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Short communication

Descriptive characteristics of callers to an emotional support and suicide prevention helpline in Bangladesh (first five years)

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ABSTRACT

Although crisis helplines are an established method of suicide prevention, there is little research on their operation in developing countries. This paper reviews calls (N = 14,344) to the only suicide prevention hotline in Bangladesh during the first five years of the helpline's operation. Call characteristics were recorded on checklists, compiled, and analyzed. Results indicate that callers are about half male, mostly between the ages of twenty and thirty-nine, and mostly not suicidal. Callers display a wide range of reasons for calling, with relationship issues, mental illness/substance abuse, and emotions constituting the majority of calls.

1. Introduction

Suicide is considered a global public health concern, with some research suggesting the problem is more severe in Asian countries than in Western ones (e.g., Chen et al., 2011). Many developing nations lack adequate statistics regarding suicide. For instance, in Bangladesh, suicide is complex to monitor (see Arafat, 2018) as it is very likely that deaths by suicide are underreported due to stigma associated with suicide and mental illness ("Mental Health and Substance Abuse," 2006). Issues of poverty, gender discrimination, and lack of mental health resources are likely to compound the problem (see Arafat et al., 2018, for an analysis of news content regarding suicide in Bangladesh that addresses risk factors and Shah et al. (2018) for a study on demographics/risk factors of patients attending a suicide prevention clinic). A handful of studies focusing on smaller regions of the nation have reported wide variation in suicide rates in Bangladesh, ranging from 7.3 to 128.8 per 100,000 (Mashreky et al., 2013; Feroz et al., 2012; ICDDR, 2003; Hadi, 2005); these few papers constitute the bulk of research on the topic in Bangladesh.

Crisis helplines are an established method of suicide prevention globally (e.g., Kalafat et al., 2007). Given that such telephone helplines are accessible during multiple points along the path to suicidal behavior (e.g., Joiner et al., 2007), and that they can provide an opportunity for people to access help when other resources might be unavailable, they play a prominent role in suicide prevention around the world. Emerging research has begun to demonstrate the effectiveness of these services (Gould et al., 2007; Kalafat et al., 2007; King et al., 2003). While such helplines have existed for several decades in many parts of the world, in developing countries they remain a relatively new resource. Research on the usage of such helplines in South Asia, for instance, remains extremely limited, with only a few papers emerging from India on the use of crisis/emotional support helplines (Shrivastava et al., 2012, 2013). Details of the demographics of users of such lines and their reasons for calling the lines remain understudied; this lack of information may hinder the design of intervention strategies for suicide in these regions. This paper serves as a step towards filling this gap by describing the calls to Bangladesh's only crisis helpline in the first five years of its operation.

2. Method

This helpline, entitled *Kaan Pete Roi* (loosely translated from Bengali to "My Ears Wait to Listen") is the first and only emotional support helpline in Bangladesh (Khan and Tasin, 2014) and is staffed by trained volunteers. *Kaan Pete Roi* follows the model of Befrienders Worldwide, a global authority on suicide prevention: the model espouses nonjudgmental, compassionate listening, provided by trained volunteers, as a method for suicide prevention (Befrienders Worldwide, 2012) . As is the case for most such helplines, the helpline is anonymous and confidential; that is, the caller is not required to share any personal information, and volunteers do not share details of the callers with anyone outside of the organization.

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Table 1
Description of Suicidal vs. Non-Suicidal Calls.

Number of Calls	Total 14,344	Suicidal 2771	Non-Suicidal 8973	Do Not Know Explicitly 2600
Gender				
Male	7193 (50.15%)	1272 (45.90%)	4507 (50.23%)	1414 (54.38%)
Female	6843 (47.71%)	1433 (51.72%)	4405 (49.09%)	1005 (38.65%)
Don't know	308 (2.15%)	66 (2.38%)	61 (0.68%)	181 (6.96%)
Call Type				
Regular	11,493 (80.27%)	2606 (94.73%)	7993 (89.13%)	894 (34.40%)
Inappropriate	440 (3.07%)	34 (1.24%)	264 (2.94%)	142 (5.46%)
Information	1413 (9.87%)	35 (1.27%)	475 (5.30%)	903 (34.74%)
Silent	411 (2.87%)	20 (0.73%)	89 (0.99%)	302 (11.62%)
Call dropped/bad connection	561 (3.92%)	56 (2.04%)	147 (1.64%)	358 (13.77%)
Age				
0–12	178 (1.24%)	23 (0.83%)	135 (1.50%)	20 (0.77%)
13–19	3879 (27.04%)	623 (22.48%)	2877 (32.06%)	379 (14.58%)
20–39	8540 (59.54%)	1857 (67.02%)	5317 (59.26%)	1366 (52.54%)
40–65	483 (3.37%)	109 (3.93%)	268 (2.99%)	106 (4.08%)
65 +	9 (0.06%)	3 (0.11%)	3 (0.03%)	3 (0.12%)
Don't know	1255 (8.75%)	156 (5.63%)	373 (4.16%)	726 (27.92%)
Time of Day				
12a.m.–3 a.m.	1131 (7.94%)	442 (15.04%)	649 (7.28%)	40 (1.67%)
3 p.m.–6p.m.	5944 (41.72%)	1209 (41.15%)	3554 (39.86%)	1181 (49.31%)
6p.m.–9 p.m.	6125 (42.99%)	1077 (36.66%)	4056 (45.49%)	992 (41.42%)
9 p.m.–12 a.m.	1049 (7.36%)	210 (7.15%)	657 (7.37%)	182 (7.60%)
Reason for Calling				
Third Party	539 (4.55%)	51 (2.42%)	365 (4.85%)	123 (5.57%)
Discrimination (e.g. gender, racial/ethnic/religious minority)	270 (2.28%)	100 (4.75%)	151 (2.01%)	19 (0.86%)
Financial/employment/education concerns	1549 (13.08%)	410 (19.47%)	1070 (14.22%)	69 (3.12%)
Relationships	3258 (27.52%)	847 (40.22%)	2227 (29.60%)	184 (8.33%)
Just to Talk	1176 (9.93%)	50 (2.37%)	1057 (14.05%)	69 (3.12%)
Information	637 (5.38%)	11 (0.52%)	289 (3.84%)	337 (15.25%)
Mental Illness/Substance Abuse	156 (1.32%)	39 (1.85%)	100 (1.33%)	17 (0.77%)
Emotional	3420 (28.89%)	510 (24.22%)	1909 (25.38%)	1001 (45.29%)
Other	834 (7.04%)	88 (4.18%)	355 (4.72%)	391 (17.69%)

Notes: 'Emotional' refers to calls in which the caller displays strong emotions such as sadness, depression, anger, or anxiety, but the reason for these emotions is unclear from the call or not important during the call.

A few key features of the helpline are noteworthy in assisting interpretation of the results. This helpline is the first and only of its kind in the nation. Given people's lack of familiarity with the idea of telephone-based mental health services, most people in the country are still unlikely to know about the existence of the service. The helpline's operating hours are every day from 3 p.m. to 9 p.m. (which is split into two three hour shifts, from 3 p.m. to 6 p.m. and from 6 p.m. to 9 p.m.), and one late night per week (Thursday), when the helpline is open until 3a.m. (again split into two three hour shifts, from 9 p.m. −12 a.m. and 12 a.m. −3 a.m.)[1] . Suicidal risk is assessed for all calls. The majority of outreach and publicity for this helpline's services has been conducted through social media, primarily Facebook. Note that due to lack of resources, intervention (i.e. police or ambulances) does not occur for any caller. However, in acute or emergency cases, the organization follows a specific protocol to try and ensure the caller's physical safety by attempting to get in touch with nearby friends or family.

For every call received, volunteers fill out a call checklist recording demographics and basic descriptive characteristics of the calls. Volunteers are trained on usage of these checklists to increase their reliability. These checklists are then entered into an online database specifically designed to house this data. The checklists have been filled out since the helpline first began operations in April 2013 up to the present; here, data from the first five years (April 2013–April 2018) are presented.

[1] When the helpline first opened on April 28th, 2013, its operational hours were Sunday, Monday, and Tuesday from 3 p.m.–9 p.m. On July 17th, 2013, this was expanded to five days a week (Sunday – Thursday) from 3 p.m. −9 p.m. Starting on July 25th, 2013, one late night a week (Thursday) from 9 p.m. −3 a.m. was added. On April 28th, 2016 the helpline was expanded to seven days a week from 3 p.m. −9 p.m., plus the late night hours on Thursday.

3. Results and discussion

This study provides an overview of the characteristics of all calls made to *Kaan Pete Roi,* the only suicide prevention helpline in Bangladesh, in the helpline's first five years of operation (April 2013-April 2018). In the following, we briefly discuss the findings from this review. A total of 14,344 calls were received during this time period. Table 1 provides an overall description of these calls for both suicidal and non-suicidal callers, including the breakdown of age, gender, time of day of call, type of call, and reason for calling.

3.1. Suicidality of callers

Similar to research from helplines in other locations (e.g., Coveney et al., 2012), a majority of callers are not suicidal; in fact, approximately 10% of all calls are information calls, in which the caller's sole purpose of calling was to obtain information about the service. This is unsurprising given the newness of the organization in the nation. However, the actual number of suicidal calls may be greater than the twenty percent of callers who openly express that the are suicidal, given the stigma around the topic.

3.2. Time of day of calls

Calls are approximately evenly distributed across both daytime shifts, with a substantial proportion (15.30%) also occurring at night. Although some research has suggested that problems associated with nightmares, sleep disturbance, or loneliness may occur more frequently at night (e.g., Bryant, 1998), given the context of Bangladesh, in which most people live with family members, a likely reason for higher number of calls during late night hours (9 p.m. −12 a.m. and 12a.m.

−3 a.m.) may be that people then have privacy from family members and the ability to speak uninterrupted.

3.3. Demographics of callers

A majority of calls, approximately 60%, come from people in the age range of twenty to thirty-nine. We do not interpret this finding as signaling that this age range suffering from distress or suicidal thoughts to a greater degree; rather, this is likely due to the fact that a majority of outreach by the helpline occurs through social media, which may be disproportionately populated by this age range. Future work should examine whether or not other age groups are aware of the service and investigate methods of outreach that would effectively reach them.

Half of the callers are male, which is in contrast with data from crisis helplines in many other contexts where females tend to dominate the calls (e.g., Ingram et al., 2008; Meehan and Broom, 2007). This may be indicative of males having greater access to resources in Bangladesh, ranging from access to internet services that enable them to learn about the service, access to phones or finances with which to pay for calls, or simply more free time in their households.

3.4. Reasons for calling

Callers display a variety of reasons for calling, with relationship issues, emotional issues, and mental illness/substance abuse being the most frequent. Most callers display relationship problems as a reason for calling (likely related to the callers being mostly in the age range of 20–39). A limitation of recording the 'reason for calling' using a quantitative checklist is its insufficient ability to capture the calls' complexities; callers are likely to call with many overlapping presenting issues. Indeed, parsing calls apart to choose one issue may be a difficult process for volunteers. However, this data does provide initial, if crude, evidence of the variety of reasons callers have, as well as pointi ng out that the service is used by people both with and without mental illness. Qualitative follow up to understand these reasons is a natural next step indeed, little research exists attempting to understand people's experiences in moments of acute suicidality, but would be necessary for intervention design. The preliminary data presented here, as a descriptive report, can be of use to health care professionals or those seeking to understand the population that make use of mental health services in Bangladesh. Understanding these populations will inform improvement of current services and design of future ones, as well as prompt work on how to reach those who need help but are still unable to make use of existing services.

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Declaration of Competing Interest

None.

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