Lived Experiences of Severe Depression and Suicide Attempts in Older Thai-Muslims Living in Rural Communities

Saifon Aekwarangkoon, Naiyana Noonil*

Abstract: Depression-related suicide appears to be increasing among older people in a number of countries and occurs consistently in multicultural contexts and among various religious communities. In this study we explored and described the experiences of eight older Thai-Muslims with a history of severe depression and suicide attempts who lived in southern Thailand. The phenomenological method of Colazzi was used to gather, analyze and present data and we employed in-depth interviews.

Analysis of the interview transcripts revealed four themes that stood out as figural for the participants: (a) "death is freedom from life", (b) "loss and loneliness leads to suicide", (c) "a healing approach through Islamic beliefs", and (d) "need someone to support". The findings revealed that the participants generally contemplate suicide in a state of abject misery. Nurse-client therapeutic relationships are important and meaningful for creating personal trust, safety and confidence through being with such people, and collaborating with them to make various choices, to enhance their self-value and touch their inner life-energy. In the healing process, nurses should consider developing positive connections, attempting to alleviate pain and sufg fering, and providing them with effective support in an acceptable Islamic manner.

Pacific Rim Int J Nurs Res 2019; 23(4) 334-344

Keywords: Attempted Suicide, Depression, Muslim, Older People, Phenomenology

Received 10 January 2019; Accepted 3 April 2019

Correspondence to: Saifon Aekwarangkoon, *RN, PhD, Associate Professor, School of Nursing, Walailak University, Thailand. Email: saifon.aekwarangkoon@gmail.com, asaifon@wu.ac.th*
Naiyana Noonil, *RN, PhD, Assistant Professor, School of Nursing, Walailak University, Thailand. Email: nnaiyana@hotmail.com*

Introduction

New cases of depression-related suicide among older people have been consistently higher than in other age groups in multicultural contexts and among various religious communities, and have increased annually worldwide, including in Thailand.[1,2] The suicide rate and behavioral patterns are different among various cultures.[3] For example, suicide rates in European countries with a significant Muslim population were found to be higher than in South Asian and Middle Eastern Islamic countries.[4] In addition, the way that most older people committed suicide was by hanging in their homes.[5] According to various studies, suffering from depression is a major cause for committing suicide, especially among older people.[1,2,3] In Thailand, depression is a common problem in older people with the potential of escalating into attempted-and-completed suicide.[1,6,7,8] Suicidal feelings and hopelessness have been considered part of aging, which may be understandable in the context of being elderly and having physical disabilities and, thus, possibly causing them to be a suicide risk.[1,2]

In Islamic cultures, suicide rates appear to be lower than in those of other religions, and the topic of suicide is considered to be a sensitive topic to discuss in the same way it is in many other cultures.[9,10] Thai-Muslims are concerned not only about their own religion's teachings but also their feelings of stigmatization.[10,11] Even though they may have a strict belief in religion, when they reach an older age, they may no longer feel that they have any meaningful purpose in life and would be better off dead.[11,12] Factors often associated with attempted suicide among older Muslims are poor morale, severe physical or psychological pain, fractured relationships, a sense of loss, living alone, and socioeconomic status.[3,5] Such diverse factors require health care providers to conduct considerable screening and treatment regarding the elderly.[1,12] These circumstances necessitate research regarding attempted suicide by older Thai-Muslims with depression. Exploring their experiences will enhance a deeper understanding of their context, and assist in treating depression effectively, prevent suicide in a family or communities, no matter the existent religious prohibitions, and thus contribute toward better mental health and healthy behaviors.[10,12]

Earlier studies conducted in many parts of Thailand to help counteract depression in older Thai-Muslims in families and communities have been inadequate.[9] More research is needed to meaningfully enlighten stakeholders on the needs of older people, how best to encourage responsibility for mental health, and help such people by promoting positive mental health.[10] The purpose of this study was to explore the experiences of older Thai Muslims with a history of severe depression and suicide attempt. It is important to analyze the lessons learned from those who have survived the challenges of life and their attempted suicide. Their experiences will benefit in developing understanding of those factors that help prevent suicide and contribute to developing practical guidelines for stakeholders in dealing with depressed older people so as to reduce the risk factors of suicide in Islamic culture.

Suicide and depression in the Thai-Muslim world

In contrast to modern medicine's view that severe depression is caused by a number of factors, include brain changes, brain chemistry, hormonal imbalances, or inherited traits[13], in Islam severe depression is also a disease that needs to be treated. However, an Islamic belief is that everything in human life is destined by Allah, and so Muslims must accept and strictly adhere to this premise.[14] Islamic belief decrees that every problem, crisis, and suffering is assigned by Allah and can be positively disentangled and solved, thus resulting in enhanced internal growth.[15] In terms of psychological well-being, it is believed that psychological problems such as depression and suicide will only occur to Muslims who lack proper understanding in religious principles because Allah is with everyone and prepares the path to heaven for them.[14] Additionally, Islam stipulates that life consists of both this life and the afterlife.[16] Every deed practiced eventually is accounted for in the afterlife.[15] Ultimately, this world has been created for temporal reasons while, on the other hand, the afterlife is the eternal home and residual place for all of mankind after this experiential world has been destroyed.[14] Allah promises every Muslim a place in heaven unless they commit unforgivable sins. Muslims who commit suicide are denied a place in heaven and are condemned to live in hell forever because suicide is considered an unforgivable sin in Islam.[14,15,16] The qualitative research reported here is part of a larger action research study on developing youth volunteers to care for older people with depression in the community. The study revealed that the youths had enough capacity to access and help the older Muslim with mild to moderate depression. However, studies regarding Thai Muslims with severe depression are lacking. Therefore, this study aimed to explore the experience of the older Thai Muslim who believed in Allah and were depressed and sought to uncover why they would try to commit suicide.

Methods

Design

This study used Colazzi's phenomenological method to gain insight into the experiences of older Thai-Muslims through the use of dialogic interviewing procedures and thematic interpretations to capture a rich and thick description of the essence of each participant's suicide attempts experience.[17]

Sample and Setting

The settings were four rural communities in southern Thailand in Nakhon Si Thammarat Province where most of the population is Muslim. The participants were purposefully selected on the basis of having experienced the phenomenon of interest and being willing to talk about this.[17] They also met the following inclusion criteria: (a) being Muslim and aged >60 years; (b) living in a rural community; (c) having a significant PHQ-9 score (≥19 being severe depression)[18], (these data were obtained from a self-report questionnaire at home to confirm depression level scores); and (d) self-reported as having had a suicide attempt within the past year.

Selecting the participants involved firstly, the researchers giving health care providers information about the study and requesting them to contact potential participants by telephone to ask permission to give their personal details and home addresses to the researchers. Secondly, after this permission was received, the researchers visited participants at home and described the study. The principal investigator (PI) and the other researchers created positive relationships, and the PI assessed depression using PHQ-9 and interviewed prospective participants about their suicide behavior history again to make sure they met the study's criteria. Four potential participants refused to join but eventually 12 people agreed to join the study, however only eight people remained in the final sample as data saturation was achieved after analysis of eight participants.[17]

Ethical considerations

The Committee on Human Rights Related to Research Involving Human Subjects, Walailak University, Thailand (Protocol Number 16/077) gave ethics approval. The ethical issues during this study involved the participants' independence, intimacy, and anonymity. The participants were informed of the objectives and details of the study, the voluntary nature of their participation as well as the risks and benefits of the study. They had the right to refuse to join the study or could withdraw at any time. They were assured that non-participation in the study would have no deleterious effects on their lives nor the healthcare services afforded to them. Each participant willingly gave permission for the interviews to be recorded and informed consents were gained from all participants. They were also informed that they could refuse to answer questions, and that the interview would be terminated if they felt distress.

Data Collection

Instrument: The *Patient Health Questionnaire-9 - Thai version* (PHQ-9) was used prior to in-depth interviews. It is a self-rated 9-item assessment for depression following the criteria of the Diagnostic and Statistical Manual of Mental Disorders. Respondents rate their symptoms for the previous 2 weeks as: 'none of the time' (0), 'rarely for 1-7 days' (1), 'often for >7 days' (2), or 'for most or all of the time' (3). A total score of 0-6 is classified as no depression, 7-12 as mild depression, 13-18 as moderate depression, and ≥19 as severe depression. These scores have proven to be effective to discern between depressed and non-depressed Thai older people.[18] This instrument was reliability tested with 30 older people in other Thai villages and the alpha coefficient for this particular study was .89.

In-depth Interviews: A guide was used for in-depth interviewing of participants, and contained questions such as: "What happened to you?, "How can you pass this time?, and "How has your religion, Islam, affected your depression and suicide attempt?" This guide was developed by the researchers based on a literature review. Its validity was approved by five experts: two psychiatrists, two psychiatric nurses, and psychologist. In addition, it had been piloted in interviews with ten older Thai-Muslims, not study participants, to assure that they understood the questions.

To gather phenomenological in-depth data, an interview was arranged in a private and distraction-free room in each participant's home with each visit lasting approximately 60-90 minutes, with the duration of each interview corresponding to each participant's condition. To probe their experiences, the interviewer started by creating rapport before proceeding to ask them common, open-ended questions, closely followed by some additional questions. Then, the participants were encouraged to reflect upon events or observations currently related to our study. Data collection and analysis were simultaneously conducted in order to develop topics relevant to the perspective of the participants and their experiences of suicide and severe depression management in their lives. The number of interviews ended after the themes were recognized and information saturation was achieved.

Data analysis

Colaizzi's existential phenomenological methodology was used for data analysis and this consists of 7 steps that were followed in this study (**Table 1**).[19,20]

Table 1 Colaizzi's method of data analysis consists of seven steps.

1. The participants' responses were transcribed verbatim. The validity and accuracy of the process was assured through repeated audio-tape listening and script reading.
2. Significant statements were identified from participants' transcripts of direct relevance to the research phenomenon.
3. Formulated meanings relevant to the phenomenon were developed after careful consideration of the significant statements close to phenomena of the participants' experiences.
4. Formulated meanings were grouped based on their similar themes and arranged into four themes: *Death is freedom from life*; *Loss and loneliness leads to suicide*; *A healing approach through Islamic beliefs;* and *Need someone to support.*
5. A full and inclusive description of the phenomenon is written, incorporating all the themes produced at step 4.
6. Rigorous discussions held by the two researchers to discuss any disagreements and continued until agreement was reached. Another significant factor in the interpretation process was concerned with the researchers' individual perception, experiences, and backgrounds, so the researcher's standpoints and biases were actively acknowledged.
7. Finally, validity was ensure through two methods: peer-briefing, and also presenting the final draft findings to the participants to gain their confirmation or modification of the outcomes of the analysis.

Trustworthiness

Member checking, peer checking, and prolonged engagement were employed to establish honesty and credibility.[21] For member checking, the participants were asked to audit the conclusions drawn from the earlier interviews. To increase the validity of the findings these were shared with these eight participants individually who then could compare their own experiences. Three experts in this field carried out peer checking. Lastly, the PI could establish a high degree of trust with the participants and evolved a better understanding of the research results through close and continual involvement with the participants. Prolonged engagement in the field is essential as an assurance for data relevancy and adequacy so that the goal of the study can be achieved.[21]

The conformability and credibility of the data could be solidified and enhanced by ensuring maximum variation of sampling. The comprehensiveness and veracity of the content were ensured by circumstantially recognizing various new data. Finally, by identifying and collating various re-occurring themes voiced by the participants to describe their particular aspects and experiences about challenges in dealing with their suffering from suicide-related severe depression, analysis could be concluded.

Findings

The eight participants had a range age of 67-91 years and the majority (75%) were female. The way of their suicide attempts were medicine overdose (75%) and hanging (25%). Further most (75%) were divorcees/widows and had a primary school education (62.5%). In addition, all participants suffered from their chronic illnesses such as hypertension, diabetes mellitus, dyslipidemia. Their monthly income was 1,000-3,700 Thai baht (around 31.54-116.69 USD) that half of them perceived as adequate.

In linking together the underlying meanings of the participants' accounts of their experiences of living with severe depression and attempting suicide, four themes emerged and are explained below with relevant participant quotes:

Death is a freedom from life

The participants experienced and endured suffering from severe depression for a long time and they could not share this suffering with others. Their suffering made them want to die and they recognized that only death could ease their torturous lives. In attempting suicide, they believed that only a fraction of a second of breath in a new world would relieve them from enduring such sadness. Only death would lead them to reach freedom from life because in the afterlife, they could leave all mental pain behind. It is a second of longing for freedom while another idea reminds them that death is an offence against Allah. However, the thought of death kept surfacing in their minds while they could not commit suicide. Being stuck on this threshold between life and death frustrated them. Severe depressive symptoms not only disturbed their inner feelings but also generated an adverse impact on their daily life functions as well as in their relationships with others. Participants perceived the effects of deep depression sufferings related to their need to die, but also with ambivalence due to their strongly-held belief in Islam. For example, Armenao, a female, said:

> *Suffering makes me want to die; only death helps me reach freedom, escape from all pain and suffering, but I can't do it because of Allah, I only wait for death.*

> *It is really hard for me to live. I am really sad, I want to cry and cry every day. My entire daily life activities have changed negatively. All I want is to stay alone...away from others. Living means nothing but I cannot commit suicide either.*

Participants also reported that they had no choice to live. They also did not know why they were here and how to live:

Every day I wake up, no choices; I don't know anything, even the reason to wake up; no goals in sight. I also don't know the meaning of my life. It is hard to live in this situation. I only live minute to minute and hope that the suffering will disappear and I would die meeting a new freedom from life with no pain. Suicide comes into my head all of the time and that makes me feel guilty to Allah. (Banglao, male)

Loss and loneliness leads to suicide

Participants believed that a sense of loss and loneliness influenced them to attempt suicide. They reported this sense of loss from two aspects: firstly, loss of belonging that is an intrapersonal, psychological process consisting of loss of self-esteem and self-control, hopelessness, powerlessness, and worthlessness. Another meaning was sense of loss in interpersonal interactions consisting of a loss of positive connections, attachments, love, understanding, caring, respect, genuineness, and support from others, especially loved ones. This sense of loss affected them so as to feel a sense of isolation between them and others that make them attempt suicide:

While I am drowning deeply in this situation, I lose all meaning of life, self-esteem, self-control, hope, and people to love. It is hard to live and I really need to die but I can't take my own life. These situations make me feel lonely because I realize that I really have nothing in my life, even self-belonging. (Loufa, female)

Realize that I live with my loved ones but still feel lonely. I always try to blend in with the family and take part in community activities but I can't connect with anyone even my family members. I perceive our relationship in a negative way, with no meaning to interact with others. I try to understand myself and others, but I still can't get rid of this loneliness. (Chabaprai, female)

Healing mind through Islamic beliefs

Participants tried to heal and balance their internal spiritual nature through a process to overcome depression and suicide by respecting Allah. They strongly believed that Allah always grants them compassion, love, protects them from harm and heals their minds. In addition, Muslims who commit suicide must live in hell forever because suicide is an unforgivable sin. Based on this belief, they strongly adhered to Allah by praying five times per day. At these times, their negative feelings and thoughts were left behind. Instead, they feel connected to their own spiritual growth in compassion, detachment, and peace from Allah which caused a positive internal change for healing their depression and reduced the risk of suicide. This activity healed the severe depression and sustains them in their lives, for example:

Allah always embraces and protects me from pain and suffering. I always receive love and compassion from Allah to heal my pain. This energy helps me survive. (Yamela, female)

Islam does not permit people to commit suicide; it is an unforgivable sin. Every time I feel depressed and want to commit suicide, I remind myself that Allah will still help and be there for me. (Rifa, female)

Need someone to support

There was the belief that, although there was no hope and they may not have had anybody, participants still needed love, understanding, caring, and support from the others, especially love ones. Attachment to loved ones creates a feeling of care and warmth in their minds and helps heal their depression and reduces the risk of suicide. They feel lonely in a crowd. Consequently, they focus their consciousness on the embrace and love of Allah. This inclination reflects that support is really an important factor for creating in life the feelings of trust, safety, and confidence. It also eases fear and anxiety in uncertainty in a life

filled with suffering because when people know there is always someone to be with, it confirms that their life is worth living as Abraham (male) said:

> *Except for Allah, there is no one who pleases me, helps me and is with me. I really have nobody and am in need of love, understanding, caring, and support from humans, too.*

Participants confirmed that they still need love from people important to them. They also need to live and die in the embrace of loved ones who understand, care, and, so, they try to seek help from others as illustrated in the following quotes:

> *I need love, warmth, and support from my loved ones or others who genuinely understand, listen to my heart and accompany me in these situations.* (Saofeyao, female)

> *I try to isolate myself because nobody can hear and connect with me. Although there is nobody with me, in reality, I really need someone who understands and helps me get through this period.* (Armenao, female)

Discussion

Older Thai Muslims in this study experienced suffering from their severe depressive symptoms of emotional, cognitive, behavioral, and physical changes that influenced their lives, making it difficult to live anymore with mental anguish.[22] Studies reveal that older people who kill themselves experience persistent despair and unendurable physical or mental pain.[3,22] Because their deep suffering led them to a loss of positive feelings and motivation, this made them feel hopeless, helpless, and desperate to avoid excruciating pain.[19,22] The participants in our study perceived that only death would liberate them from pain and suffering, but they were prevented from committing suicide because of religious principles and the stigmatization of their society and community.[11] In accordance with Islamic belief, they believed that psychological problems including depression and suicide must not occur to Muslims who truly understand the principles of their religion because Allah is with everyone.[9] Due to this belief and the concern of stigmatization, they had to keep their depression and contemplation of suicide a secret in their lives and try to relieve the suffering by themselves thus resulting in even more severe mental pain and turmoil.[22,23] Thus, they remain in frustration waiting for death to reach them and achieve complete freedom from life. This cycle is also reflected in the research of both Western and Eastern society.[11,12,23]

A sense of loss and loneliness are very important triggers that influenced participants to attempt suicide. It is exhibited as emotional changes, breeding pain and suffering for older people with severe depression.[23] The participants reported a loss of meaningfulness in intrapersonal psychological processes such as a loss of self-control, self-esteem and life-energy, hopelessness, worthlessness, and powerlessness. Older people with severe depression have a greater likelihood of reverting to a negative state with loneliness inducing the inclination towards suicide.[24,25] In some other cases, participants perceive a loss in the meaning of interpersonal interaction such as a loss of positive connections, attachment, love, and support with loved ones such as family members, friends, neighbors, and community. The findings of this study reflect that relationships, acceptance, and connection of self with others play a very significant role in triggering loneliness among depressed older people.[10,12] In addition, other studies reveal that a decline in psychological processes can isolate older people from a pleasurable environment causing them to perceive even greater loneliness.[22] These sentiments of loss and loneliness can induce older people to attempt suicide.[22,23,26]

However, within a Thai-Muslim context, the beliefs and teachings of the Islamic religion can foster

spiritual healing and greater emotional and mental balance.[10,12] Strong adherence to Allah cultivates strength of the internal world of the adherent.[9] They pray and are in the presence of Allah five times per day. Prayer and reflection bring them into closer connection with Allah and His enveloping embrace which gives them more confidence for living.[10] Religion acts as a buffer in a transformative process to change suffering and suicide from severe depression.[10,27] This healing process creates peace and compassion spiritually and protects the individual from harm including suicide.[9,12] The results of various studies reveal that the rate of suicide attempts and suicide contemplation among depressed people are affected by religious affiliation.[26,28] While people are communing with Allah in prayer, they do not have negative thoughts, negative feelings, nor negative inclinations. They are connected through a state of positive spiritual enhancing mind peacefulness that fosters internal healing and positive internal changes that can heal depression and reduce the risk of suicide.[9,28]

Although participants may strongly believe in Islam, they still need understanding, positive connection, attachment, love, and support from others, especially the loved ones in their lives. This also reflects that relationships have a major impact in ameliorating depression.[24,25] Interpersonal relationships impact internal growth and increase an individual's energy for living.[29,30] The happiness of older people depends on the care and cohesiveness in positive relationships with their family members and with others.[10] This study's findings reveal that the participants needed positive connections in order to prevent anxiety and fear in daily life degenerating into severe depression.[10,22,24] Other research indicates that people of different cultures may kill themselves as a result of persistent fractured relationships.[3] Alternately, genuine relationships enhances a sense of trust, safety, and security to live with hope and warmth which support them in reducing the risk of depression and suicide.[23,30]

Limitations

The limitation of this study relates to its setting which covers only four communities in one district. As the cultural background of the participants were of direct concern, this study was unable to represent a larger population. Another limitation is that an item of the semi-structured questionnaire was a closed question and quite directional: "How has your religion, Islam, affected your depression and suicide attempt?". The question contains an assumption that Islam did affect their mental state, which is an issue when interviewing in phenomenology because one cannot make assumptions or have biased views about people's experiences.

Conclusions and Implications for Nursing Practice

This study found that in the experience of these older Thai-Muslims they had to live within two worlds. In the present world, they faced suffering from a sense of loss and loneliness with nobody to support them and this helped to lead them to attempt suicide. They believed that the world of death was freedom from pain and various sufferings. However, Muslims believe that Allah always grants them compassion, love, and heals their minds from suffering and being lonely. Therefore, the findings reflected that older Thai-Muslims need support from someone and early detection of depression. Moreover, they also need better, deep understanding in the meaning of their religion for healing them in the therapeutic process. Developing nurse-client therapeutic relationships for enhancing positive connections, attempting to alleviate suffering, and providing them with effective support in an acceptable Islamic manner should be a concern of nurses. Therefore, nurses who take care of these groups should learn and understand Islamic beliefs to help

older people live in the world of reality with their love one(s). In addition, nurses need to find strategies and develop specific protocols to detect depression in Thai-Muslims, and take advice from people from the same culture. This is particularly pertinent when caring for those older Thai-Muslims who live alone. Nurses have an important role in providing information about strategies to reduce depression for all people, individuals, families, and communities.

Acknowledgements

This research was funded by the Office of the Higher Education Commission (OHEC). We would like to truly acknowledge the participants for their active participation.

References

1. Department of Mental Health, Ministry of Public Health. The Department of Mental Health watched the elderly risk suicide. 2017 [cited 2017 December 19]. Available from https://www.dmh.go.th/news-dmh/view.asp?id=26932
2. World Health Organization. Depression let's talk: Campaign essentials. 2017 [cited 2017 April 25]. Available from http://www.who.int/campaigns/world-health-day/2017/toolkit.pdf?us=1
3. Snowdon J. Differences between patterns of suicide in East Asia and the West. The importance of sociocultural factors. Asian Journal of Psychiatry. 2018; 37: 106-111.
4. Pritchard C, Amanullah S. An analysis of suicide and undetermined deaths in 17 predominantly Islamic countries contrasted with the UK. Psychological Medicine. 2007; 37: 421-430.
5. Karbeyaz K, Celikel A, Emiral E, Emiral GO. Elderly suicide in Eskisehir, Turkey. Journal of Forensic and Legal Medicine. 2017; 52: 12-15.
6. Bunloet A. Prevalence and factors associated with depression among the elderly community residents with chronic diseases in Samliam Urban Primary Care Unit, Khon Kaen. Srinagarind Medical Journal. 2016; 31: 25-33.
7. Wongpanarak N, Chaleoykitti S. Depression: A significant mental health problem of elderly. Journal of the Royal Thai Army Nurses. 2014; 15: 24-31.
8. Yodmai K, Somrongthong R. Depression and factors associated with the quality of life among the elderly in Numpong and Somsoong District, Khonkean Province, Thailand. European Journal of Scientific Research. 2016; 138: 193-199.
9. Dewiyanti D, Kusuma HE. Space for Muslims spiritual meanings. Procedia-Social and Behavioral Sciences. 2012; 50: 969-978.
10. Laeheem K. The effects of happy Muslim family activities on reduction of domestic violence against Thai-Muslim spouses in Satun. Kasetsart Journal of Social Sciences. 2017; 38: 150-155.
11. Sheehan L, Dubke R, Corrigan PW. The specificity of public stigma: A comparison of suicide and depression-related stigma. Psychiatry Research. 2017; 256: 40-45.
12. Mir G, Meer S, Cottrell D, McMillan D, House A, Kanter JW. Adapted behavioural activation for the treatment of depression in Muslims. Journal of Affective Disorders. 2015; 180: 190-199.
13. Mayo Clinic. Depression (major depressive disorder). 2018 [cited 2019 March 25]. Available from https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007
14. Tzeferakos GA, Douzenis AI. Islam, mental health and law: a general overview. Annals of General Psychiary. 2017: 16-28.
15. Eapen V, El-Rufaie O. Country Profile: United Arab Emirates (UAE). International Psychiatry. 2008; 2: 38-40.
16. Ciftci A, Jones N, Corrigan PW. Mental health stigma in the Muslim community. Journal of Muslim Mental Health. 2012(7). Doi:http://dix.doi.org/10.3998/jmmh.10381 Z607.0007.102
17. Thomas SP, Pollio HR. Listening to patients: A phenomenological approach to nursing research and practice. New York: Springer Publishing Company, Inc; 2002.
18. Lotrakul M, Sumrithe S, Saipanish R. Reliability and validity of the Thai version of the PHQ-9. BMC Psychiatry. 2008; 8: 46.
19. Colaizzi PF. Psychological research as the phenomenologist views it. In: Valle R, King M (eds). Existential-Phenomenological Alternatives for psychology. New York: Oxford University Press; 1978: 48-71.

20. Morrow R, Rodriguez A, King N. Colaizzi's descriptive phenomenological method. The Psychologist. 2015; 28: 643-644.
21. Anney VN. Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. Journal of Emerging Trends in Educational Research and Policy Studies. 2014; 5: 272-281.
22. Apesoa-Varano EC, Barker JC, Hinton L. Shards of sorrow: Older men's accounts of their depression experience. Social Science & Medicine. 2015; 124: 1-8.
23. Santini ZI, Fiori KL, Feeney J, Tyrovolas S, Haro MJ, Koyanagi A. Social relationships, loneliness, and mental health among older men and women in Ireland: A prospective community-based study. Journal of Affective Disorders. 2016; 204: 59-69.
24. Elias SMS, Nevile C, Scott T. The effectiveness of group reminiscence therapy for loneliness, anxiety and depression in older peoples in long-term care: A systematic review. Geriatric Nursing. 2015; 36: 372-380.
25. Ni Y, Tein JY, Zhang M, Yang Y, Wu G. Changes in depression among older peoples in China: A latent transition analysis. Journal of Affective Disorders. 2017; 209: 3-9.
26. Sabry WM, Vohra A. Role of Islam in the management of psychiatric disorders. Indian Journal of Psychiatry. 2013; 55: S205-S214. Doi: 10.4103/0019-5545.105534
27. Bulmer M, Bohnke JR, Lewis GJ. Predicting moral sentiment towards physician-assisted suicide: The role of religion, conservatism, authoritarianism, and big five personality. Personality and Individual Differences. 2017; 105: 244-251.
28. Lawrence RE, Brent D, Mann JJ, Burke AK, Grunebaum MF, Galfalvy HC, et al. Religion as a risk factor for suicide attempt and suicide ideation among depressed patients. Journal of Nervous & Mental Disease. 2016; 204: 845-850. Doi: 10.1097/NMD.000000000000484
29. Izquierdo A, Miranda J, Bromley E, Sherbourne C, Ryan G, Kennedy D, et al. Grandparenting experiences among adults with a history of depression: A mixed-methods study. General Hospital Psychiatry. 2015; 37: 185-191.
30. Knipe DW, Gunnell D, Pearson M, Jayamanne S, Pieris R, Priyadarshana C, et al. Attempted suicide in Sri Lanka-An epidemiological study of household and community factors. Journal of Affective Disorders. 2018; 232: 177-184.

ประสบการณ์การพยายามฆ่าตัวตายของผู้สูงอายุไทยมุสลิมที่มีภาวะซึมเศร้าระดับรุนแรงในชุมชน

สายฝน เอกวรางกูร นัยนา หนูนิล*

บทคัดย่อ: อุบัติการณ์การพยายามฆ่าตัวตายจากภาวะซึมเศร้าเพิ่มสูงขึ้นอย่างต่อเนื่องในกลุ่มผู้สูงอายุทุกบริบท ศาสนา และวัฒนธรรม นำไปสู่อัตราการเสียชีวิตที่เพิ่มขึ้นในหลายประเทศ การวิจัยนี้มุ่งเน้นการทำความเข้าใจประสบการณ์การพยายามฆ่าตัวตายของผู้สูงอายุไทยมุสลิมที่มีภาวะซึมเศร้าระดับรุนแรง และอาศัยอยู่ในชุมชนภาคใต้ของประเทศไทยจำนวน 8 คน ใช้วิธีการวิจัยเชิงปรากฏการณ์วิทยาและวิธีการของโคไลซ์ซี่ในการรวบรวม วิเคราะห์ และนำเสนอข้อมูลที่ได้จากการสัมภาษณ์เชิงลึก ผลการศึกษาพบ 4 ประเด็นหลัก ประกอบด้วย ความตายคืออิสรภาพของชีวิต ความรู้สึกสูญเสียและโดดเดี่ยวเหนี่ยวนำให้เกิดการฆ่าตัวตาย การเยียวยาทางจิตใจในวิถีของอิสลาม และความต้องการการสนับสนุนและประคับประคองจากผู้อื่น ผลการศึกษาครั้งนี้สะท้อนให้เห็นว่าผู้สูงอายุไทยมุสลิมที่พยายามฆ่าตัวตายจากการมีภาวะซึมเศร้าในระดับรุนแรงต้องเผชิญกับความทุกข์ที่ยังต้องการการคลี่คลาย สัมพันธภาพเชิงบำบัดระหว่างพยาบาลและผู้สูงอายุมีความหมายต่อการสร้างความรู้สึกไว้วางใจ ปลอดภัย และเชื่อมั่นด้วยการอยู่กับสิ่งที่ผู้สูงอายุกำลังเผชิญ ร่วมสร้างทางเลือก เพิ่มคุณค่า และช่วยให้ผู้สูงอายุสามารถสัมผัสกับพลังชีวิตภายในตนเอง ในกระบวนการเยียวยา พยาบาลควรสร้างการเชื่อมโยงเชิงบวกคลี่คลายความทุกข์ทรมานและความเจ็บปวดที่บีบคั้น รวมทั้งค้นหาวิธีการเยียวยาและประคับประคองทางด้านจิตใจที่มีประสิทธิภาพตามวิถีของมุสลิม

Pacific Rim Int J Nurs Res 2019; 23(4) 334-344

คำสำคัญ: การพยายามฆ่าตัวตาย ภาวะซึมเศร้า มุสลิม ผู้สูงอายุ ปรากฏการณ์วิทยา

ติดต่อที่ : สายฝน เอกวรางกูร*** *รองศาสตราจารย์ สำนักวิชาพยาบาลศาสตร์ มหาวิทยาลัยวลัยลักษณ์ Email: saifon.aekwarangkoon@gmail.com, asaifon@wu.ac.th*

นัยนา หนูนิล *ผู้ช่วยศาสตราจารย์ สำนักวิชาพยาบาลศาสตร์ มหาวิทยาลัยวลัยลักษณ์ Email: nnaiyana@hotmail.com*

สำนักวิชาพยาบาลศาสตร์ มหาวิทยาลัยวลัยลักษณ์ จังหวัดนครศรีธรรมราช ประเทศไทย