, verbal abuse, emotional ill treatment, sexual abuse, and negligence) are the types emerged in child maltreatment which expressed from women as follows:

> ***"My childhood was painful and traumatic. No one liked me or wanted me. I remember when my parents came at night while I was sleeping in the same room with my two sisters, they cover them and kiss them and no one looked at me." C2***

All types of child abuse and neglect leave lasting scars. Some may be physical, but emotional scarring has long lasting effects throughout life, damaging a person's sense of self, ability to have healthy relationships, and ability to function at home, at work and at school.

Young lady describe her experience:

"My father took me to Jordan and I was forced to have a vaginal examination to make sure I still virgin. It was disgusting and painful. It was humiliating; I hate him and I hate my life."C8

Emotional abuse is a component of all types of child abuse, whatever the actions of abuse physical, verbal, sexual it leads to long lasting deep emotional scar which hinders intact and healthy physical, social and psychological growth.

"In my childhood, my family didn't like me. They neglected me. All my brothers and sisters went to kindergarten except for me. I would sit for hours in front of my house waiting for my sisters to come back home from kindergarten. At night I started to cry silently. I wondered why they didn't take care of me like the others." C9

I. Losses (The second theme)

Loss is known to be a natural stage in our life and grief is a natural response to loss, which is expected to resolve with time. Some persons become stuck inside the emotional trauma of loss for a long period, with feelings of intense emotional pain and suffering. One participant expressed the experience of loss as follows:

"After the suicide of my boyfriend, I lost the person who gave meaning to my whole life, who made me the feel like a human. I lost my life. It was better to die." C8

II.1 Loss of parents

A parent's death typically ends a child's relationship with someone of central emotional importance, with the attendant potential for straining his or her relationship with the remaining parent or caregiver; worsening the family's economic status and living situation; creating pressure to take on responsibilities of the dead parent.

One participant who lost her father when she was an infant explained her experience:

"My father died and my mother was unable to take care of us. She was very poor, not educated, and didn't receive any support. She threw me and my brothers and sisters in an orphanage.. Beside bereavement, we lost our identity as a family." C1

II.2 Loss of cultural identity

Cultural identity includes religion, rites of passage, language, dietary habits and leisure activities. Individual immigrants to a different culture may experience feelings of alienation and mental distress, with consequent difficulty in settling into the new society. Social change, assimilation

and cultural identity may be significant factors in the relationship between migration and mental distress. This is a risk factor to suicide.

One participant who married and lived in a different culture said:

"I came to live in a place totally different from my hometown; strange language and religion. Whatever I said or did was not accepted by them. They never respected my beliefs." C2

II.3 Loss of relation

The loss of a family member or beloved one through death or separation can take a serious emotional toll on those involved. Even when unrecognized, emotional trauma can create lasting difficulties in an individual's life. It could lead to suicide. One participant, 21 years old, who lost her boyfriend expressed her experience:

"My boyfriend left me. I prefer death instead of living without him." C6

II.4 Loss of security

Security is both a feeling and a reality; they're not the same. The reality of security is mathematical, based on the probability of different risks and the effectiveness of different countermeasures. But security is also a feeling, based not on probabilities and mathematical calculations, but on psychological reactions to both risks and countermeasures. You might feel terribly afraid of terrorism, or you might feel like it's not something worth worrying about. Loss of privacy including the loss of security, loss of home and belongings could be perceived as a loss of security.

One participant said:

“They burned our house. I had no shelter for my children. They would kill my children because their father is a killer. I didn’t feel secure at all." C11

II. Psychological risk factors (The third theme)

We all have a sense of self. Whether that sense of self is positive or negative is based upon our experiences in life, our perceptions and assessment of ourselves. Often, this perception is not accurate but rather is distorted. In our study, we describe these perceptions as psychological factors which are low self-efficacy, low self-esteem, negative self-image, and maladaptive coping mechanism. These factors were expressed by a participant as follows:

“The defect I was born with, my ugly looking eyes as you see, destroys my self-esteem, trust in others and life as whole. I experience failures one after another. I was unable to make anyone like me. I cannot stick with any task: studying, university, working, or even going shopping." C10

A person with positive feelings regarding the self is said to have high self-esteem. However, self-esteem can refer to very specific areas, as well as a general feeling about the self. For instance, a person may have low self-esteem regarding physical attractiveness and high self-esteem about ability to do a job well.

“I hate myself, it is better to send me to the zoo. I don’t think I deserve more than a despicable vile animal." C3

Individuals with low self-efficacy see themselves as unable to be successful. As a result, they are often unwilling to take risks or try new things, frequently have feelings of failure, they experience self-doubt and uncertainty. One participant expressed their feeling of low self-efficacy as follows:

“What can I do? My husband is in prison. I have no money to take care of my children, my family doesn't want us, the family of my husband were threatened to be killed, my house burned, no one wants to help me. I will kill myself with my kids. This is bad luck, and it will stay with me forever." C11

A simple definition of a person's self-image is their answer to the question "What do you believe people think about you?” a participant answered:

“Ugly and ugly and ugly; a huge elephant. I hope I will die to stop seeing this ugly body." C2

III. Socio cultural factor

Within the framework of the socio cultural context many factors emerged, (poverty, stigma, and dysfunctional family). These cases live in a convergent culture they have the same nativity, language and religion.

The previous subthemes expressed as follows:

" My father died, and we were distributed to orphanages.We met as a family just on vacations, one of us was always missing. We are still not a family even though we live in the same house." C1

“My mother didn’t want me to tell anyone about the sexual harassment of my father, even my brothers. She said it would be a scandal; they will kill you and your father." C14

IV. Lack of support system

The availability of professional or non professional support systems, most likely fosters our capacity to bear difficult times, the lack of support system was expressed by women as follows:

“They help me a lot in the center; the psychologist was supportive and understanding. If I was engaged in this therapy earlier, I think I would not have tried to commit suicide”. C9

Table (3): the analysis of women interviews.

Meaningful units	Formulated meanings	Subthemes	Themes
C1 When I refused my husband's order to have anal sex, he raped me. C4 Every time I felt tired and refused to have sex with my husband, he raped me. C5 While I was drunk and disoriented, my boyfriend pushed me down and raped me. C14 My father entered my room and locked the door. He raped me. C17 My husband used to have sex with me while my hands were tied. He always had sex with against my will. In other words, he raped me.	Rape	Sexual violence	Violence
C3. I started to made prostitution to earn a living after I lost my work. C3. My mother took the money I earned from prostitution without asking about its source. C3. I tried to stop prostitution many times, but when I didn't gain money, they (my family) started shouting at me, abused me and neglected me. We are very poor and they need money for food. They don't care from where it comes from.	Fostering for prostitution		
C5. My boyfriend tried many times to harass me sexually, but I refused to do that before marriage. C5. My cousin harassed me. He touched me many times. He came to our home while I was alone. C10. When I was 11 years old, my cousin harassed me many times. He touched my genitals. C14. When I reached 16, my father started to look at me sexually and erotically. He used to enter my room while I was sleeping and said taboo words and touched my genitals. C 17. My husband brought women with him to our house. He wanted me to have sexual relations with them. I refused. It was disgusting.	Harassment		

C 1. My husband hit me. He physically abused me all the time. C1. My husband tried to suffocate me and wanted to kill me. C2. When my husband failed to have sex with me because he said that I am chubby, he started shouting and hitting me. C3. My mother hit me every time she felt stressed or tired. C4. My husband hits me and pushes me out of the house. He tried to kill me. C4. My husband pushed me out of the house all night. I was scared, shivering and crying. I have no neighbors, and my house is surrounded with trees. Many animals and harmful reptiles are found around. C8. My family hit me very often whenever they knew I was with my lover. C8. When my father and my uncle thought that I was pregnant, they hit me violently. C8. My father tried to slaughter me with a knife, but my uncle prevented him. C12. The family of my husband hit me, and they told my husband that they saw a man in my house. He hit me and forced me to go to my family house. C15. Every time I discuss the matter of fertility with my husband and tell him that he should see the doctor, he hits me aggressively. C16. My father and my brother entered my room and started hitting me severely. They insulted me by putting their shoes over my face. They broke my hand and tried to kill me. C17. When I refused my husband's order to drink alcohol, he pushed me down, hit me, and poured alcohol in my mouth by force. C17. When my husband came home drunk, I was sleeping deeply because of hypnotics. He wanted to have sex with me, so he hit me hard until I got up. C20. My husband hit me every time I gave birth to a girl. It was not my fault.	physical	Domestic violence	

C1. When I was in an orphanage, they used to curse at me. My mother and the whole family did the same. They all abused me in different ways. C2. My husband always insults me, curses at me and makes fun of me. C3. My family, my teachers, and everyone around me say bad words and shouts at me. C4. My husband shouts at me and says bad and taboo words to me. C8. My family and everyone in my village said about me bad words. Especially after they know about the relation I had with my relative. C9. My sister knows that I have relation with a boy. She said you are bad girl. C10. My mother says that I am mentally retarded, and deserve a mental hospital. Beside my ugly face, she thinks I am mad. C11. In the camp where I lived, and after my husband killed a man, they started to curse me. They said you are killer. I don't kill anyone. C12. My husband and his family accused me of betrayal. They shouted at me. It was an unbearable situation. C15. My parents shouted at me saying bad words. C16. I have never imagined that my parents and my brothers could curse at me and say bad words to me. C17. My father, my husband, and every one in our village said bad words to us, because my father is a bad man. It was normal to hear all the bad words. I hate this life and those people. C19. My mother always shouts at me saying bad words. She dares to say that because my father is dead. C20. That man (my husband) is the worst human I ever met. I cannot say the bad words he says to me and to my daughters.	Verbal abuse		
C1. My family used to blame me and deal with me as the worst woman in the world. C2. My husband started to hate me when I gained weight. He abandoned my room. C4. My husband humiliates me in front	Emotional		

of my children. C6. My boyfriend abandoned me and gave my mobile number to his friend who tried to call me to make a relation with me. C7. The sister of my fiancé knew that I was in love with a gay before I got engaged to her brother. She started to threaten me that she would tell her brother about the relation. C12. My husband and his family accused me of betrayal, which was not true. C12. When I returned back to my family's home after I had been divorced, my family started to humiliate me. They didn't talk to me, and my mother wished that I had died. C15. My husband used to call me barren. He humiliated me. He didn't talk to me. He neglected me socially and sexually. He engaged another woman and used to talk to her in front of me saying sexual words to her. It was a very humiliating situation. C16. I decided to kill myself. I wrote a letter to my family about the pain, the negligence, the abuse and the humiliation they caused me. C17. My husband used to humiliate me. He forced me to have deviant sexual relations, but I refused. I preferred death to that. C18. My father accused me of being a bad daughter who didn't deserve trust. C19. My mother was always nervous and angry at me, and she used to humiliate me.			
C1. My husband worked and earned money. He sold the land we own. He took the money and went to Jordan to marry another woman. He leaves the home empty, no money, no food, and no furniture. Every time he got money, he did the same. C2. My husband didn’t give me any money; he also took mine and never returned it. I was working in school canteens, or sometimes stitching some clothes for neighbors. He has money. He	Economical		

is a lawyer, but he tries to abuse me in this way. C4. When I asked my husband to give me money he refused. He said he would buy everything, but he didn't buy anything. C11. My family started complaining about me and my children after I divorced. They didn't take care of my children. When I came back from the university, I found that my children were hungry. No one offered them food. C12. My husband used to leave the house for a long time without giving me any money. I was unable to buy anything because I didn't know the places and because I have no money. C12. When I returned back to my home after I had been divorced, my family neglected me and my children. They didn't offer food and milk to my children. C16. I was alone in my room for a week. No one talked to me or offered food, I ate nothing, just drank water. C20. My husband earns the money, he buys alcohol with the money, and he leaves me with nine children, hungry.			
C1. My husband prevented me to use the telephone or the internet, and he didn't allow me to go outside the home. I feel helpless. I hate my life. C4. My husband prevented me from going out. He locked the doors. He used to keep me alone for a long time. C9. My brother controls our life; me and my sisters were not allowed to go outside, or to watch television. C10. My mother treated me as a piece of furniture. She wanted to dominate my life. C12. My dream was to continue my education. I want to go to the university. I did my best and study hard, but my family decided to marry me off because they didn't have money. They took me out of school, married me off, no one ask for my opinion. C14. She is my mother, the one who shut my mouth. She let my father rape me; I want to shout, to tell everyone. I want to	Controlling life behavior		

call the police, the media. This man should die or I will die. C16. My family took everything from my room. They also broke the door of my room so as to keep it open all the time. This is not humanistic. C16. My family always controls my life. They decide what to study, and where. Where to go and with whom. What to work and when. It's useless to stay alive. C17. My father forced me to marry a bad man. They control my life. There's no meaning for this kind of life. It's better to die.			
C1. Everyone in orphanages was abused. I witnessed the abuse of my mates in that place every day. C8. We lived in a hell not a house. My parents struggle all the time. My father hit my mother, divorces her, push her out. Their relation was horrible. They made me hate life and lose trust in everything. C17. My father is always drunk. He abuses my mother in all ways in front of us.		Witnessing abuse	
C5. My cousin came to our house while all my family was out, he locked the door and raped me. I was 16 years old. C16. I was young when my father started to harass me. He tried to rape me.	Sexual abuse	Child maltreatment	
C1. They hit us in the orphan house. C2. My parents hit me very much when I was child. They said that I was stubborn. C4 When we were children it was normal to be beaten. For sure we were troublemakers. C8. My mother is always angry because my father abuses her. Whenever she becomes distressed she beats me. I was the oldest. It was unfair, but I know how she feels.	Physical abuse		

C1. When I was a child in the orphanage, the people there cursed me, and shouted at me all the time. C3. My family and all the people around called me Majnona (crazy). C10. My mother said that I am talkative, and she doesn't like this habit, so she starts shouting and tells me to stop talking and go to my room. I refuse her orders and start shouting destroying everything I find in my way. C16. My parents and my brothers curse me and say bad words to me. I don't believe them. C19. When my father died, my mother started shouting at us saying bad words.	Verbal abuse		
C8. My family prevented me from going to school because I love someone. I think this is unfair. C9. When my brother came back home from prison, he prevented me and my sisters from watching TV, playing on the computer or using internet. They also prevented us from going outside the home for any reason. He forced us to wear hijab (head cover) even at home. C8. My father took me to Jordan and he forced me to make a vaginal examination to make sure I was still virgin. It was disgusting and painful, but I couldn't say no. I was a child.	Emotional ill-treatment		
C1. My father was dead. The orphanage was a bad place, but my mother neglected us. She didn't visit us or take us to stay with her. C2. No one liked me or wanted me. I remembered when my parents came home at night while I was sleeping with my sisters in the same room. They covered my sisters and kissed them, but no one looked at me. C3. Negligence was the main act in our house and our life. No money. Large family. My parents were unable to take care of us. I think we raised ourselves. C5. My parents were always very busy in their own activities. They didn't pursue our lives. They think that we just need money and clothes.	Negligence		

C9. My mother didn't send me to the kindergarten, so this made me weak in my study at school. I repeated the first class obligatory. No one took care of my study. C12. All our needs were neglected. My family was poor. We were large family. My mother needs to do everything and sometimes to work in houses to earn some money. No one has time to take care with us. C17. We were neglected; my father was drunk all the time, my mother abused most of the time. No one can look after any of us.			
C1. I was an infant when my father died. The loss of our father sent me and my siblings to orphanages. We lost each other, not just our father. C9. I lost my brothers. One died as a martyr. Another was put in prison, and the other immigrated to another country. C19. When my father died, our life changed. It became miserable, and we felt that it ended. To lose someone you love is very difficult. It makes life miserable.		Loss of parents	Loss
C2. I married a man from another culture and other religion. I was Christian while he is Muslim. I traveled to his country and lived with his family. I didn't know anyone there. I always feel like a stranger.		Loss of cultural identity	
C5. After my boyfriend left me, I saw him with another girl. I lost the one I loved very much. C6. I met him in the university, and I loved him very much. Then he left me without a reason. I lost the one I loved very much. C7. My fiancé discovered that I had a relation with another man before we were engaged. I may lose him. I love him very much. C8. When my lover died I lost the person who was the source of my happiness and he is the whole in my life. I lost my life, and it was better for me to die. C9. When I was at school. I fell in love		Loss of relation	

with the cousin of my friend. We loved each other very much for a year. My mother refused that relation. He became engaged, so I felt that the world was very dark. C12. My husband divorced me. He took my two daughters. He didn't allow me to see them. C13. My fiancé and I went to the court, and we were divorced. Everything between us is finished. I don't deserve this.			
C3. I was kept in a shelter. My father will kill me. I don't feel secure. C4. My husband pushed me out on the street at night. I was scared. Our neighborhood is not secure. C7. The sister of my fiancé violated my privacy. She threatens me. I was afraid of my family and my fiancé. C11. When I remember that I lost everything, I feel broken. My husband was put in prison. My house burned. My children were threatened to be killed. We had no shelter. C16. I lost everything. It was forbidden for me to use computer or mobile. I was not allowed to go out.		Loss of security	
C1. I never feel proud of myself or my life. C2. I failed to like myself, or to make anyone like me. I am not the person who deserves love and care. C3. I am not a human. I am the most disgusting animal in the world. I did the all bad things in the world. C5. I don't have any confidence in myself or others. My values were destroyed. I was searching for security, love and care, but I lost my self. C6. I have hurt myself with this relation. C7. It was my fault. I have a boyfriend. This is not true. I feel very bad. C8. My lover is dead, he committed suicide. It was my fault. I was unable to		Low self esteem	Psychological factors

defend my relation. I feel disappointed from myself. C9. I lose my values, my believes, and my self confidence. I was very conservative before and then I have relations with boys. C14. I feel worthless, I hate myself. This contaminated and dirty body and soul. C16. I don't deserve any respect.			
C2. Thousands of times I tried to lose weight. Every time I failed. I become more obese. I feel unable to complete any task. C3. I feel like a pipsqueak failed stupid animal. C5. I spent six years in the college instead of four and I still unable to graduate. I wasn't successful in anything. C8. I try to study in many universities, I failed to continue. I start taking some training but I never continued. I feel good for nothing. C18. I failed the Tawjihi exam. My family was disappointed in me. I am just a failure.		Low self efficacy	
C2. I look like a huge ugly cow. I hate to look in the mirror. I feel hopeless when I see this ugly body. C3. You see that I am very ugly. Everyone sees that. I hate this ugly face. It hides an ugly and dirty soul. C9. If I am beautiful and nice, the man I love will not leave me. He will come to marry me. C10. I feel anxious and stressed when I see people. I left the university because the students used to look at my ugly eyes. C13. I carry an infectious virus inside my liver. This body is sick and corrupt.		Negative self image	
C2. When I feel distressed, I start eating and eating. This exacerbates the problems. I become very fat and my stress to lose weight increases. C5. When I face failure and distress I start to drink alcohol, and smoke Hashish. C10. When the level of stress raises inside my heart, I start talking, shouting and break the things in the home.		Maladaptive coping mechanisms	

C3. My family is very poor. Fourteen people live in two rooms. We never feel full. No new clothes or future or toys. C12. We were very poor. My father works in the municipality. He cleans the roads. He forced me to marry a married man 20 years older than me because he has money, and to get rid of my responsibility. C19. My mother takes care of the family after the death of my father. She earns very little money. She works in the farms of other people. We don't have any money even for the basic needs. C20. My husband pushed me out with my nine children. No shelter or food or money. I worked as a servant.		Poverty	Socio-cultural factors
C1. Living in an orphanage is a stigma by itself. This is unfair. If one of your parents is dead you will lose security and love, in this community you will lose your respect also. C2. I live in a village, I was Christian, they were all Muslims. I feel as a stranger. They all look at me in different way. C3. Poor family. 8 ugly girls inside the family, and not educated, all these are a source of shame and stigma. The people around every time they see my father they call him "miskeen ya haram" which means poor and deserve compassion. C7. Love and relations consider shame and stigma in this culture. It's a normal reaction God places inside our soul. They cannot understand. C8. Love is the biggest shame in this community. Everything we feel is ayeeb (shameful). This is the only word we know. C9. Love and relations are not allowed in our religion. It's a great sin. I brought the shame to my family and the hell to my father. Prophet Mohamed said "if you raise your daughter in good way, you will not enter the hell." C10. Even the physical problems, which are not our fault, are a shame and considered a big shame and stigma. I		Social stigma	

didn't create myself. Why I have to pay for these ugly eyes? C11. In a struggle, my husband killed a man. Everyone in our family became a killer. Even my small children. No one accepts us or wants to help us. It was a nightmare. C12. My husband accused me of betrayal. This is a great shame. He divorced me. Court considered this a big shame and that I am not qualified to take care of my kids. C13. Physical deficit is a stigma. I have hepatitis. My fiancé divorce me. I will carry this stigma until the last day of my life. C14 My father rapes me. But I will carry this scandal and shame inside my lost virginity. C15. My husband was infertile. He didn't tell anyone, he was secretly seeking treatment. For him this was the end of his life, as a man it's a shame to be infertile. He accuses me with infertility, and he wants to marry another women. I tried to kill myself. C16. Love and relation is a big shame and "haram". Everything in this culture is shame or haram or not allowed. It's better to die. C17. My father has a bad reputation. He is a spy for the Israeli occupation. He drinks alcohol and has relations with women. no one came to visit us or talk to us. We didn't have any friends. He forced me to marry a bad man like him, because no one would marry me or my sisters. C18. In my family, which is highly educated, and from high social class it's a shame to fail Tawjihi. C19. In our village for women to raise children alone is stigma. She is not qualified to do so. When I failed in Tawjihi it was like a crisis for my mother and my family. C20. Eight daughters with a divorced mother alone is a big stigma in this community. Female by nature is a stigma. I have a mentally retarded daughter			

which is another stigma. I worked as a servant which is a big shame. But for this community to stay days with my children hungry and sleep on the floor in one room is not a shame.			
C1. My father is dead. We live in orphanages. We don't have any emotional connectedness. Even when we live in the same house, we act as strangers not as a family, brothers and sisters. C2. My parents didn't have a good relation. They were separated for long time and I was scattered between them and my grandmother. I didn't live within a family. C3. We are very poor. We live in bad conditions socially and economically. We don't have relations as a family who loves and cares for each other. C5. The term family does not apply to us. Each one lives alone. We just meet for eating, like a hotel, not a home. Each one of my parents has his own life. They struggle and they hate each other. They don't function as family. C8. The definition of a family or even a home does not apply to our situation. I didn't live with a family. My parents were two enemies who hated each other and struggled all the time. C9. After my brother died, my mother became depressed, aggressive, and anxious. She is shouting all the time. It looks like a psychiatric hospital not a home. C9. My brother set the rules for our life and our house. He is very conservative. My father allowed him to control things even if he is not mature yet. C10. My mother is the source of power in our house. She made the decisions and leads everything. My father just works and brings money. C11. My family was poor. They push me and all my sisters to marry early, so they would get rid of our responsibility. They were aggressive toward me and my sisters, they preferred my brothers.		Dysfunctional family	

C12. I live in a poor, large family. Always there were struggles and deprivation inside this house. They married me off very early, for a married man older than me. They didn't allow me to study. They want to save money for my brothers. C14. My father, the one who should be the source of protection and security, raped me, and destroyed my life. My mother stays silent, just silent. C17. Since I was small child, I remember the time my father came back home, after midnight, drunk, he was laughing, shouting, and hit my mother. We were all awake, started crying and frightened, my mother was unable to do anything. Now I have married a man like my father. I experience the same feeling every night. C19. My father was sick and disabled for more than two years. Then he died, my mother became very angry and aggressive. Our house became a hell.			
C1. I didn't receive any support until I attended this center. They support me psychologically, and legally. They helped me find a job and they offered their lawyer to help me in my divorce case. I visited a psychiatrist before who just gave me medication. It didn't help at all. C2. I start attending this center. The psychologist there is very understanding, a good listener and compassionate. She helps me, and she supports me to be more positive and to accept myself and the others. In the community mental health center they give me medication to decrease my weight through decreasing my anxiety level. It helps but not as the psychological counseling. C3. I didn't come to this shelter by myself. They tried to help and support me, they will sent me back to my family, and help me continue my life. Sometimes I feel hope and desire in life, but most often the despair and desire of death dominates. C5. A friend of mine studying nursing instructed me to go to a center for		Professional support	Support system

psychological counseling. I took the appointment and went to meet the psychologist. I didn't trust her; I didn't go back after the first meeting. I think if I had continued therapy, I won't have try suicide. C9. When my father knew that I tried to commit suicide for the first time, he took me to the community mental health center in our city. The doctor said that I just need some counseling and no need for medication. I started to visit the center and meet the psychologist there. She supports me. I will continue my study. C10. I asked my family to send me to a psychologist. I felt that I needed help. My mother refused but when I tried to commit suicide she sent me to the community mental health center in our city. I met the psychologist. She is understanding and a good listener. I like to go there and talk to her. C11. My teacher in the university advised me to visit a psychologist to help me when she knew what happen and that I tried suicide. I was studying social science. She advised me to someone she knows and made an appointment for me. I went to the center. They really support me in many ways. C12. After my husband divorced me and took my children I collapsed and tried suicide. My sister took me to the UNRWA clinic in our camp. They have counseling services. I started to have counseling sessions. It was helpful, but it was necessary to have my children back and this happened when my husband died in a car accident. C13. I was working in the hospital when I tried suicide. They refered me to the counselor who visits the hospital. I refused to go. It's stigma. C14. I went to a center that provides psycho social services for women. They tried to help in all ways. My mother rejects their interference and says that this will destroy our family. If the sexual abuse of my father didn't stop, what			

would counseling do? C15. When I tried suicide, my husband took me to a psychiatrist who refered me to a psychologist. She supports me, she also met my husband and this helped very much. C16. I stayed 2 weeks in the hospital after attempting suicide. The psychologist visited me every day. She listened to me. That was good, but my family refused to let me go. They said you are not crazy. C17. I called the help of police to protect me from my husband and my father. They referred me to a psychologist. She was very good. Also a center came and offered help and counseling services. They really empowered me.			
C1. I have no family or friends to support me. C2. I left my family and my town. Who will support me or understand me there? C3. My family is unable to support any of us. They will never support me. I brought shame to this family. C4. My family is not here. I don't have friends. By the way if I was with my family they will not support me. C5. I needed my parents to listen to me and understand my suffering. But they are always absent. C8. Who will support me? My lover who always does this is dead. C10. My mother didn't support me. She always shouts at me. C11. My family didn't want me with two children. We form huge load on them. C12. No one around helps me or supports me. They all blame me. C14. If my mother liked me she would stop the repeated violence of my father on me. C16. My family pushed me to this situation. They never support me. If they consider me their daughter they should give me some freedom to find a meaning for my life. C17. Who will support me? My father and my husband are bad men. My mother and other family members suffer from		Nonprofessional support	

deprivation and abuse. No one in this community talks to us because of my father. C19. After the death of my father no supported, loved, or understood me.. C20. I don't receive any kind of support, psychological, emotional, or physical. God is the only support to me, and to my children.			

Chapter Five

Discussion

5. Discussion

Through my experience as a women living in a Muslim and Arabic country with special circumstances, my professional experience as midwife years working very close with women and for women and currently studying mental health, all those feelings, emotions, moments, hopes, fears, losses, victories, and defeats draw the aim of my study which is: explore the risks beyond the experience of attempting suicide among a group of Palestinian women. Suicide poses a challenge for the health of women in Palestine, and it is influenced by a set of complex and interactive individual, social, cultural, and economic factors.

An ocean tide changes, pulling water from a bay. It is powered by invisible, natural forces that work steadily and silently, creating a totally new landscape in a matter of moments. We can't see the moon's gravity, but we see its effects on the tide. Similarly, changes in brain chemistry and thought patterns that lead to self-destructive behavior can appear to come from nowhere and dramatically change our worldviews. As we ponder our life circumstances or grieve the loss of loved ones, we can convince ourselves that things will never get any better or that life is not worth living. If we repeat these thoughts to ourselves often enough, we can come to believe they are true. But, later, looking back on those moments, such thoughts seem strange and alien. It is hard to understand where they came from and it is very necessary to understand how to keep the thoughts from coming back.

5.1 Discussion of the study method

This study focused on the experience of the women that attempted suicide and the risks beyond this experience. Suicide and attempted suicide become a tragic and potentially preventable public health problem. So it was crucial to understand the experience of women, the category that statistics all over the world says they attempt suicide much more times than men do.

In this study, to develop a clearer understanding of the risks that lay beyond attempt suicide, we used a qualitative descriptive phenomenological approach to glean the specific life experiences of women attempted suicide. Hallett (1995) claims that the phenomenological approach, which focuses on the subjective experience of the participants, is a natural and rational method for understanding human experience. Descriptive phenomenology is a useful approach because it analyses personal experience, thereby allowing researchers to explore the actual experiences of carers (Mu 2000; Huang et al. 2006). Phenomenological enquiry is the description of phenomena as experienced by an individual. It focuses on the participant's subjective perceptions and gives the researcher an opportunity to study phenomena in depth (Morse & Field 1996).

Our current research used the phenomenological descriptive design to understand the experience of attempt suicide and the risk beyond that experience. This design allows exploring the participants lived experiences

and formulating them into psychological understood language that is the essence of phenomenological design (Englander, 2007).

To obtain the goal of the study, face to face deep interviews with participants were conducted and the interviews were tape recorded to ensure not to miss any information. All interviews were transcribed verbatim in order to be prepared for analysis.

The analysis was based on Giorgi phenomenological psychological analysis that transforms the lived experience of ideas to words that can be easily understood (Giorgi, 1985). The role of the phenomenological analysis in this respect is to discern the psychological essence of the phenomenon (Giorgi, 1985, 1989).

5. 2 Discussion of the study findings

The research questions wonder what were the experiences of Palestinian women who tried to suicide and the factors that revolve around this phenomenon**.**

Five major themes emerged after the women´s interviews and eighteen subthemes to answer the research questions.

The first theme is violence

Violence in all its types is the first most obvious theme through our journey in exploring the risks beyond attempting suicide. Our sample in deed

reveals at least one type of violence as a major provoking factor toward suicidal thoughts.

International research has signaled that violence against women is a much more serious and widespread problem than previously suspected.

Our findings confirm the important and consistent relationship between women's suicide attempts and violence. The all women in this study showed that they were victims of one type of violence at least. These results were compatible with the majority of the results of similar research that discusses the reasons and risks lead to suicide (Rezaeian 2010, Ghaleiha 2012, Dabbagh 2005, Keyvanara and Haghshenas 2011).

Several studies reveal an association between sexual abuse and attempted suicide. With one study resulting in as much as a 10.7-fold greater risk of attempting suicide by age 21 in sexually abused subjects. (Silverman et al., 2006). The Silverman study also indicates an association between physical abuse and attempted suicide as does Fergusson (2000), who presents a dose response relationship between the degrees of physical punishment and the prevalence of suicide attempts. In current study women were raped, harassed and sexually abused by intimate partners and strangers, they express this traumatic experience as a leading to the feeling of helplessness and despair which was unbearable and lead to suicide.

Some of the studies explain the outcome of violence which is in the end result may lead to suicide. Women and girls make up the majority of

victims of sexual abuse and intimate partner violence (Guggisberg, 2006). Experiences of sexual abuse and assault are linked to suicide and suicide attempts (Ansari et al., 2001, Curtis, 2006, Holmqvist et al., 2008). Victims of sexual abuse and intimate partner violence are more likely to report having depression, post-traumatic stress disorder, anxiety disorders, eating disorders, and excessive alcohol consumption (Curtis, 2006). A survey of adolescents done by (Epstein, and Spirito, 2010) found that girls who had been victims of sexual coercion were twice as likely to have considered suicide compared to other girls. The findings of these studies compatible with the result of the current study. As sexual violence increase the risk for suicide among women.

Similarly, intimate partner violence is a risk factor for suicide (Stewart, 2005, Guggisberg, 2006, Guggisberg, 2008). Vic Health, 2004 in their study the health costs of violence which measuring the burden of disease caused by intimate partner violence showed that Intimate partner violence is the leading contributor to death in Victorian women aged 15 to 44 years, accounting for ten percent of deaths, more than half of which were due to suicide. Other studies reveal that Women who have experienced intimate partner violence are almost four times more likely to have suicidal ideation than non-abused women (Taft, 2003). In a home with firearms, the risk of suicide for victims of violence increases fivefold (Wiebe, 2003). In current study the all married women suffers from intimate partner violence, some of these women perceive some types of violence as right for the husband,

and they feel guilty of provoking the anger of the husband. In cases of emotional and verbal abuse they describe this behaviour as their fault; they push the husband to do so. But when they describe the effect of verbal and emotional violence on their selves and their emotions, they always cry and said that they wish death.

Many studies in accordance with current study support the positive relationship between childhood sexual abuse histories for a women and the particularly high risk for suicidal thoughts and behaviors (Gladstone et al., 2004). This heightened risk cannot be ascribed solely to the elevated rates of depression found among sexually abused women (Andover, Zlotnick, & Miller, 2007; Joiner et al., 2007). Psychiatric co-morbidity, particularly borderline personality disorder (Brown et al., 2002) is also a factor in abused women's risk for suicide-related thoughts and behaviors.

Reviere and colleagues (2007) show that there is a relationship between intimate partner violence or sexual violence and suicide risk behavior among women. Reviere and colleagues (2007) add that the link between intimate partner violence and the risk factor for attempting suicide may be related, in part, to feelings of powerless, depression, social isolation, and lack of financial resources. Their result was very similar to the current study findings. The women in this study were mostly not working and they express the need for financial resources which push them to stay with their families or their husband even they abused them. The feeling of

helplessness and powerless and social isolation was apparent features of our interviewed ladies.

The all women we interviewed, expresses the emotions of distress, and easy cry and unable to bear stress before they try to suicide which were confirmed in the multicounty study of the WHO (2005), which discuss the Women's Health and Domestic Violence against Women and many other studies

Around the world, mental health problems, emotional distress, and suicidal behaviour are common among women who have suffered partner violence, Krug EG et al., (2002). In the WHO Study emotional distress was identified through symptoms such as crying easily, inability to enjoy life, fatigue, and thoughts of suicide in the 4 weeks prior to the interview. In all settings, ever-partnered women who had ever experienced physical or sexual violence, or both, by an intimate partner reported significantly higher levels of emotional distress than non-abused women. Likewise, in all settings, ever-partnered women who had been abused by their partners were much more likely to have ever thought of suicide, and to have attempted it than non-abused women (WHO, 2005). This is consistent with other research in developing and industrialized nations.

This close relationship between violence and suicide can be addresses on the base of crises theory.

Women experiencing violence by other words are experiencing crisis. In fact one of the most obvious aspects of crisis is the severe emotional upset, or disequilibrium, experienced by the individual, and unresolved crises can lead to suicide. Miller, & Iscoe, (1963) describe the feelings of tension, ineffectualness, and helplessness of the person in crisis. And in our study all these symptoms expressed by our sample.

A lady experiencing violence said:

"My husband hit me, and cursed me. He rapes me after all that many times. I have sever and intolerable emotional pain. I cannot think, I have nothing to do, I feel helpless and hopeless. It was like I lost all the things I ever had". C1

Second theme is losses

Loss is a common experience that can be encountered many times during a lifetime; it does not discriminate for age, race, sex, education, economic status, religion, culture or nationality.

Most people have experienced some type of personal or professional loss at some point in their life as a byproduct of living.

Losses of different kinds were clear to foster the desire to attempt suicide in our findings. The loss of father, broken of relationship, and divorce were expressed by participant to play role in their suicidal attempts.

A survey of the literature reveals a dearth of reliable information concerning the relationship between parental loss in childhood and subsequent suicidal attempts. In a control study discusses the relationship between parental loss and suicide. Statistical analysis of the data yielded, the incidence of parental loss was found to be significantly higher in suicidal than in non-suicidal subjects. (Greer. S, 1980)

Loss of parents was appearing as one of the traumatic experiences in current study that affect the life of tow ladies and catalyst their suicidal behaviour. The death of father is crucial in this community; the father is the source of power and support financially and socially. One lady lost her father when she was infant symbolizes this event to loosing the whole family.

Dabbagh, (2005). in her study about suicide in Palestine reveals the role of losses in the despair leads to suicide in more than one case involved in her study, most of them lose their fathers, one divorced twice, some lost their homes or lands and one lose his job.

Researchers in accordance with our study arise that loss is another event which may precede adult and child/adolescent suicide attempts. Loss of someone who provides emotional, informational, and/or material support has been shown to leave adults seriously vulnerable to suicide (Conroy & Smith, 1983; Hart & Williams, 1987; Wasserman, 1988). Also, divorce, separation, and chronic family discord, but not the death of a parent, were related to suicide attempts (Crook & Raskin, 1975). This latter study,

however, didn’t match our results as it was apparent in our study the relation of mostly father dead and attempt suicide.

Cross-sectional and time series studies in the United States demonstrate that divorce is directly related to the national suicide rate. The present investigation is a longitudinal analysis of this relationship for Canada during the time interval from 1950 to 1982. During this phase of recent Canadian history, both divorce and suicide rates have followed ascending trends. Trovato, (1987). Tow ladies out of twenty in our study was provoked to attempt suicide after divorce. They loss their financial support, one lost her children and the other was unable to brought food or shelter to her children. Divorce sometimes leaves the women especially when she has children unprotected. Some ladies explain that they prefer to tolerate violence, but kept with their children and provided with shelter and food. This may explain the consequences of absent of effective security system.

In their studies, Kosky (1983) found 80 per cent of suicidal youths had suffered the death of a parent compared to 20 per cent of a non-suicidal control group. Many other studies, reviewed by Adam (1990), found a significant relationship between parental loss and increased risk of suicide. They identify precipitating events for suicide may reflect severe conflict with parents, spouse or partner; episodes of family and domestic violence; divorce or loss of a significant relationship; serious illness in the family; loss of a family member through death or separation, or the anniversary of one of these kinds of events. These results were in line with our finding as

noted that, precipitating events are most often characterized by loss or interpersonal conflict, especially when linked to poorly developed coping or conflict resolution skills. The researchers, found relationship breakdown or difficulties in establishing positive social relationships were associated with suicidal behaviour in young ladies. A recent study found nearly 75 per cent of suicides occurred within one month of the breakup of a significant relationship (Baume, Cantor & McTaggart, 1996).

All previous researches are in congruent with our findings. Loss expressed as traumatic and lead to suicide attempts.

Other research reported that nearly one third of a consecutive series of 31 female who committed suicide had experienced loss of a close interpersonal relationship within six weeks or less of their death. In other study of 50 suicides, they found that 26% had experienced such loss within six weeks, Chapman et al. (2013). Similar results were appearing in our study. Seven young ladies were provoked to attempt suicide after the breakdown of a relationship. Young lady said:

"*We were in love, but our relationship had broken down. He didn't want to stay with me, I preferred to die."C6*

Social scientists believe that behind the growing trend of youth suicide is a loss of hope and purpose in their lives. Mostly the Loss or absence of a parent can lead to using drugs, getting pregnant, or committing suicide. The study also finds that Suicide rates tend to be higher amongst those from

broken homes, relationship breakdowns cause suicide rates to soar and that the loss of moral and religious values are key factors (GREER 1980, Adam 1982). One lady we interviewed starts to use drug and alcohol after breakdown of a relation, she swing between political and religious values of others, and lost her own. She said:

"*I changed my beliefs and my values just for him. I started to wear Hijab when he asks me to do so. I want to be religious because he was a religious man (sheikh). Then he left me. I took off the Hijab and start to drink alcohol and use drugs". C5*

In our study loss was apparent 13 women out of 20 express the loss as main theme in their suicidal behavior, the death of family member, divorce, some failure. They lost the hope along with these loses one lady express this feeling:

"At the moment my father dead my life stopped, on other words I am dead also." C19

The research use crises theory to explain the suicidal behaviours after loss. The unexpected death of a loved one is universally devastating that it's almost always precipitating for crises (Lazarus's, 1980).

Nowak (1978) suggests that the impact of a particular life event depends upon its timing, intensity, duration, sequencing, and the degree of interference with other developmental events. In the United States the suicide prevention movement has historically been linked to the crisis

intervention movement, suicide considered one possible lethal outcome of a life crisis. In the midst of severe disorganization and inability to cope, some individuals decide that there simply is no hope or that the pain is too great, and make the decision to take their own lives (Lester and Brockopp 1973; Farberow and Shneidman 1961).

Third theme Psychological factors

In our study positive result between negative body image and suicidal attempt appear clearly six ladies experience body image dissatisfaction. Many researches discuss the relation of negative body image and suicide and there were positive relation especially in young people.

Kim DS et al. 2009, and Eaton DK et al. 2005, report that Body Mass Index was significantly associated with both body image dissatisfaction and suicidal ideation among boys and girls, even after controlling for covariates. The association between overweight Body Mass Index status and suicidal ideation became significant in both sexes. Other study found that body image dissatisfaction, feelings of social exclusion and stigmatization have been associated with increased suicidality in dermatology patients (Gupta MA; Gupta AK. 2013). In both genders, body image dissatisfaction contributed to suicidal ideation, after controlling for covariates (i.e., perceived family economic hardship, parent-related negative life events, delinquent behaviors, unhealthy behaviors, and self-efficacy). Such association existed throughout all body mass index ranges,

and underweight males and normal females were most vulnerable to suicidal ideation if they are dissatisfied with their bodies (Kim DS, 2009).

In the current study one of the ladies attempt suicide after gaining weight. Another one thinks that she is ugly. Other has defect in her eyes. They express the dissatisfaction of body image to be direct or indirect leading to suicide. They become socially isolated and depressed sometimes. They think that this was the reason for the other to abuse them.

Low self-esteem has also been linked to the development of emotional problems, anxiety disorders, suicidal behavior, behavior disorders and depression (BHAR et al, 2008). Our findings confirmed that women attempting suicide had low self-esteem. Relevant literature on this subject also demonstrates the link between low self-esteem and suicide attempts (BHAR et al, 2008).

The researchers give associations with suicidality as a process (Beskow et al. 2005, Williams JMG. and Pollock LR. 2001, Mehlum et al. 2005). Statements about events and established attitudes from early phases in life such as loss, low self-esteem, identity issues and attitudes to feelings as a nonissue are seen as contributors to the commencement of the suicide process.

Throughout the stories, vulnerability, as well as the courage and strength to carry different loads over time, becomes visible. Eighteen of the twenty interview subjects tell of events and conditions in early stages, or

later of their life, which have contributed to forming their attitudes to themselves and to life in general. ‘That was presumably in the beginning, the problems started; it is something about self-esteem.

The fourth theme is sociocultural factors

A number of studies conducted by social scientists have noted that family breakdown in general, and the absence of marriage in particular, tends to heavily influence suicide rates. These studies are in congruence with our study as dysfunctional family appears to be one of the subthemes (Hughes 1999, Sheftall et al. 2013).

Suicide rates also tend to be higher amongst those from broken homes. Studies by Goldney (1982), Deykin (1986), Trovato (1986), and Adams, Bouchoms and Steiner,(1982). ~~for example,~~ show a statistically significant incidence of separation and divorce in the families of adolescents who attempt suicide as compared with control groups.

A 1987 study by Wodarski and Harris linked the increase in suicides in America to the proliferation of single-parent households. And a 1988 study of 752 families found that youths who attempted suicide differed little in terms of age, income, race and religion, but were "more likely to live in non-intact family settings."

Recently a Flinders University professor of social sciences reported that research shows a very close link between suicidal behaviour and parent-child relationships (Hughes, 1999).

Psychologists from the University of Leiden conducted a study of nearly 14,000 Dutch adolescents between the ages of 12 to 19. They found that slightly more than 10 per cent of the adolescents living in non-intact families reported having attempted suicide, compared to 5.3 per cent of peers living in intact families (Garnefski and Diekstra, 1982).

Perceptions of social and family support and connectedness have been shown to be significantly associated with lower rates of suicidal behaviour (O'Donnell et al,,2004). Other findings suggest that feelings of loneliness are associated with an increased risk of suicide attempt (Hjelmeland and Groholt, 2001. Stravynski, and Boyer, 2001), and that family and social support are protective factors [Nock et al., 2008]. In his study on the impact of parental status on the risk of completed suicide (Qin and, Mortensen, 2003) concluded that having children, especially young children, is protective against suicid. While in our study the family and children didn't seem to protect from suicide.

Nock et al., (2008) wrote in his review that lack of education and unemployment, which are associated with social disadvantage, may represent increased risk for suicidal behaviours, although the mechanisms through which these factors may lead to suicidal behaviour are not yet understood. Schmidtke, (1996) concluded from the WHO/EURO Study that "compared with the general population, suicide attempters more often belong to the social categories associated with social destabilization and poverty". The both studies are compatible with the finding in our study.

Poverty, early marriage, low level of education, unemployment, raised as major contributing factor in provoking suicidal behavior among women in our study which is correspondent to other studies.

Cultural and social stigma was apparent; it was associated with honor and guilt feeling

One lady said:

"We are a family that consists of 12 persons. We didn't have food to eat, we were living in two rooms. Poverty pushed me to prostitution and shame; I have no place in my home or even in this life. I decided to leave this life and I will". C3

Other studies support our findings. A systematic literature review was carried out in order to identify the key demographic, psychological, and clinical variables associated with the repetition of suicide attempts. Studies published from 2000 to 2012 were identified and selected 86. Suicide re attempters were associated with higher rates of the following characteristics: unemployment, unmarried status, diagnosis of mental disorders, suicidal ideation, stressful life events, and family history of suicidal behavior. Additional research is needed to establish adequate differentiation and effective treatment plans for this population (Mendez et al. 2013).

In an effort to understand and prevent suicide, Hu Li Za Zhi.(2007). have investigated medical, psychosocial, cultural, and socio-economic risk

factors associated with the environment as a promising line of research. There is now considerable evidence that childhood and family adversities in general such as childhood sexual and physical abuse, witnessing domestic violence, parental separation or divorce and living with substance abusing, mentally ill or criminal family members may be both strongly interrelated and individually related to suicidal behavior in adolescents as well as adults.

Researchers suggest that, Child and family support programs, employment support for mothers, and legal guarantees of gender equality, could moderate problems of socio-economic disparity and poverty, which predicts both parents' and children's suicidal behaviors in modern societies. In our study we deeply agreed the finding and recommendation of this study.

One of the women said”

“***I have 9 children, one is mentally retarded. I am divorced, not educated, with no job or profession. My husband abused me and my daughters before divorce. We had no family to support us. We need governmental support, and social support. We need laws to protect our rights as women”. C20***

Korean adolescent revealed factors for suicide attempts. They indicated higher levels of dysfunctional family dynamics and maladaptive personalities. In addition, adolescents who attempted suicide expressed a

significantly lower level of life satisfaction and less effective coping strategies compared with those adolescents who had not attempted suicide (Kim 2008). In our study women attempt suicide call back the dysfunctional family dynamic early in their life.

Incarcerated American Indian/Alaska Native women have multiple physical, social, and emotional concerns, many of which may stem from adverse childhood experiences and adult outcomes. Assessment included physical neglect, dysfunctional family, violence witnessed in the home, physical abuse, and sexual abuse. The most prevalent was dysfunctional family, followed by witnessing violence, sexual abuse physical abuse, and physical neglect (De Ravello L, Abeita J, Brown P, 2008). Adverse childhood experiences were expressed from our participants and it was correlated to adult outcome such as suicide.

Khan M (2005) in the finding of his research Suicide prevention and developing countries, identify factors associated with higher psychiatric morbidity and suicidal behaviour in women in developing countries. Which include early age at marriage, lack of autonomy in choosing male partner (arranged marriage), pressure to have children early in marriage (in many cases for a male offspring), economic dependence on husband and the joint family system. Domestic violence is also a serious problem in developing countries. Under these circumstances, the young married woman's position is severely compromised, making her vulnerable to psychiatric morbidity

and suicidal behaviour. These factors were clearly expressed by the women we interviewed in our research.

Lack of support

While problems in interpersonal relationships may increase the risk of suicidal behaviour, social isolation can also be a precipitating factor for suicidal behaviour. Social isolation lay behind Durkheim's concepts of ''egoistic'' and ''anomic'' suicide (Durkheim, 1897), both of which were related to the idea of inadequate social connectedness. A large body of literature suggests that individuals who experience isolation in their lives are more vulnerable to suicide than those who have strong social ties with others. Following the death of a loved one, for example, a person may attempt suicide if there is insufficient support provided during the grieving period by those close to the bereaved person.

Most of the ladies in our study suffer from loneliness, isolation and lack of social support. Also stigma associated with mental health services obscured women to seek professional support.

Studies of Japanese social resident survey and relationship of social support with suicide, showed that people in the group that had suicide ideation during their lives reported receiving significantly less support from their family and had greater feelings of dissatisfaction with that support than those in the other groups (Endo et al, 2013). In our finding, Most of the women interviewed express the evidence of insufficient and unsatisfactory

social or family support at the time of distress and crises. Furthermore, in the same study people who had suicide ideation during the month immediately preceding the survey reported providing less support to their family, relatives or friends, as well as receiving less support from family than other groups, and having stronger feelings of dissatisfaction with social support (Endo et al, 2013).

Conventionally, from the perspective of social and collective knowledge, various dysfunctions of social relationships have been proposed as a cause of suicide. Failure of social integration, such as unemployment, isolation and divorce, has been viewed as a weakness of the network between the individual and society, and has been repeatedly indicated to be an important cause of suicide (Yur'yev et al., 2013). The demographic characteristics of the participants in our study shows high level of unemployment, and others experience loss of relations and divorce which foster social isolation and decrease social interaction and support.

Tandon et al (2013). Use cluster analysis to explore how coping, stress, and social support align and intersect with each other and relate to levels of suicidal behaviours. The cluster defined by high coping, moderate support, and high stress. And cluster marked by low coping, low support, and low stress. They reported the high levels of depressive symptoms and high levels of suicidal ideation as well as high levels of perpetrating intimate partner violence compared to other groups. In our sample maladaptive coping is one of the subthemes discussed before and its relation with

increase suicidal attempts among the sample was apparent. High stress and low support also defined in the sample. This results seems compatible with our results, the three factors increase the risk of suicide.

Other study support our findings is the study of Mi Park (2010) which investigates the effect of social support on suicidal ideation in young and middle-aged adults. The results supported the hypotheses, showing an association between suicidal ideation and poor social support and by type of social support in middle-aged adults.

The outstanding finding is that the absence of a counselor for worries as an emotional support was highly associated with suicidal ideation in middle-aged men and women (Mi Park 2010). In our sample didn't appear to have any counseling or professional support before attempted suicide. Some cases seek help after the attempt, and some said it was helpful.

Economic support as a form of instrumental support was stronger in middle-aged women than in younger women. The multivariate analysis showed that lack of emotional support increased the suicidal ideation of middle-aged women. While the lack of economic support increase suicide more among women. This was the case in most of our sample. They are unemployed, or still young and studying. In both cases they need economic support. The situation was more vulnerable when the women have a child who depends on her economically.

In this Study of Latina girls to high extent explain the risk provoking suicidal behaviour among our sample of Palestinian women. Suicidal behavior in Latina young women often arises after experience of a painful or distressing event in the family. Research indicates that a disruption in family structure, due to migration, divorce, or death—or by intense conflicts among family members—may trigger suicidal behavior (Gulbas et al., 2011). All this factors expressed by our sample and discussed before in this chapter. Additionally, many attempters report being a witness to or victim of physical or sexual assault, often committed by a parent or extended kin member (Zayas et al., 2010). In our study 18 out of 20 suffer from violence, and mostly physical and sexual or witnessing abuse. This particular event, or trigger, should be understood as part of a context of similar events that insult the girl's emotional status. With persistent patterns of instability, tension, conflicts, and victimization, the Latina feels vulnerable, feeling misunderstood, trivialized, unsupported, and unprotected, and possibly violated physically, psychologically, and emotionally. A trigger event that reminds her of or revives her emotional agony may evoke suicidal behavior at a moment when she was primed by an emotionally fragile state (Zayas et al., 2010).

Ladies express their need for support as follows:

"*After my husband been arrested and entered prison. We need someone to stand beside and to supports us. Someone to provide food and shelter for me and my children. Provide us with safety and peace of mind. We were*

threatened to be killed every moment. No one offer this support, nor my family or the family of my husband. Death was the best choice for me and for my children." C11

The absence of national suicide prevention plan and culturluy sensetive services in palestine, hinder the help seeking behaviour among most of individual who have suicidal thoughts. Other cultural factors mostly as stigma. Studies describe barriers in other culture and help seeking behaviour as follows.

This study sought to describe self-reported barriers to professional help seeking among college students who are at elevated suicide risk.

The most commonly reported barriers included perception that treatment is not needed, lack of time, and preference for self-management, and stigma (Czyz et al, 2013).

Other study reveal that only a small proportion of individuals with suicide behavior in south China had ever sought help. Seeking help was associated with a better mental health status (Wen, 2012).

Encrenaz et al (2012), found in his study about talking to health professional about suicidal ideation that Around 20% of people with suicidal ideation had talked about this distress to a health professional. It was more frequent for people with more severe suicidal behaviors (plan or

a prior attempt), among women, those aged 30 or more, those suffering from major depressive episode, panic disorder, or drug use disorder. Above all, it was more frequent among those who had also talked to friends or relatives.

He recommends that Prevention strategies encourage suicidal persons to seek help for their distress, whoever that is, may be the more important strategies to develop.

World Health Organization (2010), and US Department of Health and Human Services (2001), stressed the need for suicide prevention efforts all over the world, which is classified into three levels: universal, selective and indicated. This initiatives aiming at strengthening social support, promoting development of coping skills, and changing policies and norms to encourage effective help-seeking behaviours, and enhancing the early detection and treatment of at-risk individuals were created.

In Palestine we need the development of national plan for suicidal prevention. Main element in this plan should be prevention of violence.

Women said in a cry of Pain:

"The police said that they will protect me. They sent me to the shelter; it is the same as prison. Then they sent me to the mental hospital. It was horrible. And now they want to send me back home. My father will kill me, you will see, for the honor of the family". C3

Chapter Six

Conclusion and Recommendations

6.1 Conclusion:

During this study, we investigated a range of different but interconnected contexts of attempting suicide in the Palestinian women. The findings show that multifactor lies in the context of attempting suicide. The main interrelated risks responsible for suicide attempt among women are violence, loss, psychological factors, socio-cultural factors, and lack of support system.

Understanding risks beyond attempted suicide among Palestinian women is critical in providing effective and culturally sensitive suicide prevention and care programs.

It is critical to acknowledge the multiplicity and interconnection of various factors in a given social and individual situation. As a result, suicide prevention and care provision should devise a holistic approach, taking into account interaction of medical as well as social, cultural, and family factors in their assessment and care provision.

Furthermore, reliable databases for suicidal behaviors and more in-depth analyses of such databases should generally be promoted within the Palestinian community

6.2 Recommendations:

Whenever possible, community-based suicide prevention efforts should begin with a strategic planning effort that includes an assessment of the

suicide problem in the community and the resources available to address the problem. Due to the nature of suicidal behaviors, the strategic planning process should result in a multi-faceted approach that will address the population of interest on multiple levels.

Recommendations are grouped in these categories and will be discussed in details

- Strengthening national commitment and actions
- Promoting primary prevention
- Involving the education sector
- Strengthening the health sector response
- Supporting research and collaboration

1. Strengthening national commitment and action

- Promote democracy, equity, equality, and human rights
- Establish, implement and monitor multi-sectoral action plans to address preventing suicide.
- Enlist social, political, religious, and other leaders in speaking out against suicide
- Enhance capacity and establish systems for data collection to monitor suicide behaviours, the attitudes and beliefs that perpetuate it.

2. Promoting primary prevention

- Develop, implement and evaluate programmes aimed at primary prevention of suicide and its risk factors.
- Prioritize the prevention of women and child abuse.
- Programs to enhance the mental health of the general population.
- Make physical environments safer, and free from the means of suicide.

3. Involving the education sector

- Referral tracking protocols, including information sharing agreements and privacy protection, should be in place prior to professional training in order to help track people identified at risk through service receipt.
- Training curricula should be tailored to the specific needs of the audience to be trained, taking into account the suicide prevention roles they will fulfill after the training. The desired knowledge, behavioral, and attitudinal outcomes for each training participant should align with the needs of their setting, role, and responsibilities.
- Training content, materials, and examples should reflect the predominant community cultural norms and values and be sensitive to minority populations being served.
- Training should be implemented after the lines of referral and follow-up are clearly established and where available resources, including

appropriately trained service providers, have been identified and aligned to address the needs of youths identified at risk for suicide.

- Individuals who demonstrate a capacity for maintaining effective, interpersonal interactions with target and who serve in a role that easily facilitates their responsibilities should be given priority in receiving training.
- Protocols and policies taught during training should include information about specific suicide prevention resources and support available in the communities in which the trainees live or work.
- Individuals who can serve as trainers to other gatekeepers (i.e. train-the-trainer) should be considered as a means to promote sustainability of community-level training. Candidates to become trainers should have the required instructional skills as well as the motivation and capacity to effectively train others.
- Training all involved all of suspected contact with target at risk. For example; doctors, mental health nursing, social worker, psychologist, school counselor, and police personal. Training should include diagnosis, identify at risk group, protection, referring, counseling and prevention.

4. Strengthening the health sector response

- Develop a comprehensive health sector response to the various impacts of suicide.

- Use mental health services as entry points for identifying and supporting people at risk, and for delivering referral or support services.
- Develop 24 hour crises team.

5. Supporting research and collaboration

- Support research on the causes, consequences, and costs of suicide and on effective prevention measures.
- Increase support to programmes to reduce and respond to people at risk, and suicide survivor.

6. Recommendation for the media

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates. Some media activities help reduce suicide rate could be:

- Trends in suicide rates
- Recent treatment advances
- Individual stories of how treatment was life-saving

- Stories of people who overcame despair without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals can take to prevent suicide by others

7. Recommendation to stop violence against Palestinian Women

- The government needs to adopt a new Palestinian law which enforces penalties against those who commit violence against women. The law should aim at eradicating violence against women based on international human rights standards including those basic principles which do not discriminate between genders where it comes to family violence and the protection of victims.
- The present Palestinian law does not include any text regarding incriminating husbands who rape their wives. It is known that sexual intercourse against the woman's will may result in an unwanted pregnancy in addition to contributing to her fear and insecurity of not having control over her body.
- There is a need to enhance methods of research and to publish reliable information regarding the issue of family violence, violence against women and the "honor killing" crimes.
- There is a need to develop the mechanism which support cases in courts related to family violence and violence against women. This mechanism is to guarantee the rights of the victims of violence who cannot fend for themselves.

8. Recommendation for future research

Directions for future research include continued phenomenological studies about individuals' experiences with suicide. These studies could determine whether the themes identified in this study are representative of the experiences of other individuals. Certainly studies that can include larger numbers of more diverse participants would be particularly helpful in this regard, as would studies that particularly address male's experiences with suicide. Future research could provide support for the themes.

6.3 Limitations:

There are several limitations to this study. Stigma related to issues such as suicide, it is possible that participants have not exposed the full reasons behind their suicide attempt. We made every effort to overcome this limitation, however, through establishing trust and rapport during interviews.

Translation of data from Arabic to English might have contributed to partial distortion or loss of meanings of participant accounts. This limitation was minimized through translation and back-translation of transcripts by the research team.

6.4 Acknowledgment:

This project was supported by An-Najah National University, first of all I would thank my supervisors, Dr. Aidah Al-Qaisi and Dr. Sabrina

Russo, for their support and help. Without their support and interest this study will never be done. Thanks for both of you. The Ministry of Health allowed the recruitment of cases from community mental health centers, special thanks to community mental health center in Tulkarem city for their cooperation and interest in the study. The authors would also like to thank the Ministry of social affairs for facilitating the recruitment of some participant. We would also like to appreciate the NGO centers that help in recruiting cases and offer suitable place for interviews. Special thanks to the women who attempt suicide for their willingness to share their experience with us. Special thanks for special persons help in editing, translating and formulating the words of this study. For everyone help, encourage and support this serves as special thanks.

References

1. Abu-Hijleh, N. (1998). **Stressful life events and suicidal behavior in adolescents.** *Arab Journal of Psychiatry*, 9, 94e98.

2. Adam KS., et al. (1982). **Parental Loss and Family Stability in Attempted Suicide**. *Archives of General Psychiatry* 39.

3. Ahmed, K., van Ginneken, J., Razzaque, A., & Alam, N. (2004). **Violent deaths among women of reproductive age in rural Bangladesh**. *Social Science & Medicine,* 59, 311e319.

4. AL-KRENAWI,A. , GRAHAM,J. , A. SEHWAIL,M. (2001-2002) . **BEREAVEMENT RESPONSES AMONG PALESTINIAN. WIDOWS, DAUGHTERS AND SONS FOLLOWING THE HEBRON MASSACRE .** *OMEGA,* 44(3) 241-255.

5. American Association of Suicidology (2008). **Recognizing and responding to suicide risk: Essential skills for clinicians**. Washington, DC: *American Association of Suicidology*.

6. Amnesty International (2005). **Israel and the Occupied Territories Conflict , Occupation, and Patriarchy: Women Carry the Burden.** *Amnesty International*; Giniva.

7. Andover, M.S., Zlotnick, C., & Miller, I.W. (2007). **Childhood physical and sexual abuse in depressed patients with single and multiple suicide attempts.** *Suicide and Life-Threatening Behavior*, 37, 467–474.

8. ANDREW T, TONY H., CHWEN CH., and RACHEL J.(2000). **Psychosocial and psychiatric risk factors for suicide. Case—control psychological autopsy study**. *The British Journal of Psychiatry*, 360-365

9. Andrews, G., Corry, J., Slade, T., Issakidis, C., & Swanston, H. (2004). **Child sexual abuse. In M. Ezzati (Ed.), Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors.** Geneva: World Health Organization.

10. Angst, J., Degonda, M. and Ernst, C. (2002). **"The Zurich Study: XV. Suicide attempts in a cohort from age 20 to 30."** *European Archives of Psychiatry & Clinical Neuroscience* 242(2-3): 135-41.

11. Ansari G, Chipps J, Stewart G. (2001). **Suicide in NSW: the NSW suicide data report.** *NSW Public Health Bulletin*.; 12(3):80-4.

12. Arango, V., Underwood, M.D., & Mann, J.J. (1996). **Fewer pigmented locus coeruleus neurons in suicide victims: Preliminary results**. *Biological Psychiatry*, 39(2), 112-120.

13. Barraclough, B., Bunch, J., Nelson, B., & Sainsbury, P. (1974). **One hundred cases of suicide: Clincal aspects**. *British Journal of Psychiatry,* 125, 355-373.

14. Batty, G.D., Whitley, E., Kivimaki, M., Tynelius, P., Rasmussen, F. (2010). **Body mass index and attempted suicide: cohort study of 1,133,019 Swedish men,** *American Journal of Epidemiology* 172, 890–899.

15. Beautrais, A.L. (2001). **Suicide and serious suicide attempts: Two populations or one?** *Psychological Medicine*, 31(5), 837-845.

16. Beautrais, A.L. (2006a). **Suicide in Asia.** *Crisis*, 27, 55–57.

17. Beautrais, A.L. (2006b).**Women and suicidal behavior**. *Crisis*, 27, 153–156.

18. Bertolote, J.M., Fleischmann, A. (2002). **A global perspective in the epidemiology of suicide .** *Suicidology*, 7(2), 6-8**.**

19. Beskow J, Palm Beskow A, Ehnvall A. Suicidalitetens spra° k. (2005). **The Language of Suicide .** *Studentlitteratur*, Lund, Sweden.

20. BHAR S, GHAHRAMANLOU-HOLLOWAY M, BROWN G, BECK AT. (2008). **Self-esteem and suicide ideation in psychiatric outpatients.** *Suicide Life-Threat*; 38: 511-516.

21. Bill,B. , Ipsch,L. , Lucae,S. , Pfister,H. , Maragkos,M. , Ising,M. , Bronisch,T. (2012). **Attempted Suicide Related Posttraumatic Stress Disorder in Depression .** *An Exploratory Study***.** 3,138-144.

22. Bongar, B., Greaney, S., & Peruzzi, N. (1998). **Risk management with the suicidal patient. In P.M. Kleepsies (Ed.), Emergencies in mental health practice: Evaluation and management** (pp. 199-216). New York, NY: Guilford Press.

23. Borowsky, I. W., Ireland, M. and Resnick, M. D. (2001). **"Adolescent suicide attempts: risks and protectors."** *Pediatrics* 107(3): 485-93.

24. Brown, M.Z., Comtois, K.A., & Linehan, M.M. (2002). **Reasons for suicide attempts and nonsuicidal selfinjury in women with borderline personality disorder.** *Journal of abnormal psychology*, 111, 198–202. de Jong, M.L. (1992). **Attachment, individuation, and risk of suicide in late adolescence.** *Journal of Youth and Adolescence*, 21, 357–373.

25. Capron , D. W., Cougle, , J.R., Ribeiro, J. D., Joiner, T. E., Schmidt, N.B.(2012). **An interactive model of anxiety sensitivity**

relevant to suicide attempt history and future suicidal ideation. *Journal of Psychiatric Research* , (46) 174-180.

26. Carpenter, K.M., Hasin, D.S., Allison, D.B., Faith, M.S.(2000). **Relationships between obesity and DSM-IV major depressive disorder, suicide ideation, and suicide attempts: results from a general population study,** *American Journal of Public Health* 90, 251–257.

27. Centers for Disease Control and Prevention. (2005). **Web-based injury statistics query and reporting system (WISQARS)**. Atlanta, GA: *Centers for Disease Control and Prevention.*

28. Centers for Disease Control and Prevention. (2007). **Suicide: Facts at a glance.** Retrieved June 15, 2008. http://www.cdc.gov/ncipc/dvp/Suicide/SuicideDataSheet.pdf.

29. Chapman AL, Gratz KL, Turner BJ. (2013). **Risk-Related and Protective Correlates of Nonsuicidal Self-Injury and Co-Occurring Suicide Attempts among Incarcerated Women.** *The American Association of Suicidology*.

30. Christensen, H., Batterham, P.J., Soubelet, A., Mackinnon, A. (2012). **A test of the Interpersonal Theory of Suicide in a large community-based cohort** . *Journal of Affective Disorders*,

31. Christopher D. Morano; Ron A. Cisler; John Lemerond.(1993). **Risk factors for adolescent suicidal behavior: loss, insufficient familial support, and hopelessness**. v28 n112 ,p851(15).

32. Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., Bongar, B. (2013, January 28). **A Tool for the Culturally Competent Assessment of**

Suicide: The Cultural Assessment of Risk for Suicide (CARS) Measure. Psychological Assessment. *Advance online publication.* doi: 10.1037/a0031264

33. Crockwell, L., & Burford, G. (1995). **What makes a difference? Adolescent females' stories about their suicide attempts**. *Journal of Child and Youth Care,* 10(\), 1-14.

34. Curtis C. (2006). **Sexual abuse and subsequent suicidal behaviour: exacerbating factors and implications for recovery.** *Journal of Child Sexual Abuse.;*15(2):1-21.

35. Cutcliffe, J.R. (2005). **Toward an understanding of suicide in first-nation Canadians**. Crisis, 26(3), 141-145.Cutcliffe, J.R., Joyce, A., & Cummins, M. (2004). **Building a case for understanding the lived experiences of males who attempt suicide in Alberta, Canada.** *Journal of Psychiatric.*

36. Czyz EK, Horwitz AG, Eisenberg D, Kramer A, King CA.(2013). **Self-reported barriers to professional help seeking among college students at elevated risk for suicide.** *J Am Coll Health.* 61(7):398-406.

37. Dabbagh,N. (2005). **Suicide in Palestine: Narratives of Despair,** London. C. Hurst & co.

38. Dabbagh.N. (2012). **Behind the Statistics: The Ethnography of Suicide**

39. **De Castro, A. (2003). Introduction To Giorgi's Existential Phenomenological Research Method**. *Psychology from the Caribbean,*(11), 45-56.

40. De Ravello L, Abeita J, Brown P. (2008). **Breaking the cycle/mending the hoop: adverse childhood experiences among incarcerated American Indian/Alaska Native women in New Mexico**. *Health Care Women Int*. (3):300-15.

41. Dorpat T. (2010). **Suicide, Loss, and Mourning.** *Suicide and Life-Threatening Behavior*, Vol 3 Issue 3.

42. Douki, S., Ben Zineb, S., Nacef, F., & Halbreich, U. (2007). **Women's mental health in the Muslim world: cultural, religious, and social issues.** *Journal of Affective Disorders*, 102(1e3), 177e189

43. Driessnack M., Sousa V.D, Mendes IAC.(2007). **An overview of research designs relevant to nursing: part 2: qualitative research designs**. *Rev Latino-am Enfermagem julho-agosto*; 15(4),684-8.

44. Eaton DK, Lowry R, Brener ND, Galuska DA, Crosby AE. (2005). **Associations of body mass index and perceived weight with suicide ideation and suicide attempts among US high school students.** *Arch Pediatr Adolesc*, Med. National Center for Chronic Disease Prevention and Health Promotion, 159(6):513-9.

45. Eisner, L.R.,(2010). **A Transdiagnostic Model of Suicidal Ideation**. A *dissertation*: University of MIAMI,17,1-117

46. Ellenhom, R. (2005). **Parasuicidality and patient careerism: Treatment recidivism and the dialectics of failure.** *American Journal of Orthopsychiatry*, 75(2), 288-303.

47. Encrenaz G, Kovess-Masféty V, Gilbert F, Galéra C, Lagarde E, Mishara B, Messiah A. (2012). **Lifetime risk of suicidal behaviors and**

communication to a health professional about suicidal ideation. Results from a large survey of the French adult population. *Crisis*, (3):127-36.

48. Endo G, Tachikawa H, Fukuoka Y, Aiba M, Nemoto K, Shiratori Y et al. (2013). How **perceived social support relates to suicidal ideation: A Japanese social resident survey**. *International Journal of Social Psychiatry*.

49. Epstein JA, Spirito A. (2010). **Gender-specific risk factors for suicidality among high school students.** *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*. 14(3):193-205.

50. Fawcett,J., Clark, D.C., & Busch, K.A. (1993). **Assessing and treating the patient at risk for suicide.** *Psychiatric Annals*, 25(5), 244-255.

51. Fergusson, D. M. and Lynskey, M. T. (2005). **"Childhood circumstances, adolescent adjustment, and suicide attempts in a New Zealand birth cohort."** *Journal of the American Academy of Child & Adolescent Psychiatry* 34(5): 612-22.

52. Fergusson, D. M., Woodward, L. J. and Horwood, L. J. (2000). **"Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood."** *Psychological Medicine* 30(1): 23-39.

53. Figueroa-Haas C.(2009). **Psychological issues associated with breast augmentation.** *Issues in Mental Health Nursing*.;30(6):377-82.

54. Frank, E., Dingle, A.D.(1999). **Self-reported depression and suicide attempts among U.S. women physicians**, *American Journal of Psychiatry*. 156, 1887–1894.

55. Gal G , Goldberger Kh , Kabaha A , Haklai Z, Geraisy N, and Gross R. (2012). **Suicidal behavior among Muslim Arabs in Israel.** *Soc Psychiatry Psychiatr Epidemiol*, 47:11–17. Itzhak Levav.

56. Garnefski, N. and Diekstra,R.(1997). **Adolescents from one parent, stepparent and intact families; emotional problems and suicide attempts.** *Journal of Adolescence,* 20, pp. 20 1-208.

57. Ghaleiha,A. , Afzali,S. , Bazyar,M. , Khorsand,F. , Torabian,S. (2012). **Characteristics of Hospitalized Patients Following Suicide Attempt in Hamadan District, Iran.** *Oman Medical Journal* 27(4), 304-309.

58. Giorgi, A. & Giorgi, B. (2003). **The descriptive phenomenological psychological method.** In P.Camic, J.E. Rhodes, & L. Yardley (Eds.), **Qualitative research in psychology: Expanding perspectives in methodology and design** (pp. 243-273). Washington, DC: *American Psychological Association.*

59. Gladstone, G.L., Parker, G.B., Mitchell, P.B., Malhi, G.S., Wilhelm, K., & Austin, M.P. (2004**). Implications of childhood trauma for depressed women: An analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization.** *American Journal of Psychiatry*, 161, 1417–1425

60. Glaser, B.G., & Strauss, A.L. (1967). **The discovery of grounded theory: Strategies for qualitative research**. Chicago: Aldine Publishing Company.

61. Goldsmith, S.K., Pellman, T.C., Kleinman, A.M., & Bunney, W.E. (2002). **Reducing suicide: A national imperative**. Washington, DC: National Academy Press.

62. Gomes, F. , O'Brien, B. Nakano, Spano,A. (2009) . **Attempted Suicide in Reproductive Age Women**, *Health Care for Women International*, 30(8), 707 – 719

63. GREER, S. (1980).**The Relationship between Parental Loss and Attempted Suicide: A Control Study**. *The British Journal of Psychiatry*.305-314.

64. Guggisberg M. (2006). **The interconnectedness and causes of female suicidal ideation with domestic violence.** *Australian e-Journal for the Advancement of Mental Health*.;5(1):7

65. Guggisberg M. (2008) **Intimate partner violence: a significant risk factor for female suicide.** *Women against Violence: An Australian Feminist Journal.* (20):9-17.

66. Gulbas L., Zayas L., Nolle A., Kuhlberg J., Hausmann-Stable, C., Baumann,A., & Pen B. (2011). **Family relationships and Latina teen suicide attempts: Reciprocity, asymmetry, and detachment.** *Families in Society*, 92, 317–323.

67. Gupta MA, Gupta AK.(2013). **Coetaneous body image dissatisfaction and suicidal ideation: mediation by**

interpersonal sensitivity. *J Psychosom Res*. Department of Psychiatry, Schulich School of Medicine and Dentistry, University of Western Ontario, London, 75(1):55-9.

68. Hall, R. C., Platt, D. E.,&Hall, R. C. (2009). **Suicide risk assessment: A review of risk factors for suicide in 100 patients who made severe suicide attempts.** *Psychosomatics,* 40, 18-27.

69. Hatcher, S. Sharon, C. ,Coggan,C. (Aug 2009). **Beyond Randomized Controlled Trials in Attempted Suicide Research.** *Suicide & Life - Threatening Behavior, Research Library.* Hawton, K. (2001). **Studying survivors of nearly lethal suicide attempts: An important strategy in suicide research**. *Suicide and Life-Threatening Behavior,* 52, 76-84.

70. Hedeland,R. , Jorgensen,M. , Teilmann,G., Thiesen,L. , Valentiner,M. , Iskandar,A. (2013). **Risk factors Childhood suicide attempts with acetaminophen in Denmark: Characteristics, social behaviour, trends and risk factors.** *Scandinavian Journal of Public Health,* 0: 1–7

71. Hewitt, John P. (2009). **Oxford Handbook of Positive Psychology**. *Oxford University Press.* pp. 217–224.

72. Hirst, S. D. (2002). **An Idiographic and Phenomenological Approach in Palestine**. *A Reasarch Paper*, 36, 286-305.

73. Hjelmeland H, Groholt B.(2005). **A comparative study of young and adult deliberate self-harm patients.** *Crisis*. 26(2):64–72.

74. Holmqvist R, Carlberg M, Hellgren L. (2008**). Deliberate self-harm behaviour in Swedish adolescent girls reports from public assessment and treatment agencies.** *Child and Youth Care Forum*.;37(1):1-13.

75. Hughes, P, (1999). **Changes in the family linked to rise in teenage suicides,** *The Age*.

Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide. *JOURNAL OF WOMEN'S HEALTH.* Volume 15, Mary Ann Liebert, Inc.

76. Jacobs, D.G., Brewer, M., & Klein-Benheim, M. (1999). **Suicide assessment: An overview and recommended protocol**. In D. Jacobs (Ed.). *The Harvard medical school guide to suicide assessment and intervention* (pp. 3-39). San Francisco, CA: Jossey-Bass Publishers.

77. Jamison, K.R. (1999). **Night falls fast: Understanding suicide.** New York: Alfred A. Knopf.

78. Jobes, D.A., Moore, M.M., & O'Connor, S.S. (2007). **Working with suicidal clients using the Collaborative Assessment and Management of Suicidality** (CAMS). *Journal of Mental Health Counseling,* 29(4), 283-300.

79. Joiner, T., Sachs-Ericsson, N. J., Wingate, L. R., Brown, J. S., Anestis, M. D., & Selby, E. A. (2007). **Childhood physical and sexual abuse and lifetime number of suicide attempts: a persistent and**

theoretically important relationship. *Behaviour Research and Therapy*, 45, 539e547.

80. Joiner, T.E., Jr., Sachs-Ericsson, N.J., Wingate, L.R., Brown, J.S., Anestis, M.D., & Selby, E.A. (2007). **Childhood physical and sexual abuse and lifetime number of suicide attempts: A persistent and theoretically important relationship.** *Behavior Research and Therapy*, 45, 539–547.

81. Joiner, T.E., Walker, R.L., Rudd, M.D., & Jobes, D.A. (1999). **Scientizing and routinizing the assessment of suicidality in outpatient practice**. *Professional Psychology: Research and Practice*, 30(5), 447-453.

82. Kaplan, M. , McFarland,B. , Huguet,N. (2011). **Characteristics of adult male and female firearm suicide decedents: findings from the National Violent Death Reporting System**. *Injury Prevention*, 15, 322–327.

83. Keyvanara M. and Haghshenas A. (2011).**The Sociocultural Contexts of Attempting Suicide among Women in Iran.** *Health Care for Women International*, 31: 9, 771 — 783.

84. Khan M. (2005). **Suicide prevention and developing countries**. *Journal of the Royal Society Medicine*. V o l u m e 9 8, 98:459–463.

85. Kim DS, Cho Y, Cho SI, Lim IS. (2009). **Body weight perception, unhealthy weight control behaviors, and suicidal ideation among Korean adolescents**. *J Sch Health. Institute of Health and Environment,* Seoul National University, 79(12):585-92.

86. Kim HS. (2008). **Risk factors for suicide attempts among Korean adolescents.** *Child Psychiatry Hum Dev.* Sep;39(3):221-35.

87. Kim, J.S., Lee, K. (2010). **The relationship of weight-related attitudes with suicidal behaviors in Korean adolescents.** *Obesity (Silver Spring) 18*, 2145–2151.

88. Kirkcaldy BD, Siefen GR, Urkin J, Merrick J. (2006).**Risk factors for suicidal behavior in adolescents.** *Minerva Pediatr.* Oct;58(5):443-50.

89. Leenaars, A.A. (2002a). **The quantitative and qualitative in suicidological science**: An editorial. *Archives of Suicide Research*, 6, 1-3.

90. Leenaars, A.A. (2002b). **In defense of the idiographic approach: Studies of suicide notes and personal documents.** *Archives of Suicide Research*, 6, 19-30.

91. Lester,D. , Abdel-Khalek, A. (2002). **Can Personality Predict Suicidality? A Study in Two Cultures**. *International Journal of Social Psychiatry*. 48: 231, 1-10.

92. Levington, C, & Gruba-McCallister, F.P. (1993). **Survival of suicide as an opportunity for transcendence**. *Journal of Humanistic Psychology*, 33(4), 75-88.

93. Luborsky,L., Crits-Christoph,P.(1997). **Understanding transference: The Core Conflictual Relationship Theme method (2nd ed.).** *A dissertation: California Institute of Integral Studies*,17,1-152

94. Main A, Women's Health Victoria. (2009) **Women and body image.** Melbourne: *Women's Health Victoria*.

95. Mann, J.J., & Arango, V. (1999). **The neurobiology of suicidal behavior**. In D. Jacobs (Ed.), *The Harvard medical school guide to suicide assessment and intervention* (pp. 98-114). San Francisco, CA: Jossey-Bass Publishers.

96. Maria A. et al. (2006).**The Impact of Physical, Psychological, and Sexual**

97. May,A. ,Klonsky ,D. (2013). **Assessing Motivations for Suicide Attempts: Development and Psychometric Properties of the Inventory of Motivations for Suicide Attempts**. *Journal of Suicide and Life-Threatening Behavior* ,1-11.

98. Mcintosh, J.L. (2008). **U.S.A. suicide: 2005 official final data**. Retrieved June 15, 2008, from http://ww.suicidology.Org/associations/l045/files/2005datapgs.pdf.

99. McKeown, R. E., Garrison, C. Z., Cuffe, S. P., Waller, J. L., Jackson, K. L. and Addy, C. L. (1998). **"Incidence and predictors of suicidal behaviors in a longitudinal sample of young adolescents."** *Journal of the American Academy of Child & Adolescent Psychiatry* 37(6): 612-9.

100. Mehlum L. Om motiver og intensjoner ved selvmordshandlinger. (2005). **About motives and interventions concerning suicidal acts.** In Uutholdelige liv. Om selvmord, eutanasi og behandling av døende. (Unbearable Lives. About Suicide, Euthanasia, and Treatment of the Dying) (Herrestad H, Mehlum L eds), Gyldendal Akademisk, Oslo, Norway, 29–4.

101. Mendez P,De Leon V, Miret M, Baca E, Lopez J.(2013). **Suicide re attempters: a systematic review.** *Harv Rev Psychiatry*. (6):281-95. doi: 10.

102. Mertens, D.M., & McLaughlin, J.A. (2003). **Research and evaluation methods in special education.** *Thousand Oaks*, CA: Sage Publications.

103. Mi Park S, il Cho S, Moon S. (2010).**Factors associated with suicidal ideation: Role of emotional and instrumental support.** *Journal of Psychosomatic Research*, 69 ,389–397.

104. Michel, K., Maltsberger, J.T., Jobes, D.A., Leenaars, A.A., Orbach, I., Stadler, K., et al. (2002). **Discovering the truth in attempted suicide.** *American Journal of Psychotherapy*, 56(3), 424-437.

105. Milner A, McClure R, De Leo D. (2012).**Socio-economic determinants of suicide: an ecological analysis of 35 countries**. *Soc Psychiatry Psychiatr Epidemiol*, 47:19–27.

106. Milner,A., LaMontagne,A. .**Cause and effect in studies on unempl oyment, mental health and suicide: a meta-analytic and conceptual rev iew**. *Psychological Medicine*, pg 1-9.

107. Moore, S.H. (1997) . **A Phenomenological Study of Meaning in Life in Suicidal Older Adults .** *Archives of Psyehiatric Nursing*,9(1), 29-36.

108. Naved, R. and Akhta, R. (2008).**Spousal Violence against Women and Suicidal Ideation in Bangladesh.** *Women's Health Issues*, Volume 18, Issue 6 , Pages 442-452.

109. Nock MK, Borges G, Bromet EJ, Cha CB, Kessler RC, Lee S.(2008). **Suicide and suicidal behavior.** *Epidemiol Rev*. 30:133–54.

110. Nrugham,L. , Holen,A. , Sund,M.(February 2010). **Associations Between Attempted Suicide, Violent Life Events,Depressive Symptoms, and Resilience in Adolescents and Young Adults**. *The Journal of Nervous and Mental Disease* • 198(2),1-5.

111. O'Donnell L, O'Donnell C, Wardlaw DM, Stueve A.(2004). **Risk and resiliency factors influencing suicidality among urban African American and Latino youth.** *AM J Community Psychol*. 33:37–49.

112. Ormrod, J. E. (2006). **Educational psychology: Developing learners**. *Upper Saddle River, N.J.: Pearson/Merrill Prentice Hall.* (5th ed.).

113. Osler, M., Nybo Andersen, A.M., Nordentoft, M. (2008). **Impaired childhood devel- opment and suicidal behaviour in a cohort of Danish men born in 1953.** *Journal of Epidemiology and Community Health*, 62, 23–28.

114. Peter,P. , Roberts,L.(2009). **'Bad' Boys and 'Sad' Girls? Examining Internalizing and Externalizing Effects on Parasuicides Among Youth**. *EMPIRICAL RESEARCH* . 39,495-503.

115. Qin P, Mortensen PB.(2003).**The impact of parental status on the risk of completed suicide.** *Arch Gen Psychiatry*. 60:797–802.

116. Reis,C. Ed,M.. **An Investigation of Suicide Risk and Counseling Participation Among College Students. A dissertation:** *University of Virginia*,17,1-157

117. Rezaeian M. (2010). **Suicide Among Young Middle EasternMuslim Females,The Perspective of an Iranian Epidemiologist.** *Social Medicine Department, Rafsanjan Medical School, Rafsanjan,* Iran, Vol. 31(1):36–42.

118. Rihmer, Z., Gonda,X., Torzsa,P., Kalabay, L., Akiskal H.S., Eory, A.(2013). **Affective temperament, history of suicide attempt and family history of suicide in general practice patients**. *Journal of Affective Disorders* ,149 , 350–354.

119. Rogers, J.R. (2001). **Theoretical grounding: The "missing link" in suicide research**. *Journal of Counseling and Development*, 79(1), 16-25.

120. Schmidtke A, Bille-Brahe U, De Leo D, Kerkhof A, Bjerke T, Crepet P, et al.(1996). **Attempted suicide in Europe: rates, trends and sociodemographic characteristics of suicide attempters during the period 1989–1992. Results of the WHO/Euro Multicentre Study on Parasuicide.** *Acta Psychiatr Scand*. 93:327–3.

121. Sharma BR, Gupta M, Sharma AK, Sharma S, Gupta N, Relhan N, and Singh H.(2007). **Suicides in Northern India: comparison of trends and review of literature**. *J Forensic Leg Med.* 14(6):318-26.

122. Sheftall, A.H., Mathias C. W., Furr, R. M. , Dougherty D.M. (2013). **Adolescent attachment security, family functioning, and suicide attempts**. *Attachment & Human Development*, 15(4), 368-383.

123. Shneidman, E.S. (1996). **The suicidal mind**. New York: Oxford University Press.

124. Shneidman, E.S. (1998). **Further reflections on suicide and psychache**. *Suicide and Life-Threatening Behavior, 28(3),* 245-250.Silverman, A. B., Reinherz, H. Z. and Giaconia, R. M. (2006). **"The long-term sequelae of child and adolescent abuse: a longitudinal community study.***" Child Abuse & Neglect* 20(8): 709-23.

125. Simon, R.I. (2006). **Imminent suicide: The illusion of short-term prediction**. *Suicide and Life-Threatening Behavior*, 36(3), 296-301.

126. Simon, T.R., Swann, A.C. (2001). **Characteristics of impulsive suicide attempts and attempters.** *Suicide and Life- Threatening Behavior,* J2(Suppl), 42-48.

127. Smith, A.R., Witte, T.K., Teale. (2008). **Revisiting impulsivity in suicide: Implications for civil liability of third parties**. *Behavioral Sciences and the Law*, 26,119-191.

128. Smith, J.A., & Osborn, M. (2003). **Interpretive phenomenological analysis**. In J. Smith (Ed.), *Qualitative psychology*: A practical guide to research methods (pp. 51-80).

129. Stein DJ, Chiu WT, Hwang I, Kessler RC, Sampson N, et al. (2010). **Cross-National Analysis of the Associations between Traumatic Events and Suicidal Behavior: Findings from the WHO World Mental Health Surveys.** *PLoS ONE* 5(5): e10574.

130. Stewart S. (2005). **Suicidality, interpersonal trauma and cultural diversity: a review of the literature**. *Australian e-Journal for the Advancement of Mental Health;* 4(2):305

131. Stravynski A, Boyer R. (2001). **Loneliness in relation to suicide ideation and parasuicide: a population-wide study. Suicide Life Threat Behave**. 31(1):32–40.

132. SUN F.K., LONG A., BOORE J. , TSAO, L.I. (2006**). A theory for the nursing care of patients at risk of suicide.** *Journal of Advanced, Nursing* 53(6), 680–690

133. SUN, F-K. , LONG, A. (2008). **A theory to guide families and carers of people who are at risk of suicide**. *Journal of Clinical Nursing*, 17, 1939–1948.

134. Taft A. (2003). **Promoting women's mental health: the challenges of intimate/domestic violence against women**. *Australian Domestic and Family Violence Clearinghouse* Issues Paper.;8.

135. Tandon SD, Dariotis JK, Tucker MG, Sonenstein FL. (2013). **Coping, stress, and social support associations with internalizing and externalizing behavior among urban adolescents and young adults: revelations from a cluster analysis**. *J Adolesc Health*. (5):627-33.

136. Thakur, M., Hays, J.,&Krishnan, R. R. (1999). **Clinical, demographic, and social characteristics of psychotic depression.** *Psychiatry Research*, 86, 99-106.

137. **to Understanding Suicide.** A *dissertation: M.S. Antioch University* ,17,1-102

138. Trovato,f.(1987). **A longitudinal analysis of divorce and suicide in Canada**.*Journal of Marriage and Family*, Vol. 49, No. 1.

139. US Department of Health and Human Services. (2001)**National strategy for suicide prevention: goals and objectives for action.** *Rockville*, MD: Public Health Service.

140. Vic Health. (2004).**The health costs of violence: measuring the burden of disease caused by intimate partner violence.** *Melbourne: VicHealth*; [cited 25 January 2011];

141. Wanner,B. , Vitaro,F., Tremblay,R. Tureck,G. (2012). **Childhood trajectories of anxiousness and disruptiveness explain the association between early-life adversity and attempted suicide.** *Psychological Medicine*, 1- 10.

142. Wen C, Wang WQ, Ding LJ, Feng L, Wong JC, Kua EH.(2012). **Suicidal and help-seeking behavior in Xiamen, south China.** *Asia Pac Psychiatry*. 5(3):168-74.

143. Wichstrom, L. (2000). **"Predictors of adolescent suicide attempts: a nationally representative longitudinal study of Norwegian adolescents."** *Journal of the American Academy of Child & Adolescent Psychiatry* 39(5): 603-10.

144. Wiebe DJ. (2003) **Homicide and suicide risks associated with firearms in the home: A national case-control study**. *Annals of emergency medicine*.;41(6):771-82. Wing,A. (1997). **Acritical race fiminist conceptualization of violance: south african and palestinian women.** *Albany low review*, 33(4), 75-88.

145. Williams JMG, Pollock LR. (2001). **Psychological aspects of suicide process. In Understanding Suicidal Behaviour.** John Wiley & Sons, Chichester, 76–93. 36.

146. Wise, T.L. (2004). **Pivotal therapeutic moments: A patient's perspective on surviving suicide**. Psychiatric Rehabilitation Journal, 25(1), 88-92.

147. Women's Health Australia(. 2000).**The Australian Longitudinal Study of Women's Health report 1995-1999.** Newcastle, NSW: University of Newcastle and University of Queensland.

148. World Health Organization, & World Organization of Family Doctors. (2008). **Integrating mental health into primary care: a global perspective.** Geneva: World Health Organization.

149. World Health Organization. (2004). **Estimates of numbers of deaths by sex, cause and WHO Region for 2002.** *Revised global burden of disease* (GBD) 2002 Estimates. Geneva: World Health Organization.

150. World Health Organization. (2004). **Suicide rates.** Retrieved may 15, 2011, from http://www.who.int/mental health/media/en/374.pdf.

151. World Health Organization. (2009). **Mental and behavioral disorders: Figures and facts about suicide**. Geneva: WHO.

152. World Health Organization. **Suicide prevention (SUPRE**). Mental Health, 2010, retrieved 2 February 2010, from http://www.who.int/mental_health/prevention/

suicide/suicideprevent/en/index.html.

153. World Health Organization. Mental health suicide prevention (SUPRE). (2013) Available at: www.who.int / mentl_health / prevention / suicide / suicideprevent / en / index.html [Accessed September 24, 2013].

154. World Health Organization. **Report on the 2001 World Health. Mental health new understanding,** new hope.Geneva: WHO, 2001. Available at: http://onsm.ces.edu.co/uploads/files/373302_whr01_es.pdf [Accessed 25 january 2013].

155. Wortzel, H.S., Matarazzo, B., Homaifar, B. (2013). **A Model for Therapeutic Risk Management of the Suicidal Patient.** *Journal of Psychiatric Practice*, *19(4)*,323-326.

156. Ying, Y.H.,Chang, K.(2009). **A Study of Suicide and Socioeconomic Factors.** *Suicide & Life - Threatening Behavior* , 39(2), 214.

157. Yoshihama, M., Horrocks, J., & Kamano, S. (2009). **The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan.** *American Journal of Public Health*, 99, 647e653.

158. Yur'yev, A., Varnik, P., Sisask, M., Leppik, L., Lumiste, K., & Varnik, A. (2013). **Some aspects of social exclusion: Do they influence suicide mortality?** *International Journal of Social Psychiatry*, 59, 232–238.

159. Zayas L., Gulbas L., Fedoravicius N., & Cabassa L. (2010**). Patterns of distress, precipitating events, and reflections on suicide attempts by Young Latinas**. *Social Science & Medicine,* 70(11), 1773–1779.

160. Zhang J, and Tao M. (2013).**Relative deprivation and psychopathology of Chinese college students.** *J Affect Disord. Elsevier B.V.* 150(3):903-7.

161. Zhang, G. , Yan,F. , Li, Y. , Mckeown,R. (2013) **. Body mass index and suicidal behaviors: A critical review of epidemiological evidence**. *Journal of Affective Disorders* 148, 147–160.

Annex I

Participant's information sheet

Title of the study

Palestinian women attempt suicide risks beyond the experience.

Introduction:

I'm Einas abu safa student community mental health nursing master program at An-Najah National University, the fourth term. My supervisor is Dr. Aidah Alkaissi, and Dr. Sabrina russo.

You are being asked to be a volunteer in a research study**.** Below you will find information about the purpose of this study and a description of what you can expect if you agree to participate. You will also find information about potential risks and benefits of being a part of this study and how your privacy will be handled (confidentiality). Please be sure to read all information carefully. If you have any questions, please contact either me or my research advisor, Dr. Sabrina russo.

The purpose of this study:

The purpose of this study is to explore women experiences of surviving a suicide attempt. For this study, a *suicide attempt* means an act of deliberate self-harm that was intended to result in death. About 20-25 adults will participate in this study.

Eligibility:

In order to participate in this study:

1. You must be an adult, 18 years of age or older.

2. You must be able to speak freely in Arabic language.

3. You must have survived at least one suicide attempt, as defined in the "Purpose" section.

What you expected to do:

You as a women who attempted suicide and for the purpose of the study you are chosen the study and your participation means that I will conduct interviews with you if you are willing to attend the interview will be recorded and it is expected to last 60 - 90 minutes and it will be implemented in your home or the institution recruit you as an appropriate time with you.

Privacy:

All data is recorded only for the study purpose, and will remain stored in a locked cabinet during the study and destroyed after the study is complete. No real names will be mentioned in the study and you will be identified by codes.

Participant Rights:

Your participation in this study is voluntary. You do not have to be in this study if you don't want to be. You have the right to change your mind and leave the study at any time without giving any reason, and without penalty. Any new information that may make you change your mind about being in this study will be given to you.

Benefits:

Research has shown that talking about painful or traumatic experiences can be helpful. For instance, after talking or writing about a difficult life experience, people in general can experience a sense of emotional release, a greater sense of connectedness and understanding, and in some circumstances, can even experience health benefits. An indirect benefit (i.e., one that will not be experienced directly by you) may be that some of the information shared by you may be used to more effectively understand and treat suicidal thoughts and suicide attempts in other individuals

Harm:

The risks of participating in this research study are expected to be small. Participating in this study and speaking about a suicide attempt may bring up painful or stressful thoughts or feelings. We expect that these thoughts and feelings will pass quickly. If you do experience discomfort as a result of the interview, you may tell me at any point during/after the interview. You may stop the interview at any time, with or without telling me why.

Finally, you can discuss any issues that may come up due to your participation in the study with your primary therapist, if you have one.

Your safety is the highest concern; therefore I will take all the necessary steps to keep this commitment. In the unlikely event that participation in this study increases your immediate risk for suicide, I will take steps to recommend the most appropriate follow-up care. This may include referral to an appropriate treatment facility for emergency evaluation.

If after the interview still has something to convey, we are ready for more clarifications. Should you not hesitate contact us at the following telephone number

Dr. Aidah Alkaisss
0597395520

Dr. Sabrina russo.

0598353210
Einas abu Safa
phone number is: 0598399222

معلومات حول الدراسة للمشتركين

عنوان الدراسة:

النساء الفلسطينيات اللواتي حاولن الانتحار والعوامل الكامنة وراء هذه التجربة.

مقدمة :

إنا الطالبة ايناس ابو صفا، طالبة ماجستير تمريض الصحة النفسية المجتمعية في جامعة النجاح الوطنية, أقوم بالتحضير لرسالة الماجستير حول موضوع حول النساء الفلسطينيات اللواتي حاولن الانتحار والعوامل الكامنة وراء هذه التجربة بإشراف الدكتورة عايدة القيسي والدكتورة سابرينا روسو.

الانتحار هو فعل متعمد لايذاء النفس بهدف الموت. وهي ظاهرة تزداد باضطراد عالميا ولها اثار سلبية كبيرة على المجتمع والافراد. في هذه الدراسة سنعمد للبحث في الاسباب الكامنة وراء الانتحار لفتح الباب لوضع سياسات وخطط لحد من الانتحار والوقايه منه بالاستناد الى دراسات وابحاث علمية.

هدف الدراسة:

الهدف من الدراسة هو محاولة اكتشاف الاسباب الكامنة وراء محاولة النساء الفلسطينيات الانتحار، وبالتالي فهم ظاهرة الانتحار بين النساء في المجتمع الفلسطيني، ووضع توصيات انطلاقة من نتائج البحث قد تساهم في الحد من الظاهرة مستقبلا.

دورك في الدراسة :

كونك سيدة فلسطينية وحاولتي الانتحار سابقا فأن تجربتك تشكل خبرة جيدة ومفيدة للدراسة, لذلك وبعد موافقتك سأقوم بعمل مقابلة معك لمدة 60-90 دقيقة وسيتم تسجيل المقابلة على

كاسيت لتسهيل عملية جمع المعلومات وسيتم التركيز على عدة نقاط حول مراحل معينة من حياتك، وسيتم ترتيب الوقت بما يتناسب مع وقتك.

سرية المعلومات:

سوف تكون جميع المعلومات لاستخدام الدراسة فقط, وجميع المستندات والتسجيلات سوف تحفظ في مكان آمن ومحكم الإغلاق، وجميع التسجيلات سوف تتلف بعد الدراسة ، ولن يتم ذكر الأسماء الحقيقة للمشاركين.

حق الرفض بالمشاركة في الدراسة أو الانسحاب :

مشاركتك في الدراسة هي مشاركة طوعية، لك الحق في رفض المشاركة أو الانسحاب من الدراسة في أي وقت من غير تقديم أسباب ولن يكون هناك أي ضرر عليك.

الفوائد المتوقعة من الدراسة:

قد تعود المشاركة في الدراسة ببعض الفوائد على المشاركين، فقد اثبتت الكثير من الابحاث ان الحديث عن التجارب المؤلمة والصدمات التي نمر بها قد تكون مفيدة في التخلص من اثارها وفهمها بصورة اكثر عمقا وبالتالي اعتبارها فرصة للنمو والتعلم.

قد تجدين في البحث فرصة لاستكشاف نقاط القوة الكامنة بداخلك والتي ساعدتك على البقاء حيه مما سيعطيك دافع للنظر للامام بصورة اكثر ايجابية.

اما الفوائد غير المباشرة هي ان المعلومات المقدمة منكي سوف تسهم بشكل اكبر بفهم ظاهرة الانتحار واسبابها في المجتمع الفلسطيني، وخاصة ان هذه الظاهرة اصبحت اكثر انتشارا. مع العلم ان عدد الدراسات التي تناقش قضايا الانتحار في فلسطين محدودة بشكل كبير لذا قد تكون هذه الدراسة هي احد الاسس الهامة في وضع خطة للحد والوقاية من ظاهرة الانتحار لاحقا.

الاضرار المتوقعة من الدراسة:

يتوقع ان تكون المخاطر من المشاركة في الدراسة صغيرة وان تمر بشكل سريع.

يتوقع ان الحديث عن التجارب التي مررتي بها قد تعيد الى ذاكرتك المشاعر المؤلمة التي مررتي بها عند المرور بهذه التجارب ويتوقع ان تمر هذه المشاعر بسرعة. وفي حال الشعور بالاجهاد او عدم المقدرة على الاستمرار او عدم الرغبة بالحديث بامكانكك ترك المقابلة دون ابداء اي سبب في اي لحظة خلال او بعد المقابلة.

بامكانك ان رغبتي طلب حضور معالجتك النفسية ان وجدت المقابلة معكي.

ان سلامتك هي الاهتمام الاكبر والرئيسي لذا سنتخذ كل الاجراءات الازمة للوقاية من اي اثار سلبية قد تعود عليكي من مشاركتك بالدراسة.

معلومات للاتصال:

ان كان لديكي بعد المقابلة اي ستفسار او سؤال او في حال رغبتي بمعرفة النتائج والاطلاع عليها بامكانك الاتصال علينا وفق الارقام الموجودة هنا.

دكتورة عائدة القيسي

0597395520

دكتورة سابرينا روسو

0598353210

ايناس ابوصفا

0598399222

Annex II

Consent Form

The undersigned, ... (name), born ... ... confirms to have read / been explained requests to participate in research project on "Palestinian women attempt suicide risks beyond the experience."

I have been given a copy of your request / project orientation and are willing to participate in the project. I have received both verbal and written information about the study, and I'm aware that my participation is voluntary. I am informed that at any time, without having to explain it might withdraw from study if I wish. If needed I can be contacted for a new interview or clarification of ambiguous relationship.

... ...

(Date) (Signature of informant)

The undersigned confirms that she provided information about the project and has handed over the above a copy of the request / project orientation and consent to participation.

... ...

(Date) (Signature of project leader)

نموذج موافقة على المشاركة في الدراسة :

الاسم:.....

لقد تلقيت المعلومات المكتوبة والكلامية حول الدراسة التي ستكون حول النساء الفلسطينيات اللواتي حاولن الانتحار والعوامل الكامنة وراء هذه التجربة، وأوافق على المشاركة بالدراسة بشكل طوعي، وقد تم أخباري انه بإمكاني الانسحاب من الدراسة في أي وقت دون إعطاء أي أسباب .

التوقيع: التاريخ

Interview guidance Questions

1. What was happening in your life at the time you try to suicide?
2. Did you feel stressed before in your life?
3. How do you cope with such stressors and situations before?
4. Did you try to do this at the time you decide to suicide? Why it didn’t work this time?
5. Who is your support system during?
6. How is your child hood?
7. What is the thing you do and you feel proud of?
8. What is the decision you made give you self confidence and power?
9. What do you like yourself?
10. If another women same as your condition and she want to suicide what you can say to her or advice her?

اسئلة ارشادية للمقابلات

1. ماذا حدث في حياتك في الوقت الذي حاولتي فيه الانتحار؟
2. هل شعرتي بالتوتر من قبل في حياتك؟
3. كيف امكنك التعامل مع مثل هذه الضغوطات والحالات من قبل؟
4. هل جربتي فعل الشيء نفسه في الوقت الذي قررتي فيه الانتحار؟ لماذا لم ينجح؟
5. حدثيني عن طفولتك؟
6. من يدعمك خلال حياتك وخلال فترات التوتر؟
7. ما هو الشيء الذي فعلتيه ويشعرك بالفخر؟
8. ما هو القرار الذي اخذتيه واعطاكي الثقة في النفس والقوة؟
9. ما الذي يعجبك في نفسك؟
10. اذا ارادن امرأة بنفس ظروفك الانتحار, ماذا تقولين لها وتنصحينها؟

جامعة النجاح الوطنية

كلية الدراسات العليا

النساء الفلسطينيات اللواتي حاولن الانتحار، الاسباب الكامنة وراء التجربة دراسية نوعية، الأسلوب الوصفي

إعداد

ايناس ابو صفا

إشراف

د. عائدة القيسي

د. سابرينا روسو

قدمت هذه الأطروحة استكمالاً لمتطلبات درجة الماجستير لتخصص تمريض الصحة النفسية المجتمعية بكلية التمريض في جامعة النجاح الوطنية في نابلس – فلسطين.

2014

النساء الفلسطينيات اللواتي حاولن الانتحار، الاسباب الكامنة وراء التجربة
دراسية نوعية، الأسلوب الوصفي

إعداد
ايناس ابو صفا
إشراف
د. عائدة القيسي
د. سابرينا روسو

الملخص

الانتحار هو مشكلة صحية عامة في جميع أنحاء العالم. يعرف على انه قيام الشخص او محاولته ايذاء نفسه بهدف الموت.

استخدمت الدراسة المنهج الوصفي النوعي لاستكشاف خبرات النساء اللواتي حاولن الانتحار والأسباب التي ادت الى هذه المحاولات.

العينة كانت هادفة لتحقيق أهداف الدراسة تم اختيار عشرون امرأة حاولن الانتحار سابقا. الطريقة التي تم استخدامها في التحليل هي طريقة جورجي (Giorgi method) وهي طريقة تستخدم لتحليل الأسلوب النوعي الوصفي للظواهر(phenomenological qualitative descriptive design) .

نتائج الدراسة أبرزت خمس موضوعات رئيسية ، وثمانية عشر موضوع فرعي. وهي العنف (العنف الجنسي، والعنف الأسري، الشهادة على العنف، وسوء معاملة الأطفال)؛ الخسائر (فقدان الوالدين، وفقدان الهوية الثقافية، وفقدان العلاقة، وفقدان الأمن)؛ عوامل الخطر النفسية (منخفض الكفاءة الذاتية، وانخفاض احترام الذات، والصورة الذاتية السلبية، وعدم القدرة على التاقلم)، والعوامل الثقافية الاجتماعية (الفقر، وصمة العار، والعائلة المفككة) وعدم وجود نظام دعم (غير المهنية، والمهنية).

الخلاصة والتوصيات: إن نتائج الدراسة اهمية فهم ظاهرة الانتحار في المجتمع الفلسطيني خاصة بين النساء والاسباب الكامنة خلف هذه التجربة. وقد عكست النتائج الحاجة إلى برامج وطنية لمحاربة ظاهرة الانتحار والحد من انتشارهاز والذي قد يشمل تنفيذ برامج وطنية للصحة النفسية، ومحاربة العنف ضد النساء، وتوفير الدعم الاقتصادي والاجتماعي وخاصة بالنسبة للإناث، وتعزيز القيم الإسلامية بدلا من العادات والتقاليد.

الكلمات الرئيسية: محاولة الانتحار، والخبرة، والمخاطر، وصفية الظواهر.