

**SUICIDAL TENDANCIES AMONGST PATIENTS WITH EPILEPSY AT  
KYABUGIMBI HEALTH CENTRE IV, BUSHENYI DISTRICT**

**GUMISIRIZA ALEX**

**DCM/0159/143/DU**

**A RESEARCH REPORT SUBMITTED TO THE SCHOOL OF ALLIED HEALTH  
IN PARTIAL FULFILMENT OF THE AWARD OF A DIPLOMA  
IN CINICAL MEDICINE AND COMMUNITY HEALTH OF  
KAMPALA INTERNATIONAL UNIVERSITY**

**JULY, 2017**

## **DECLARATION**

I hereby declare that this report is of my own effort and has never been used or forwarded by anyone of any institution or organization.

Signature ..... Date.....

Mr. GUMISIRIZA ALEX

## **APPROVAL**

I hereby certify that this research has been done by this student towards achieving his award of Diploma in Clinical Medicine and Community Health under my supervision.

Signature..... Date.....

Mr. BATUME ELIAS

(Psychiatric Clinical Officer)

## **ACKNOWLEDGEMENT**

I thank the almighty God that has helped me through this course and this piece of work I particular.

Heartfelt appreciation to my supervisor Mr. Batumi Elias for his selfless guidance throughout the course of this research. He has been more that a supervisor.

Appreciation to my family, my wife Ninsiima Lovence, you have been supportive financially, socially and morally.

Lastly but not least , my friends like Sigirenda Benjamin, Ahimbisibwe Jackson, Ainomugisha Joan and many others, am indebted for your support and encouragement due the study of this course

## **DEDICATION**

I dedicate this book to my family; my wife **Ninsiima Lovence** and my sons, **Amanya Berrious** and **Aheereza Genius** not forgetting my parents **Mr. Gumisiriza Francis** and **Mrs. Kekyihabura Jovlet**.

## Table of Contents

DECLARATION .....	i
APPROVAL .....	ii
ACKNOWLEDGEMENT .....	iii
DEDICATION .....	iv
ABSTRACT .....	vii
General objective.....	vii
LIST OF ABBREVIATIONS .....	viii
DEFINITION OF KEY TERMS. ....	1
CHAPTER ONE .....	2
1.1    Background .....	2
1.2    Problem Statement .....	3
1.3    General objective .....	4
1.4    Specific objective.....	4
1.5    Research questions.....	4
1.6    Significance of the study .....	4
CHAPTER TWO: LITERATURE REVIEW .....	5
2.1    Perceptions of people with epilepsy.....	5
2.2    : Suicidal ideation and tendency among epilepsy patients .....	6
2.3    Relationship between perception of epilepsy and suicidal behaviour among epilepsy patients .....	7
CHAPTER THREE: METHODOLOGY .....	9
3.0    Introduction .....	9
3.1    Study design .....	9
3.2    Study site.....	9
3.3    Study population.....	9
3.4    Sample size selection. ....	9
3.4.1    Inclusion criteria .....	9
3.4.2    Exclusion criteria: .....	9
3.4.3    Definition of variables.....	10
3.4.4    Research tool .....	10
3.5    Data collection.....	10
3.5.1    Data management.....	10
3.5.2    Data analysis.....	10

3.6	Ethical considerations .....	11
3.7	Limitations of the study.....	11
3.8	Dissemination of results .....	11
CHAPTER FOUR: RESULTS .....		12
4.0	Introduction .....	12
4.1	Socio-demographics of the respondents.....	12
4.2	Table2: Perception of epileptic patients towards the illness.....	14
4.3	Relationship between illness perception and suicidal ideation.....	16
4.4	Significant relationship .....	17
CHAPTER FIVE: DISCUSSION .....		18
5.0	Introduction .....	18
5.1	Socio-demographics.....	18
5.2	Perceptions of patients with epilepsy .....	19
5.3	Suicidal ideation and tendencies among epilepsy patients.....	19
5.4	Relationship between perception of epilepsy and suicidal tendencies among epileptic patients .....	20
5.5	Conclusion.....	21
5.6	Recommendation .....	21
REFERENCE.....		22
Appendix II: Consent Form .....		24
Appendix III: Questionnaire .....		26
Appendix v: Authorization Letter .....		31

## **ABSTRACT**

**Introduction** Epilepsy is the world's most common brain disorder (WHO, 2005). The numbers of people around the world who have epilepsy are estimated to be 65million (US Epilepsy foundation, 2016). The association also defines epilepsy as a neurological condition that affects the nervous system.

### **Problem statement**

Suicidal behaviour in epileptic patients is a real problem, frequently under-diagnosed by physicians EAtock Et al, 2007. This research will therefore investigate the relationship between illness perception and suicidal behaviour among people with epilepsy.

### **General objective**

To assess the relationship between illness perception and suicidal tendencies among people with epilepsy.

### **Specific objective**

To determine the rate of suicidal ideation and attempt among epileptic patients, investigate the relationship between the perception of epilepsy and suicidal behaviour and assess illness perception of patients with epilepsy.

### **Results.**

32.5% of the respondents had suicidal ideation and tendency with only 7.7 % having the highest tendency (17+ points). Most of the respondents agreed that the illness was temporary and did not have statistical significance in relation to suicidal ideation ( $f=0.06$ ,  $p=79$ )

### **Conclusion**

Perception of epileptic patients about the illness was negative, as vast majority of the sample agreed that; the illness was permanent, had major consequence on their lives, had a serious financial impact on them, gives difficulty to those who are close to them, they felt depressed about the illness and the illness could not be cured

The relationship between perception and suicidal tendencies was minimal

### **Recommendation**

- The health workers should provide adequate counselling services to epileptic patients; Epileptic patients should be screened for depression. Stake holders should create employment opportunities; the health centre should sensitize the community about epilepsy.



## **LIST OF ABBREVIATIONS**

<b>HIV</b>	:	Human Immuno-deficiency Syndrome
<b>IPD</b>	:	In Patient Department
<b>KIU</b>	:	Kampala International University
<b>KIU-TH</b>	:	Kampala International University Teaching Hospital
<b>KIU-WC</b>	:	Kampala International University Western Compas
<b>MoH</b>	:	Ministry of Health
<b>OPD</b>	:	Out Patient Department
<b>PWE</b>	:	People with Epilepsy
<b>SAHS</b>	:	School of Allied Health Sciences
<b>SPSS</b>	:	Statistical Package for Social Scientists
<b>UAHEB</b>	:	Uganda Allied Health Examinations Board
<b>UN</b>	:	United Nations
<b>WHO</b>	:	World Health Organization

## **DEFINITION OF KEY TERMS.**

**Depression:** a feeling of severe despondency and dejection.

**Epilepsy** : a neurological condition that affects the nervous system.

**Perception:** the ability to see, hear, or become aware of something through the sense.

**Suicidal ideation:** having thoughts of committing suicide.

**Suicidal tendency:** attempt to commit suicide.

**Suicide:** the act of intentionally causing one's own death

## CHAPTER ONE

### 1.1 Background

Epilepsy is the world's most common brain disorder (WHO, 2005). The numbers of people around the world who have epilepsy are estimated to be 65million (US Epilepsy foundation, 2016). The association also defines epilepsy as a neurological condition that affects the nervous system. It is also the most common non-infectious neurologic disease in low and middle income countries with incidence estimated at 1-1.9 cases/1000 per year (sander, 2003).

Epilepsy and depression are interlinked and lead to an increased risk of suicidal ideation and suicide De Boer Et al, 2008. Epilepsy itself is independently associated with suicidal ideation since there are various other factors related to epilepsy that further increase the risk of suicide Kaiser Et al, 2006. Kaiser and others also add that mood disorders are prevalent in epilepsy disorders, particularly depression, anxiety disorder, schizophrenia and substance abuse.

Depression not only affects the quality of life but is also a predator for suicidal ideation in epileptic patients. Individuals with prolonged depressive disorder were likely to exhibit anhedonia and suicidal ideation Ibeakwe Et al, 2007. Studies on prevalence of suicide in epilepsy are reported at 5-10% whereas the prevalence of suicidal ideation was quoted as high as 36.7% Stefanello Et al, 2010.

Despite being one of the most cost-effective disorders to treat, there are twice as many people living with epilepsy in low and lower-middle –income countries than higher income nations and more than 60% of those affected in these regions are not accessing any appropriate treatment Newton Et al, 2012s. Newton, who works in the welcome Trust programmes in Tanzania and Kenya, added that epilepsy needs to be brought into the agenda of non-communicable diseases since it was not mentioned in the UN General Assembly Meeting in New York to address the global burden of non-communicable diseases, and yet it represents a substantial burden of ill health.

Epilepsy in sub-Saharan Africa is mainly secondary, reflecting persistently high risks at birth, and the adverse neurological sequelae of viral, bacterial, malarial and other parasitic infections during and beyond childhood, mainly due to lack of regional information on this important condition Caplan Et al, 2005. Even when epilepsy is recognized, treatment sought, the treatment gap is exacerbated by scarcity of

trained health personnel, the cost and difficulty of access to technical investigation and poorly sustained drug treatment Preux Et al, 2005.

Whereas there is scarcity of research information about relationship between epilepsy and suicidal behaviours, Kaiser and others (2006) reported prevalence of epilepsy in west Uganda where they identified individuals complaining of seizures by means of a population census in 12 villages. Active epilepsy was confirmed in 61 of 4743 inhabitants (crude prevalence rate = 1.3%.

Distribution of epilepsy in the study area was clustered, ranging from prevalence of 0.2% to 3.4% in different villages (WHO, 2006).

## **1.2 Problem Statement**

Historically, epilepsy was believed to be a spiritual disease Mosaku Et al, 2006. It was believed that only spiritual powers were behind the disease that gods could deprive healthy man of his senses, throws him to the ground, convulses him and then rapidly restore him to his former normal state Demirci et al, 2007. They add that unfortunately, the historical perception has continued to influence patients' attitude towards epilepsy making it a feared disease. The effect has seen patients with epilepsy being ostracized and stigmatized leading to them developing suicidal behaviours. A case in a point is Madagascar where patients who succumb to epilepsy are denied burial in the family graveyard (Baskind, 2011).

Epilepsy therefore signifies a medical diagnosis as well as a social challenge Tellez Et al, 2007. The persons living with epilepsy have more psychosocial challenges compared to the general population, especially that they often experience stigma De-Boer Et al, 2008. Few studies have attempted to address the link between epilepsy and suicidal behaviours. Some of these studies have found higher risk of death from suicide in people with epilepsy, ranging from 3.5-5.8 times higher than in the general population (JAMA Psychiatry 2015).

Suicidal behaviour in epileptic patients is a real problem, frequently under-diagnosed by physicians EAtock Et al, 2007. Possible risk factors for suicidal behaviours in all epileptic patients are not fully evaluated (Shorvon, 2012). Yet when one or more risks factors are discovered, referring physicians and families can try to understand the relationship between perception and suicidal behaviour Mosaku Et al, 2006. This research will therefore investigate the relationship between illness perception and suicidal behaviour among people with epilepsy.

### **1.3 General objective**

To assess the relationship between illness perception and suicidal tendencies among people with epilepsy.

### **1.4 Specific objective**

To determine the rate of suicidal ideation and attempt among epileptic patients attended to at Kyabugimbi Health Centre IV, Bushenyi District.

To investigate the relationship between the perception of epilepsy and suicidal behaviour among epileptic patients attended to at Kyabugimbi Health Centre IV, Bushenyi District.

To assess illness perception of patients with epilepsy at Kyabugimbi health centre IV, Bushenyi district.

### **1.5 Research questions**

What are the epileptic patients' perceptions about this mental disorder (of Kyabugimbi Health Centre IV, Bushenyi district)?

What is the rate of suicidal ideation and tendencies among epilepsy patients attended to at Kyabugimbi Health Centre IV, Bushenyi District?

What is the relationship between the perception of epilepsy and suicidal tendency among epilepsy patients attended on at Kyabugimbi Health Centre IV, Bushenyi district?

### **1.6 Significance of the study**

The main purpose of this study is to assess between the perception of epilepsy and suicidal behaviour among epileptic patients. It will therefore contribute towards creating new knowledge about the cause of suicidal behaviours and how to reduce it. The data generated can be used by policy makers, learners and health workers in planning for appropriate health interventions among people living with epilepsy so that their lives become better. This study will be conducted in partial fulfilment for the requirement for the award of a Diploma in Clinical Medicine and Community Health.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Perceptions of people with epilepsy**

Historically, epilepsy was believed to be a spiritual disease Masaku Et al, 2006. It was believed that only spiritual powers were behind the disease and gods could deprive a healthy man of his senses, throw him to the ground. They add that unfortunately, this historical perception has continued to influence patients' attitude towards epilepsy making it a feared diseases.

The perception of epilepsy varies among individual patients, according to their cultural beliefs Demirci Et al, 2007. In Nigeria, epileptic patients have a common belief that the condition is contagious; hence some of them avoid public places or meeting people Ibekwe Et al, 2007. In Burkina Faso, epilepsy is considered to be contagious (by 44%) and hereditary (by 40%); while only 15% link it to a problem in the head and 7.8% think it being due to worms in the head Sanya et al, 2005.

One aspect of the socio-cultural belief among people with epilepsy is that it is contagious and that it can be spread by urine, saliva or faeces excreted at all times or during a convulsion Daoud Et al, 2007. This results in isolation and unwillingness of witness to touch and protect the patient from injury during a seizure Dua Et al, 2006.

Seizures and epilepsy are attributed to several other causative factors besides direct contagion (Jacoby, 2005) and that the supernatural beliefs such as witch craft are frequently cited by the patients as causing seizures. Such patients versed in magical art often believe that they were cursed and could therefore spend scarce resources on traditional healers seeking care and healing (De-Boer, 2008).

Another widely held belief among people with epilepsy is that breaking taboos may cause seizures Eatock Et al, 2007. Angered ancestors may send the ailment as a punishment for socially inappropriate behaviour (Kalinin, 2005). Fundamental theories of stigma emphasize its important functional role as delineating between the normal and the deviant in society.

The linking of epilepsy to deviant social behaviour is a striking example of this premise Daoud Et al, 2007.

## **2.2: Suicidal ideation and tendency among epilepsy patients**

Suicidal behaviour is common in Epileptic patients. Risk factor for suicidal ideation are associated with social and vocational disturbances, such as low economic status, lack of social support and unemployment and psychiatric co-morbidity Sanya Et al, 2005. suicidal behaviour is an important worldwide health problem and consists of the a wide spectrum of self-destructive behaviour including suicidal ideation, suicidal attempts and suicide itself (Sanya, 2005). Suicidal ideation is a medical term for thoughts, wishes and plans intended to result in suicide (WHO, 2011) and can vary from passive ideas to ideas with detailed planning and intent on committing suicide.

Suicide is an important cause of death with epilepsy and the significance of the epilepsy as a suicide risk factor varies in available studies Preux Et al, 2005. Suicide is present as a cause of death in 11% of patients with epilepsy which is significantly more than the rate of suicide in the general population of the USA (1.5%:11.6/100000) jones et al, 2003. The available literature shows that suicide rates in patients with epilepsy can vary from 0.7% to 24% jones Et al, 2003.

Suicide is often said to be common in population with epilepsy. It has been reported that suicide in epilepsy may occur at the same rate as that reported among the patients with manic-depressive illness Blumer Et al, 2002. Several attempts to ascertain the rate of suicide have been made but many have set by methodological problems Stefanello Et al, 2010. It has been said that suicide account for more than 10% of all death in people of epilepsy (compared with 1.4% in the general population) Jone Et al, 2003, although overall the data presented suggest that less than 5% of the death in people with epilepsy were due to suicide.

A study conducted by Mosaku Et al, 2006 showed that in general population, suicidal attempt in women was 2 times higher than men whereas the successful suicide rate in men was 3 times higher than women.

The same report indicated that prevalence of suicide is similar to patients under the age of 40 and higher. However, the suicidal attempt occurs usually under the age of 40 and the prevalence of suicide attempts is 10 times more than that of successful suicide. After unsuccessful suicide, the risk of next successful suicide is approximately 10% newton et al, 2008.

A study conducted by Mendex Et al, 1989 showed the rate of suicidal attempts in cases under treatment with Phenobarbital was 47% versus 4% in the general population Demirci Et al, 2007. The same study also revealed that one of the underlying factors for suicidal behaviours was a psychiatric disorder, and

also assessed the induced agents for suicidal attempts that interracial psychopathologic factors were the most important factors.

Suicidal attempts in patients with epilepsy were compared with suicidal attempts in other powerlessness disorders which showed the prevalence rates of suicidal attempts in patients with epileptic seizure and powerlessness were 30% and 7%, respectively (Kalinin, 2007). Therefore, an adverse psychosocial status was not the only reason for this high prevalence.

Suicide may occur among patients with very severe epilepsy, but also in patients that recently achieved a complete seizure freedom Daoud Et al, 2007 recent research suggest that almost a third of epileptic patients that got suicidal ideation were euthymic or had only very mild depressive symptoms.

### **2.3 Relationship between perception of epilepsy and suicidal behaviour among epilepsy patients**

The socially constructed belief about epilepsy has resulted in patients with epilepsy (PWE) being ostracized, stigmatized and misunderstood CAPLAN Et al, 2005. The social implications are serious in Madagascar; patients with epilepsy are refused burial in family grave (Baskind, 2011). In many African countries, the PWE is an outcast as African belief epilepsy is a spiritual disease. According to African belief, other possible aetiologies include witchcraft and poisoning Jacoby Et al, 2007 a combination of these traditional beliefs, poverty, lack of medical care, and inability to fulfil their social roles has negative impact on the lives of people living with epilepsy, leading to suicidal behaviours Demirci Et al, 2007.

People in sub- Sahara in Africa rely heavily on traditional healers for their health care needs and PWE have always sought care from healers before they are seen by the formal medical system Ebekwe Et al, 2007. Seizures are widely associated with witchcraft and traditional healers are seen as having power to mediate witchcraft. Some traditional healers endorse an explanation for epilepsy in which the whole family unit is seen as victim. With such expounded poor perception about the disease. Patients may commit or attempt to commit suicide Kalinin Et al, 2005.

The sociocultural belief also greatly influence the health seeking behaviour and management thereafter Kaiser Et al, 2006. It is estimated that 80% of the population of a developing countries, like Nigeria live in the rural areas and lack of access to western type hospitals but rather seek help from traditional healers, churches and others Mosaku Et al, 200. When such wrong treatment and care attempt fail,



patients develop thoughts of suicide, since some reports show that some patients don't believe that epilepsy can be treated medical d-bora et al, 2008.

Jacoby Et al, 2005 reported that social stigma leading to low self-esteem among PWE is one of the factors for suicidal ideation. They maintain that stigma extends beyond the individual to family members and other close associates, and stigmatization of a whole tribe based partially on high rates of epilepsy may cause suicide. Courtesy stigma may even extend beyond the family to include health care workers who provide services to PWE Mosaku Et al, 2006.

People with epilepsy are negative impacted not only by the need to limit their productive activities to avoid seizure-related injuries, But also by restrictions on other important social and economic functions due to epilepsy-associated stigma newton Et al, 2008. Osuntokun and odeku (2010) described patients abandoned by their wives because of nocturnal enuresis due to convulsions.jilek-Aall Et al, 2009 found PWE unwilling to discuss their disadvantage marital choices, but community representatives readily reported that female with epilepsy were viewed as poor wives and were more likely to commit suicide because of their condition.

## **CHAPTER THREE: METHODOLOGY**

### **3.0 Introduction**

This chapter presents the methodology that was used to carry out the study .study , design, study site, study population, sample size selection, selection criteria, data collection procedure, data analysis and management, quality assurance, ethical consideration, limitation of the study and dissemination of results.

### **3.1 Study design**

The researcher used a descriptive cross-sectional design that employed quantitative method. It is a cross-sectional study because data was collected from a group of respondents at a single point in time, preferably within two weeks.

### **3.2 Study site**

The study was conducted in Kyabugimbi health centre IV, Bushenyi District located in the western part of Uganda. The health centre is located about 9km off Mbarara-Ishaka road at Nyakabirizi Division Ishaka-Bushenyi municipality. It is the health centre that serves the whole population in the district and surrounding districts like Sheema, Buhweju and Rubirizi. It has OPD, IPD, maternity, dental clinic, mental health clinic, HIV clinic and an operating theatre. The health centre was suitable for the study because it served as a big number of epilepsy patients.

### **3.3 Study population**

The study population comprised of all people with epilepsy attending Kyabugimbi Health Centre IV, Bushenyi District.

### **3.4 Sample size selection.**

The researcher accessed medical records from the health centre detailing the patients with epilepsy. The researcher then conveniently sampled patients who participated in the study. Convenient sampling was chosen because the study population was not static; they were mobile and come to the health centre only for a limited period.

#### **3.4.1 Inclusion criteria**

All people with epilepsy attended at Kyabugimbi Health Centre IV Bushenyi district who were 10 years and above.

#### **3.4.2 Exclusion criteria:**

- a) Patients in Kyabugimbi health centre IV not suffering from epilepsy.

- b) Patients with epilepsy but not attending Kyabugimbi Health Centre IV.
- c) Patients who did not consent to participate in the study
- d) Epileptic patients below 10 years.

### **3.4.3 Definition of variables**

Dependent variables of the study included, suicidal tendencies among patients suffering from epilepsy.

The independent variables included the personal characteristic of respondents like sex, age, education level, tribe as well as perception of epileptic patients regarding their illness.

### **3.4.4 Research tool**

The researchers used semi-structured questionnaire with both open and close ended questions for socio-demographics, illness perception questionnaire (IPQ-R) to assess the perception of patients and MINI for suicidal ideation. The researcher administered this questionnaire by himself, he read the questions translated to the respondents and wrote down the answers against each question.

## **3.5 Data collection**

The researcher got a letter from SAHS of KIU-WC introducing him to the study area. He explained the purpose of the research to the respondents and sought their consent by asking them to sign the consent form.

The researcher and his assistants visited Kyabugimbi health centre IV in Bushenyi district to collect data, the data collectors created good working relationship with the respondents.

The respondents were guided as they filled the questionnaire and also offered clarifications required on some of the question.

### **3.5.1 Data management**

Data was obtain from respondents using questionnaires and were checked for completeness daily before losing contact with the respondents. Each questionnaire was coded and entered into SPSS.

### **3.5.2 Data analysis**

Data was analysed using SPSS. Data was assessed for normality and appropriate statics was computed. Associations were determined using chi square and ANOVA. Descriptive statistics was presented in tables.

### **3.6 Ethical considerations**

The researcher got introductory letter from the administration of SAHS of KIU-WC that sought permission to access the target population before conducting the research. The researcher explained to the respondents the study purpose and sought content from respondents before they were involved in the study.

### **3.7 Limitations of the study**

Data was collected during rainy season and rains may affect data collection in that it can lead to time wastage or destroy filled questionnaires. However, the researcher used an umbrella all the time to protect him and the questionnaires from rain.

The researcher also faced financial constraints as lot of money was needed for secretarial services and transport.

### **3.8 Dissemination of results**

The copies of the dissemination will be given to;

- a) Uganda allied health examinations board
- b) Office school of allied health sciences KIU
- c) University library KIU
- d) Supervisor
- e) Study area i.e. Kyabugimbi health centre IV
- f) Researcher

## CHAPTER FOUR: RESULTS

### 4.0 Introduction

This chapter describes the result obtained from a study aimed at assessing the relationship between illness perception and suicidal tendencies among people with epilepsy. It describes how patients with epilepsy at Kyabugimbi health centre IV, Bushenyi district preview their illness, relationship between illness perception and the rates of suicidal tendencies and suicidal ideation among epileptic patients

### 4.1 Socio-demographics of the respondents

**Table1: socio-demographics**

Variable	frequency	percentage
Gender (n=40)		
Male	26	65.0
Female	14	35.0
Age (n=40)		
10-19	10	25.0
20-29	14	35.0
30-39	10	25.0
40-49	4	10
50+	2	5.0
Tribe (n=40)		
Munyankore	33	82.5
Bakiga	3	7.5
Baganda	2	5.0
Bakonjo	2	5.0
Marital status (n=40)		
Never marries	24	60.0
Married	11	27.5

Divorced	5	12.5
Widow	1	2.5

#### Religion (n=40)

Roman catholic	21	52.0
Protestant	12	30.0
Muslim	3	7.5
Pentecostal	2	5.0
Others	2	5.0

#### Education level (n=40)

<b>No formal</b> education	8	20.0
Primary	19	47.5
Secondary	9	22.5
Tertiary	4	10.0

#### Occupation (n=40)

Professional	3	7.5
Peasant	28	70.0
Student	9	22.5

#### Living arrangement (n=40)

Mother	11	27.0
Both parents	10	25.0
Biological relative	2	5.0
Wife and children	12	30.0
Others	5	12.5

The table above show that the vast majority (82.5%) of the sample were Banyankole by tribe while other tribes were very few, Bakiga were (5.0%) and Bakonjo(5.0%).

The findings on the age show that the majority (35.0%) of the sample were in the age of 20-29 years. The age range of 10-19 years and 30-39 years were equally present by 25.0%, 10% were in the range of 40-49

years and only 5.0% were aged 50+.majority of the sample(65.0% ) were male whereas 35% were female. Roman Catholic of constituted majority of the sample 52.0% almost twice the sample of the Protestants 30.0%, Muslim were only 7.5% while Pentecostal and others were 5.0%. On the level of education, nearly half of the sample 47.7% attained secondary education, 22.5% attained primary level of education, and 20.0% did not go to school while 10.0% attained tertiary level of education. The result obtained regarding employment status show that only 7.5% of the sample was professional (70.0%) were peasants while 22.5% were students. Only 25.0% of the samples were living with both parents, 27.0% were living with their mothers, 5.0% were living with biological relatives and 12.5% lived with others.

#### 4.2 Table2: Perception of epileptic patients towards the illness

Scales	Disagree (%)	Neither (%)	Agree (%)
Temporary illness	36(90.0)	-	4(10.0)
Permanent illness	1(2.5)	2(5.0)	37(92.5)
Last for a long time	-	2(5.0)	38(95.0)
Illness will pass quickly	36(90.0)	4(10.0)	-
Life time illness	1(2.5)	2(5.0)	37(92.5)
Serious condition	-	1(2.5)	39(97.5)
Has major consequences	-	1(2.5)	39(97.5)
Has minor consequences	40(0.0)	-	-
Affect how others see me	2(5.0)	2(5.0)	36(90.0)
Has serious financial impact	-	8(20.0)	32(80.0)
Difficulties for those close to me	-	-	40(100.0)
I can control my symptoms	10(25.0)	2(5.0)	28(70.0)
I can determine the illness	5(12.5)	3(7.5)	32(80.0)
Course depends on me	5(12.5)	4(10.0)	31(77.5)
Cant affect my illness	29(72.5)	5(12.5)	6(15.0)
I influence my illness	37(92.0)	1(2.5)	2(5.0)
My actions have no effect	32(80.0)	3(7.5)	5(12.5)
Illness will improve in time	28(70.0)	4(10.0)	8(20.0)
Very little that can be done	29(72.5)	-	11(27.5)

<b>Treatment will cure my illness</b>	32(80.0)	4(10.0)	4(10.0)
<b>Negative effects available</b>	-	-	40(100.0)
<b>Treatment can control my illness</b>			40(100.0)
<b>Nothing helps my condition</b>	36(90.0)	3(7.5)	1(2.5)
<b>Puzzling condition</b>	30(75.5)	-	10(25.0)
<b>My illness is a mystery to me</b>	30(75.5)	-	10(25.0)
<b>Don't understand my illness</b>	30(75.5)	-	10(25.0)
<b>Illness makes no sense</b>	39(97.5)	1(2.5)	-
<b>Have a clear understanding of my condition</b>	3(7.5)	3(7.5)	34(85.0)
<b>Symptoms keep changing</b>	18(45.5)	-	22(55.0)
<b>Symptoms come and go</b>	13(32.5)	-	27(67.5)
<b>My illness is unpredictable</b>	26(65.0)	--	14(35.0)
<b>Cycles of better and worse</b>	13(32.5)	-	27(67.5)
<b>Depressed about my illness</b>	4(10.0)	-	36(90.0)
<b>Illness upsets me</b>	3(7.5)	-	37(92.5)
<b>Makes me feel angry</b>	3(7.5)	9(22.5)	28(70.0)
<b>Illness does not worry me</b>	38(95.0)	-	2(5.0)
<b>I feel anxious</b>	7(17.5)	4(10.0)	29(72.5)
<b>Illness makes me feel afraid</b>	6(15.0)	2(5.0)	32(80.0)

**4.3 Table 3: Suicidal ideation suicidal rates**

MINI suicide score	Frequency	Percentage (%)
<b>0 (none)</b>	<b>27</b>	<b>67.5</b>
1-8 points (low)	<b>4</b>	<b>10</b>
9-16 points (moderate)	<b>6</b>	<b>15</b>
17+ points (High)	<b>3</b>	<b>7.5</b>
<b>Total</b>	<b>40</b>	<b>100</b>



A.M.I.N.I questionnaire was used to assess the risk of suicidal tendencies among the sample and findings revealed that there was no risk of suicidal attempts among 67.5 of the sample and there was low risk among 10%, moderate risk among 15% and high risk among 7.5%.

### 4.3 Relationship between illness perception and suicidal ideation

**Table 4: comparisons between suicide categories and illness perception of epileptics**

Variable	Category	N (%)	M (SD)	F	P=Value
Temporary illness	Disagree	36(90)	0.63(1.01)	0.06	79
	Neither	-	-		
	Agree	4(10)	0.50(1.00)		
Affects how others see me	Disagree	2(5)	1.00(1.41)	0.51	60
	Neither	2(5)	-		
	Agree	36(90)	63(1.01)		
I can control my symptoms	Disagree	10(25)	40(96)	0.84	0.43
	Neither	2(5)	-		
	Agree	28(70)	75(96)		
Cant affect my illness	Disagree	29(72.5)	72(1.09)	1.12	0.33
	Neither	5(12.5)	-		
	Agree	6(15)	66(81)		
My actions have no effect	Disagree	32(8)	56(94)	0.40	0.67
	Neither	3(7.5)	66(1.15)		
	Agree	5(12.5)	1.00(1.41)		
Very little can be done	Disagree	29(72.5)	75(1.09)	1.90	0.05
	Neither	-	-		
	Agree	11(27.5)	27(64)		
My illness is a mystery to me	Disagree	30(75)	83(1.08)	5.95	0.02
	Neither	-	-		
	Agree	10(25)	-		
Don't understand my illness	Disagree	30(75)	80(1.09)	3.91	05

	Neither Agree	- 10(25)	- 10(31)		
My illness is unpredictable	Disagree Neither Agree	26(65) - 14(35)	65(1.01) - 54(1.01)	0.60	80
Illness makes me angry	Disagree Neither Agree	3(7.5) - 37(92.2)	66(57) - 62(1.03)	00	94

#### 4.4 Significant relationship

ANOVA was used to assess the relationship between illness perception and suicidal ideation, the result showed that about the length of time the illness would take most of the sample agreed that the illness was temporally and this did not have statistical significant relationship with suicidal ideation ( $F=0.06$ ,  $P=79$ ). about how people view epileptic patients in regard with the illness the findings show that most of the sample agreed that the illness affects the way people view them and this was not statistically significant and so not associated with suicidal ideation ( $F=51$ ,  $P=0.60$ ). Most of the sample agreed that they can control their symptoms however, it did not have a statistically significant association with suicidal ideation ( $F=0.84$ ,  $P=43$ ), Majority of the sample disagreed with the statement that nothing I do will affect my illness and this was not statistically Significant ( $F=1.90$ ,  $P=0.15$ ). Only few respondents agreed that the illness is a mystery to them while the majority disagreed this had a statistically significant relationship ( $F=5.79$ ,  $P=02$ ). Most of the respondent ( $F=3.91$ ,  $P=05$ ). Most of the sample disagreed that their illness is unpredictable and this did not have a significant relationship with suicidal ideation ( $F=0.60$ ,  $P=80$ ). Majority of the sample agreed that the illness makes them angry ( $F=00$ ,  $P=94$ ).

## **CHAPTER FIVE: DISCUSSION**

### **5.0 Introduction**

In this chapter the finding on perception of epileptic patients towards the illness, suicidal tendencies among epileptic patients, relationship between illness perception and suicidal tendencies are discussed. The socio-demographic of the sample will also be discussed.

### **5.1 Socio-demographics**

The study targeted respondent of 10 years and above, the results of the study show that most respondents were in the age of 20-29 years possibly because at this age bracket individuals tend to get more concerned about their future and their health is crucial to achieve their future dreams. There were more male compared to female. Concerning religion Roman Catholic constituted majority of the sample and this finding was expected since according to Uganda population census (2014) Roman Catholics were the majority. The level of education among the respondents was low as 20% didn't attain any formal education. The low level of education among the respondents could have caused the high rate of epilepsy since predisposing factors such as substance use during pregnancy, malnutrition in infants, poor knowledge of the need for antenatal care and immunization, and poor health seeking behaviours are common among the people with low education status. Regarding employment status, the result show that only 7.5% of the sample was professional and most of them were peasant, possibly most of the respondents dropped out of the schools because of stigma associated with epilepsy, low self esteem or fall sick and get injuries that affect their attendance at schools and at work. Low socio-economic status is associated with suicidal behaviours as Sonya et al, 2005. Noted that suicidal behaviour is common in epileptic patients, risk factors for suicidal ideation are associated with social and vocational disturbances, such as low economic status, lack of social support and unemployment and psychiatric co-morbidity. About living arrangement, 25% of the sample were living with both parents and this implied that they were protected especially during fits however 27% were living with only their mothers and most likely they had separated due to conflict that could have arose due to giving birth to an epileptic child. People who never married were more half followed by those who had divorced were .it is likely that stigma associated with epilepsy made it difficult for respondents to get married or stay in marriage.

## **5.2 Perceptions of patients with epilepsy**

The result of this study show epileptic patients felt like they were a burden to the people around them as all the sample agreed that the illness gives difficulty to those who are close to them. This may cause distress and social isolation among epileptic patients. Similarly, Demirci Et al, 2007 noted that, perception of epilepsy varies among individual patients, according to their local cultural beliefs. In Nigeria, epilepsy patients have a common belief that the condition is contagious hence some of them avoid public places or meeting people (Ibekwe Et al, 2007).

On the understanding of the illness, the results show that majority of the respondents agreed that they had clear understanding of their illness, while a few disagreed and majority of the sample disagreed that the illness is a mystery to them. This reflects good knowledge on the illness and consequently positive perception about the illness which could have resulted from adequate sensitization and health education given to epileptic patients by the health workers. On the consequently positive perception about the illness which could have resulted from adequate sensitization and health education given to epileptic patients by the health workers. On the contrary, Musaku Et al, 2006 observed that historically, people did not have clear understanding of epilepsy and associated it to spiritual powers.

The findings of the study show that epileptic patients of the sample disagreed that the illness can be cured; however all the sample agreed that the negative effect of the illness could be controlled. The belief that the illness cannot be cured may make the epileptic patients to think that it is witchcraft and only source of hope is traditional healers who are believed to have powers to do the “impossible”. Similarly, Jacoby (2005) noted that seizures and epilepsy are attributed to several other causative factors besides direct contagion and that the supernatural beliefs such as witchcraft are frequently cited by patients as causing seizures. Such patients versed in magical art often believe they are cursed and may therefore spend their scarce resources on traditional healers seeking care and healing (De-Boer, 2008).

## **5.3 Suicidal ideation and tendencies among epilepsy patients**

The finding revealed that the rate of suicidal ideation among the sample was high at 7.5%. Similarly Sanya Et al, 2005 noted that suicidal behaviour is common in epilepsy patients. Risk factors for suicidal ideation are associated with social and vocational disturbances, such as low economic status, lack of social support and unemployment and psychiatric co-morbidity. Suicidal behaviour is an important worldwide health problem and consists of a wide spectrum of self-destructive behaviour including suicidal ideation, suicide attempts and suicide itself (Sanya Et al 2005).

In this study, the risk of suicidal ideation was high (7.5%) compared to the findings by Preux Et al, 2005 which states that the rate of suicidal ideation in USA was (1.5%) and that suicide is an important cause of death in patients with epilepsy and the significance of epilepsy as a suicide risk factor varies in available studies. Suicide is present as a cause of death in 11% of patients with epilepsy which is significantly more than the rate of suicide in the general population of the USA (1.5;11.6/100000) Jones Et al, 2003. The available literature shows that suicide rates in patients with epilepsy can vary from 0.7% to 24% (Jones et al, 2003).

#### **5.4 Relationship between perception of epilepsy and suicidal tendencies among epileptic patients**

There was a relationship between perception of epileptic patients about their illness and suicidal ideation; majority disagreed the illness is a mystery to them and this had a statistically significant relationship with suicidal ideation ( $F=5.79$ ,  $P=0.02$ ). Most of the respondents disagreed that they don't understand their illness which had a statistically significant association with suicidal ideation ( $F=3.91$ ,  $P=0.05$ ). Most of the sample disagreed that their illness is unpredictable and this did not have a significant relationship with suicidal ideation ( $F=0.60$ ,  $P=0.80$ ). Negative perception of epileptic patients can lead to discrimination and all kinds of mistreatment which may result in suicidal ideation Caplan et al, 2005 noted that the socially constructed beliefs about epilepsy have resulted in patients with epilepsy being ostracized, stigmatized, and misunderstood. The social implications are serious as in Madagascar, patients with epilepsy are refused burial in the family grave (Baskind, 2011). In many African countries, the person with epilepsy is an outcast as Africans believe epilepsy is a spiritual disease. According to the African belief, other possible aetiologies include witchcraft and poisoning Jacoby Et al; 2007. a combination of these traditional beliefs, poverty, lack of medical care and inability to fulfil their social roles has a negative impact on the lives of people living with epilepsy, leading to suicidal behaviours (Demirci Et al, 2007).

From the study about the length of time the illness would take most of the sample agreed that the illness was temporary, the way people view the respondents in regard with the illness, control over illness their action having influence on the illness, how much can be done to improve their illness, illness being unpredictable and feeling about their illness were not statistically associated with suicidal ideation. Possibly it was because this study took a small sample size and patients already attending health care meaning they were receiving health education and so the attitude was positive.

## **5.5 Conclusion**

Perception of epileptic patients about the illness was negative, as vast majority of the sample agreed that; the illness was permanent, had major consequence on their lives, had a serious financial impact on them, gives difficulty to those who are close to them, they felt depressed about the illness and the illness could not be cured. However, majority agreed that they can determine their illness, the negative effect of the illness can be controlled, had clear understanding of the illness. The rate of suicidal ideation was high among the sample which exposes them to risk of suicidal behaviours and loss of life.

The relationship between perception and suicidal tendencies was minimal as most of the factors tested were not statistically significant.

## **5.6 Recommendation**

- The health workers of Kyabugimbi Health Centre IV should provide adequate counselling services to epileptic patients to help them cope up with challenges such as stigma.
- Epileptic patients should be screened for depression and if found positive they should be appropriately managed.
- The stake holders should create employment opportunities that will suite the conditions of epileptic patients to help engage in income generating activities to earn a living and also occupy them.
- The government should employ teachers who qualify in areas of special needs so that they can appropriately handle the children with epilepsy in school.
- The health centre should sensitize the community about epilepsy to which will help reduce on stigma attached to epilepsy.

## REFERENCE

- Caplan R., Siddarth P., Gurbani S., Hanson R., Sankar R. (2005): Depression and anxiety disorder in pediatric epilepsy.
- Charles R Newton and Hector H Garcia (2008): Epilepsy in poor regions of the world. *The Lancet*, Volume 380.
- Daoud A, AL-Safi S, Ootom S, Wahba L, Alkofahi A.(2007): Public knowledge and attitudes towards epilepsy in Jordan. *Seizure* 2007.
- De-Boer H.M., Mula M., Sander J.W. (2008): The global burden and stigma of epilepsy; *Epilepsy Behavior*.
- Demirci S, Donmez CM, Gundog ar D, Baydar CL. (2007): Public awareness of, attitudes toward, and understanding of epilepsy in Isparta, Turkey. *Epilepsy Behavior*, 2007.
- Dua T de Boer HM, Prilipko LL, Saxena S. (2006): Epilepsy Care in the world: results of an ILAE/IBE/WHO Global Campaign against Epilepsy survey.
- Eatok J., Baker G. (2007): Managing patient adherence and quality of life in epilepsy. *Neuropsychiatric Disorder Treatment*.
- Ibekwe R.C., Ojinnaka N.C., Iloeje S.O. (2007): Factors influencing the academic performance of school children with epilepsy. *Journal of tropical pediatrics*.
- Jacoby A, Austin JK. (2007): Social stigma for adults and children with epilepsy.
- Jacoby A, Snape D, Baker GA. (2005): Epilepsy and social identity: the stigma of a chronic neurological disorder. *Lancet Neurology*.
- Kaiser A., Kepp W., Asaba G., Mugisa C., Kabambe G., Rating D., and Leichsenring M. (2006): The prevalence of epilepsy follows the distribution of onchocerciasis in a west Ugandan focus. *Bulletin of the WHO*.
- Kalinin V, Polyanskiy DA. (2005): Gender and suicidality prediction in epilepsy. *Epilepsy Behavior. English Journal of Medicine*.

- Mosaku K, Fatoye., Kamolafe M., Ola B.(2006): Quality of life and associated factors among adults with epilepsy in Nigeria. International journal of psychiatric Medicine.
- Preux P-M, Dreut-Cabanac M.(2005):epidemiology and etiology ofepilepsy in sub-sharan Africa . the Lancet: Neurology. Medical Publication.
- Sanya E.O, Salami T.A.T, Goodman, Buhari o, and Araoye M.O.(2005): Perception and attitude to epilepsy among teachers in primary,secondary and tertiary educational institutions in middle belt Nigeria. Tropical Doctor, Vol.35, No.3.
- Stefanello S, Marin-Leon L, Fernandes PT, Min LL, Botega NJ. Suicidal thoughts in epilepsy: a community-based study in Brazil. Epilepsy Behavior.
- World Health Organisation, [http://www.who.int/mental\\_health/neurology/epilepsy/en/](http://www.who.int/mental_health/neurology/epilepsy/en/)



## **Appendix II: Consent Form**

**Title of the study:** Illness Perception and Suicidal Tendencies among patients with epilepsy.

**Mr. Gumisiriza Alex** a student at K.I.U-W is conducting a research on the above title.

The purpose of this study is to assess the relationship between illness perception and suicidal tendencies among people with epilepsy. The study will contribute towards creating new knowledge about the cause of suicidal tendencies and how to reduce it.

### **Study procedures**

On agreeing to participate in the study, you will be asked to answer a number of questions about yourself for demographic purposes, and several questions will be asked to assess your status on illness perception and suicidal tendencies among the patients. This is expected to take about 20 minutes of your time.

### **Risks or Discomforts**

There are minimal risks of taking part in this study. Answering some of our questions may make you uncomfortable.

Benefits of taking part in the study:

If you take part in this study there will be no direct benefits for you. However, you will help us conduct our study about the illness perception and suicidal behaviour in epilepsy which will help us to improve on the service provided to epileptic patients.

### **Confidentiality**

All your information will be used for research purposes only. Your information will be kept private. Should a decision be made of not getting involved, no penalty for that and if you don't want to answer a certain question during the study, that is also okay.

**Privacy** Anyone who is working with any of the information you give us has to sign an agreement not to share it. Your questionnaires will be coded for security purposes. All information given to us is confidentially protected and can't be accessed by any other person.

### **STATEMENT OF CONCENT**

Mr. Gumisiriza Alex has clearly explained to me the terms and conditions about the confidentiality of the information given to him on guiding of filling of the questionnaire.

These questions have been answered voluntarily without any expectation of any payment.

Signature of the participant.....date.....

### Appendix III: Questionnaire

A questionnaire about illness perception and suicidal tendencies among patients with Epilepsy:

Instructions: tick in the box against the most correct alternative.

#### SECTION A: SOCIO-DEMOGRAPHIC QUESTIONNAIRE

1. Tribe.....
2. Age.....
3. Gender
  - a) Female ☐
  - b) Male ☐
4. Marital status
  - a) Never married ☐
  - b) Married ☐
  - c) Divorced ☐
  - d) Widowed ☐
5. Religion
  - a) Roman catholic ☐
  - b) Muslim ☐
  - c) Protestant ☐
  - d) Pentecostal ☐
  - e) Others (specify).....
6. Education level
  - a) No formal education ☐
  - b) Primary education ☐
  - c) Secondary school ☐
  - d) Tertiary ☐
7. Occupation
  - a) Professional ☐
  - b) Peasant ☐
  - c) Student ☐
  - d) Others (specify).....

8. Living arrangement

- a) Mother ☐
- b) Biological distant relative ☐
- c) Wife and children ☐
- d) Siblings ☐
- e) Others (specify) ☐

**ILLNESS PERCEPTION QUESTIONNAIRE (IPQ-R)**

Name.....

Date.....

**YOUR VIEWS ABOUT YOUR ILLNESS**

Listed below are a number of symptoms that you may not have experienced since your illness. Please indicate by circling Yes or No, whether you have experienced any of these symptoms since your illness, and whether you believe that these symptoms are related to your illness.

	I have experienced this illness			This symptom is related to	
	Yes	No		Yes	No
Pain	Yes	No	_____	Yes	No
.Sore throat	Yes	No	_____	Yes	No
Nausea	Yes	No	_____	Yes	No
Breathlessness	Yes	No	_____	Yes	No
Weight loss	Yes	No	_____	Yes	No
Fatigue	Yes	No	_____	Yes	No
Stiff joints	Yes	No	_____	Yes	No
Sore eyes	Yes	No	_____	Yes	No
Wheeziness	Yes	No	_____	Yes	No
Headaches	Yes	No	_____	Yes	No

Upset stomach	Yes	No	_____	Yes	No
Sleep difficulties	Yes	No	_____	Yes	No
Dizziness	Yes	No	_____	Yes	No
Loss of strength	Yes	No	_____	Yes	No

We are interested in your own personal views of how you now see your current illness.

Please indicate how much you agree or disagree with the following statements about your illness by ticking the appropriate box.

	<b>VIEWS ABOUT YOUR ILLNESS</b>	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGRRE
IP1	My illness will last a short time					
IP2	My illness is likely to be permanent rather than temporary					
IP3	My illness will last for a long time					
IP4	This illness will pass quickly					
IP5	I expect to have this illness for the rest of my life					
IP6	My illness is serious					
IP7	My illness has major consequences on my life					
IP8	My illness does not have much effect on my life					
IP9	My illness strongly effects the way others see me					
IP10	My illness has serious financial consequences					
IP11	My illness causes difficulties for those who are close to me					
IP12	There is a lot which I can do to control my symptoms					
IP13	What I do can determine whether my illness gets better or worse					
IP14	The course of my illness depends on me					
IP15	Nothing I do will affect my illness					
IP16	I have the power to influence my illness					
IP17	My actions will have no effect on the outcome of my illness					
IP18	My illness will improve in time					
IP19	There is very little that can be done to improve my illness					
IP20	My treatment will be effective in curing my illness					
IP21	The negative effects of my illness can be prevented (avoided) by my treatment					
IP22	My treatment can control my illness					
IP23	There is nothing that can help my condition					
IP24	The symptoms of my condition are puzzling to me					

IP25	My illness is a mystery o me					
IP26	I don't understand my illness					
IP27	My illness doesn't make any sense to me					
IP28	I have a clear picture or understanding of my condition					
IP29	The symptoms of my illness change a great deal from day to day					
IP30	My symptoms come and go in cycles					
IP31	My illness is very unpredictable					
IP32	I go through cycles in which my illness gets better and worse					
IP33	I get depressed when I think about my illness					
IP34	When I think about my illness I get upset					
IP35	My illness makes me feel angry					
IP36	My illness doesn't worry me					
IP37	Having this illness makes me feel anxious					
IP38	My illness makes me feel afraid					

## SUICIDALITY

In the past month did you;

				Points
C1	suffer any accident?	NO	YES	0
	IF NOT TO C1, SKIP TO C2; IF YES, ASK C1a:			
C1a	Plan or intend to hurt yourself in that accident either passively or actively?	NO	YES	0
	IF NOT TO C1a, SKIP TO C2: IF YES, ASK C1b			
C1b	Did you intend to die as a result of this accident?	NO	YES	0
C2	Think that you would be better off dead or wish you were dead?	NO	YES	1
C3	Want to harm or to hurt or to injure yourself?	NO	YES	2
C4	Think about suicide?	NO	YES	6

IF YES, ASK ABOUT THE INTENSITY AND FREQUENCY OF THE SUICIDAL IDEATION:

Frequency	Intensity
Occasionally <input type="checkbox"/>	Mild <input type="checkbox"/>
Often <input type="checkbox"/>	Moderate <input type="checkbox"/>
Very often <input type="checkbox"/>	Severe <input type="checkbox"/>

Can you control these impulses?  
and state that you will not act  
on them while in this program?  
only score 8 points if response is NO. NO YES 8

C5	Have a suicide plan?	NO	YES	8
C6	Take any active steps to prepare to injure yourself or to prepare for a suicide attempt In which you expected or intended to die?	NO	YES	9
C7	Deliberately injure yourself without intending to kill yourself?	NO	YES	4
C8	Attempt suicide? Hoped to be rescued/ survive <input type="checkbox"/>	NO	YES	10

Expected/ intended to die ☐

**In your lifetime:**

C9 Did you ever make a suicide attempt?

NO YES 4

IS AT LEAST 1 OF THE ABOVE (EXCEPT C1) CODED YES?

IF YES, ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1- C9)  
CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS  
INDICATED IN THE DIAGNOSTIC BOX:

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT  
OF THIS PATIENT'S CURRENT AND FUTURE SUICIDE RISK IN  
THE SPACE BELOW:

NO	YES
<b>SUICIDE RISK CURRENT</b>	
1-8 Points Low	<input type="checkbox"/>
9-16 Points Moderate	<input type="checkbox"/>
≥ 17 points High	<input type="checkbox"/>

## Appendix v: Authorization Letter



**KAMPALA  
INTERNATIONAL  
UNIVERSITY**

TEACHING HOSPITAL

School of Allied Health Sciences (SAHS) Ishaka,  
P.O.BOX 71 Bushenyi,  
Tel: 0703786082/0773786082  
Email: christinekyobuhaire@gmail.com

### **OFFICE OF THE ADMINISTRATOR –SAHS**

The Incharge Kyabugimbi HC IV  
BUSHENYI DISTRICT

Dear Sir/Madam,

**SUBJECT: DATA COLLECTION**

Academic research project is an Academic requirement of every student pursuing a 3 year Diploma in Clinical Medicine & Community Health (DCM) of Kampala International University- Western Campus (KIU-WC). DCM program is housed in the School of Allied Health Sciences (SAHS).

The students have so far obtained skills in Proposal writing especially chapter one, Three & Questionnaire design. The student's topic has been approved by SAHS Research Unit and is therefore permitted to go for data collection alongside full proposal & dissertation writing. As you may discover the student is in the process of full proposal development. However, the student MUST present to you his questionnaire and his research specific objectives that he wishes to address. We as academic staff of Allied Health Sciences are extremely grateful for your support in training the young generation of Health Professionals. I therefore humbly request you to receive and allow the student **GUMISIRIZA ALEX** Reg.No. **DCM/0159/143/DU** in your health facility to carry out his research. His topic is hereby attached. Again we are very grateful for your matchless support and cooperation.

Topic: **SUICIDAL TENDENCIES AMONGST PATIENTS WITH EPILEPSY AT KYABUGIMBI HC IV, BUSHENYI DISTRICT.**

Sincerely Yours,



**Christine Kyobuhaire, Administrator- SAHS**

CC: Dean SAHS

CC: Associate Dean SAHS

CC: Coordinator, Research Unit- SAHS

CC: H.O.D Dept. Public Health

CC: H.O.D Laboratory Sciences

CC: Coordinators; TLC & DEC

*"Exploring the Heights"*