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# Desire for Suicide, Social Stigma and Suicidal Behavior among Females Living in Shelter Homes

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## Abstract

A disproportionately high number of adverse health outcomes, particularly mental health issues, disproportionately impact female residents of shelter homes. This study aimed to investigate suicidal thoughts and behaviors, as well as social stigma, among female residents in shelter homes. The sample comprised 200 females residing in various shelter homes in South Punjab, with the study utilizing the Suicidal Affect-Behavior-Cognition Scale (SABCS), the Okasha Suicidality Scale, and the Self-Stigma of Seeking Help (SSOSH) to measure the identified variables. Employing a descriptive and correlational research design, the study revealed significant associations among suicidal conduct, societal stigma, and the propensity to commit suicide among

females residing in shelter homes. Notably, stigma emerged as a prominent risk factor influencing both suicidal thoughts and actions. The findings of this research contribute valuable insights into the likelihood of suicide attempts among female shelter home residents and underscore the pivotal role that social stigma plays in this context. This knowledge can inform targeted interventions and support strategies for improving the mental health outcomes of this vulnerable population.

**Keywords:** Intolerance, Patience, Disparity, Seerah, Etiquettes.

## Introduction

Examining the urge for suicide, the stigma associated with it, and suicidal behavior among female residents in shelter homes was the main focus of this study. Suicide is a major issue around the world of the modern era. An international public health concern is suicide in females that living in shelter homes. There are numerous unrelated causes of suicide in our culture. Diverse cultural viewpoints and accidental causes contribute to suicide. The percentage of suicide fatalities in our culture is rising daily. Because they must deal with so many emotional, societal, and cultural issues that they are unable to express or talk about. Women in our society are particularly vulnerable to suicide attempts. Because of a variety of problems, including failed love marriages, running away from home, domestic abuse, trauma, and sexual abuse, many women in our culture are forced to live in shelter houses. Women who reside in shelter homes are stigmatized and treated differently by society, who does not view them as good women. As a result, these women suffer from mental health issues like stress and depression, which makes them consider and actually commit suicide. As a result, this research clarified how their mental health conditions' severity and complexity impact their thoughts, feelings, and actions toward suicide.

Approximately 800,000 suicide fatalities were place worldwide in 2017, translating to a death rate of 10.4 per 100,000 people (7 for women and 14 for males) **(Jiang et al., 2018).** For those aged 15 to 29 and 30 to 49, suicide continues to rank as the second and fifth most common causes of death, respectively. Worldwide, suicide is the leading cause of death for young girls between the ages of 15 and 19 **(Ajdacic-Gross et al., 2008).** According to statistics from the World Health Organization (WHO), suicide claims a life around every 40 seconds, ranking it as the thirteenth most common cause of death globally **(Krug et al., 2002).**

An international public health concern is suicide. Approximately one million people commit suicide annually, 10–20 million attempt suicide, and 50–120 million are

greatly impacted by the suicide or attempted suicide of a close friend or family member. Since 60 percent of suicides worldwide occur in Asia, at least 60 million people their experience suicide or suicidal thoughts every year (**Beautrais, 2006**). In the US, the largest age group for female suicide rates is 45 to 64 years old, while the lowest age groups are 10 to 14-year-old girls and older women 75 years and beyond. Nearly the past few eras, there has been a progressive increase in the suicide rate among women, despite the fact that it is still nearly three times lower than that of men. In the United States in 2019, there were approximately six suicide fatalities per 100,000 women. By contrast, in 2000 there were roughly four suicides for every 100,000 women (**Curtin et al., 2021**).

The highest rates of suicide among women belong to American Indians or Alaska Natives, whereas the lowest rates are found among women who identify as Hispanic, Black, or African American. While they account for the largest percentage of suicide deaths in both genders, women are the group most affected by guns. In 2020, the number of women who committed suicide with a firearm was 1.8 per 100,000, compared to 1.7 and 1.5 per 100,000 for suffocation and poisoning, respectively (**Ryan, 2023**). In general, suicide claims the lives of men more frequently than women. Nearly 80% of suicides happen in low- and middle-income nations, Southeast Asia is thought to account for 39% of all suicides in low- and middle-income nations (**Ahmed et al., 2017**) where access to resources and services makes it more difficult to identify victims and provide follow-up care (**Grendas et al., 2019**).

Since 60% of all suicides worldwide occur in Asia, at least 60 million people their experience suicide or suicidal thoughts every year. With an estimated 207 million people, Pakistan is the second most populous nation in South-East Asia and the fifth most populous nation worldwide. The largest province, Punjab, was home to 52.9% of the nation's population in the 2017 provisional census. It was followed by Sindh (23%), KPK (14.7%), Baluchistan (5.9%), FATA (2.4%), and Islamabad (0.96%). Numerous economic, sociological, and religious issues contribute to the poor state of mental health in Pakistan, which is further exacerbated by the country's small labor population. Just 0.04% of Pakistan's total health budget, or an estimated $9.31 per capita, is set up for mental health. In addition, 12.4% of the nation's population is assessed to be impoverished, while the unemployment rate is 6% (**Ali & Gul, 2018**).

Apart from the influences of culture and religion, Pakistani society still stigmatizes suicide, which contributes to the fact that suicides remain remarkably underreported because of medical-legal issues (**Naveed et al., 2017**). In terms of the overall burden of sickness and death combined, women bear a greater burden than males due to suicide behavior. Gender-related susceptibility to psychopathology and psychosocial stressors is probably the reason behind women's increased risk of engaging in suicide behavior. Programs for preventing suicide should include tactics tailored specifically for women. It is necessary to conduct more research on suicidal behavior in women, especially in developing nations (**Watve & Raju, 2015**).

Females' suicidal ideation and attempts are a serious public health problem. According to the World Health Organization here were 8.9 suicides per 100,000 people in Pakistan alone in 2019 (13.3% of males and 4.3% of females). This means that one person commits suicide every hour. Between 15 and 35 individuals die by suicide every day (**Rehman & Haque, 2020**). However, in order to effectively prevent and reduce the risk of suicidality as well as the numerous other interconnected harms and risks experienced by this extremely vulnerable population, more targeted research is required that looks at a variety of suicidality risk factors. Moreover, a large portion of recent research focuses primarily on the effects on suicide ideation. This study contributes to the field by investigating suicidal ideas and attempts.

Most clinical risk factors for suicide are comparable in the male and female populations. Despite the fact that depression is more common in women. Depression is twice as common in women as in men and is the most common risk factor for serious suicidal conduct in both sexes. The gender gap in the emergence of suicidal ideation and suicide attempts first emerged during puberty, and it appears that this gender difference is related to the earlier age of first onset of depression in women rather than the persistence or recurrence of the disorder (**Fergusson et al., 2000**).

Moreover, women are more likely than men to attempt suicide (**Canetto & Sakinofsky, 1998**) and has been recognized as a significant public health concern that needs to be detected and addressed as soon as possible (**Goldsmith et al., 2002**). According to biosocial models, suicide thoughts and behaviors can be triggered by both bad life events and negative affective states at the individual level (**Linehan, 1999**). Events that are based on risk factors, such as rape, can have a significant impact on a woman's suicidal thoughts (**Dube et al., 2001**), childhood sexual abuse (**Esposito & Clum, 2002**).

### Hypotheses of the Study:

- There would be significant correlation between social stigma and suicidal desire in females living in shelter homes.
- Social stigma would be significant predictor of suicidal behavior among females living in shelter homes.

## RESEARCH METHODOLOGY

### Research Design

The current study employed a descriptive and co-relational research design because questionnaires and interviews were the methods used to gather the data.

### Population

The target population of the current study was females who were residing in South Punjab's shelter homes.

## Sampling Technique

Because only females who have a suicidal desire would be included in the current study, a purposeful sampling strategy from non-probability sampling techniques was adopted.

## Sample

There were 200 girls in South Punjab's shelter houses, ages 20 to 40, who made up the study's overall sample size.

## Instruments:

### The Suicidal Affect-Behavior-Cognition Scale (SABCS)

"The Suicidal Affect-Behavior-Cognition Scale" (SABCS) is a psychosocial suicide risk assessment tool used to measure an individual's risk for suicide and self-harm that has demonstrated ability to predict future suicidal behavior. Individuals circle each response and sum up the results, with higher scores indicating greater risk **(MacDonald, 2015).** It consists of a series of questions that assess various aspects of suicidal thoughts and behaviors. This scale help mental health professionals better understand and evaluate a person's psychological state related to suicide risk. The scale was predictive of forthcoming suicidal behaviors and suicidality (r = .68, .73, respectively), showed convergent validity, and the SABCS-4 demonstrated clinically relevant sensitivity to change **(Harris et al., 2015).**

### The Okasha Suicidality Scale

Mental health practitioners utilize a test called "The Okasha Suicidality Scale" to evaluate a person's risk of suicide. Prof. Ahmad Okasha, a well-known psychiatrist from Egypt, created it. Given that it assesses past suicide ideation and attempts, the Okasha scale is useful in assessing suicidal ideation. Three of the four items on the Okasha Suicidality Scale deal with suicidal ideation in varying degrees of intensity. A total score ranging from 0 to 12 can be achieved by adding the points earned for each item on the ordinal scale, which is coded from 0 to 4 (never, scarcely ever, often, and often) **(Okasha et al., 1981).**

### Self-Stigma of Seeking Help (SSOSH)

"Self-Stigma of Seeking Help" (SSOSH) is a tool used to assess an individual's perception and experiences of self-stigma related to seeking mental health support. The SSOSH is a 10-item scale designed "to assess concerns about the loss in self-esteem a person would feel if they decided to seek help from a psychologist or other mental health professional" **(Vogel et al., 2006, p. 326).** The SSOSH scale typically consists of multiple-choice questions that gauge various aspects of self-stigma, such as beliefs about weakness or shame associated with seeking help, concerns about negative social consequences, and fear of being labeled or judged. The SSOSH is a scale that asks individuals to rate the degree to which they believe that getting counseling would jeopardize their self-esteem. The responses are rated from 1 (strongly disagree) to 5

(strongly agree) on a 5-point scale. Five items had their scores reversed, meaning that higher scores correspond to more self-stigma (Vogel et al., 2013).

### Analysis Plan

The data gathered for the study was analyzed using SPSS (24.00). Utilizing frequency distribution, the percentage of the demographic data was obtained. Descriptive statistics, regression analysis, and correlation were also applied to the collected data in the current study.

### Ethical Consideration

The participants received an explanation of the purpose, methodology, and reasoning behind this study. The entire scope of the potential harm to each research subject, society, and individual was shielded from this investigation. In the meanwhile, all APA-recommended ethical criteria were adhered to, including informed permission, authorization from the creators of the instrument, and confidentiality. Participants acknowledged assurances that any information they provided would be kept private and not be utilized improperly. After building a rapport, contestants received guarantees that the data they shared would be kept confidential and utilized exclusively for research. Every participant was approached individually, and no information was disclosed.

## RESULTS

After data collection was finished, SPSS (24.00) was used for statistical analysis. Many statistical techniques were used to analyze this data. The primary component of any study in any discipline is its results. The findings showed what you learned from the study, how significantly your goals and hypothesis were acknowledged or rejected in light of the findings, and which factors influenced the outcomes of the research.

**Table 1:** *Demographics Characteristics*

| Variables | F | % |
|---|---|---|
| **Age** | | |
| 16-20 | 42 | 21.0 |
| 21-25 | 43 | 21.5 |
| 26-30 | 51 | 25.5 |
| 31-35 | 36 | 18.0 |
| 36-40 | 28 | 14.0 |
| **Marital Status** | | |
| Married | 16 | 8.0 |
| Un Married | 59 | 29.5 |

| | | |
|---|---|---|
| Divorced | 82 | 41.0 |
| Separated | 32 | 16.0 |
| Widow | 11 | 5.5 |
| **Residence** | | |
| Urban | 117 | 58.5 |
| Rural | 83 | 41.5 |
| **Family System** | | |
| Joint | 176 | 88.0 |
| Nuclear | 24 | 12.0 |
| **Education** | | |
| Primary | 47 | 23.5 |
| Middle | 58 | 29.0 |
| Metric | 58 | 29.0 |
| Intermediate | 29 | 14.5 |
| Graduate | 8 | 4.0 |
| **Reason to live in Shelter home** | | |
| Love marriage | 36 | 18.0 |
| Run from home | 45 | 22.5 |
| Divorce | 43 | 21.5 |
| Domestic Violence | 38 | 19.0 |
| Family Issues | 38 | 19.0 |
| **Duration in Shelter home** | | |
| 1-6 months | 150 | 75.0 |
| 7-12 months | 50 | 25.0 |

Based on the aforementioned chart, the bulk of respondents, or 25.5% of the sample as a whole, were between the ages of 26 and 30. Two-thirds of the respondents were in the 16–20 age range, followed by 21.5% in the 21–25 age range, 18% in the 31–35 age range, and 14% in the 36–40 age range. Results indicate that 41% of defendants were widowed, 29.5% were single, 16% were separated, 8% were wedded,

and only 5.5 percent were divorced. The results showed that 41.5% of respondents were from rural areas, while 58.5% of respondents were from metropolitan areas. The table's results indicate that 88% of respondents were part of a joint family structure, while 12% were part of a nuclear family system.

The findings showed that 29% of respondents had a middle level of education, and 29% had a metric level as well. Primary level education was obtained by 23.5% of respondents, intermediate level education by 14.5%, and graduate level education was attained by just 4% of respondents. The explanation given by 22.5% of respondents is that they fled their houses to live in shelters. The reason given by 21.5% of respondents for living in shelter houses is divorce-related. 38% of the respondents overall cited domestic problems as their reason for living in shelter houses, with 18% of those cases involving love marriage. According to the results, 25% of respondents were living in shelter homes for seven to twelve months, while 75% of respondents were living there for one to six months.

**Table 2:** *Correlation Coefficient for the variables i.e., Self-Stigma of Seeking Help, Suicidal Affect-Behavior-Cognition Scale and the Okasha Suicidality Scale.*

Note: SABCS= Suicidal Affect-Behavior-Cognition Scale.
SSOS= Self-Stigma of Seeking Help.
TOSS= The Okasha Suicidality Scale.

| Variables | SOSS | SABCS | TOSS |
|---|---|---|---|
| 1 | correlation | .710** | .491** |
| | Sig. | .000 | .000 |
| | N | 200 | 200 |
| 2 | correlations | | |
| | Sig. | .674** | |
| | N | | .000 |
| | | | 200 |

Note: N=200. **p< 0.01

Table 2 shows that all the variables Self-Stigma of Seeking Help has moderately positive correlation with Suicidal Affect-Behavior-Cognition Scale and the Okasha Suicidality Scale. It means that there is moderate positive correlation between these variables. There is positive correlation between Suicidal Affect-Behavior-Cognition Scale and Self-Stigma of Seeking Help. Similarly, there is positive correlation between

the Okasha Suicidality Scale and Self-Stigma of Seeking Help. The results indicate that the increase in one variable result in increase in the other variable.

**Table 3:** *Summary of Linear Regression Analysis of The Okasha Suicidality Scale with Self-Stigma of Seeking Help*

| Predictor | $R^2$ | $\Delta R^2$ | $F$ | *Sig.* |
|---|---|---|---|---|
| SSOSH | .388 | .384 | 105.744 | .000 |

Note: SSOSH = Self-Stigma of Seeking Help.
P<0.05

**Table 4:** *Coefficients for Linear Regression Analysis The Okasha Suicidality Scale with Self-Stigma of Seeking Help*

| Model | B | SE B | $\beta$ | T | Sig |
|---|---|---|---|---|---|
| Constant | 35.272 | 2.874 | | 2.250 | |
| SOSSH | .311 | .113 | .201 | 2.758 | 0.006 |

Note: SSOSH = Self-Stigma of Seeking Help.
Predictors = TOSS (The Okasha Suicidality Scale).
P<0.05

Table 3 & 4 demonstrated the results of Multiple Regression Analysis to test significant relationship between The Okasha Suicidality Scale and Self-Stigma of Seeking Help. The results reveal that the predictor explained 38% variation. ($R^2$=.38, $F$=105.7, $p$<.05).

## Findings

The study's conclusions showed that suicidal conduct, societal stigma, and the urge to commit suicide are significantly associated and **stigma can act as a significant risk factor** for suicidal ideation and attempts. Subsequent research showed that most of the female residents of shelter homes were in the 16–30 age range. The bulk of them were from South Punjab's metropolitan areas and joint families; the majority of them were divorced or single. The majority of them only have a primary or basic education, and the main causes of their being in shelter homes were domestic abuse, divorce, and fleeing their homes.

## Discussion

Suicide is a risky and quickly rising phenomenon everywhere, even in Pakistan. Suicide rates are rising daily in Pakistan. Suicide occurs worldwide and in Pakistan among

all walks of life. Suicide is defined as "intentional death" or "self-inflicted death," which denotes a person's deliberate and willing choice of death. Our culture views living in shelter homes as being really horrible, and the societal stigmatization that these women endure leads to mental health issues in these women, which in turn causes them to consider or actually attempt suicide. This study's primary goal was to look into the suicidal behavior, social stigma, and suicide desire among female residents of South Punjabi shelter houses. Social stigma is one of the biggest issues facing Pakistani women living in shelter homes. Because these women are not seen as good in our culture and society and are instead perceived as having poor moral character, they must deal with many social injustices and lack of trust from the public. This study was carried out to find out how social stigma affects these women and how it influences suicidal feelings and actions in these women in Pakistani ethos.

In our first hypothesis we hypothesized that the presence of social stigma and suicidal desire in females living in shelter homelands are correlated, researches done in past also support our results. Social stigma and suicidal desire are positively correlated. Suicide is one of the leading causes of mortality worldwide today, with many people making fruitless attempts at it. An estimated one million people die as a result of it each year (Rogers et al., 2011). The term "par suicides" refers to the several unsuccessful attempts at suicide that people make. Although precise statistics on suicide are difficult to get, many examiners acknowledge that assessments are frequently low. Approximately half of all suicides are caused by other mental health issues, such as schizophrenia or alcoholism, or they do not include any obvious mental health issues at all, despite the fact that suicide is frequently associated with hopelessness (Maris, 2001).

Suicide takes place in a larger social context, and researchers have gathered a number of data points regarding the social contexts in which these deaths occur. For example, it was discovered that the rate of self-inflicted mortality varies by nation (Kirkcaldy et al., 2010). The rates of suicide are quite high in South Korea, Russia, Hungary, Germany, Austria, Finland, Denmark, China, and Japan—more than 20 suicides per 100,000 people annually—while they are typically low in Egypt, Mexico, Greece, and Spain—less than 5 per 100,000 people. Tight ties and beliefs could contribute to the representation of these public divisions. For example, countries with a high Catholic, Jewish, or Muslim population tend to have lower rates of suicide. Perhaps in some countries, strong prohibitions against suicide or a deeply ingrained, rigid tradition prevent many people from taking their own lives (Stack & Kposowa, 2008).

The rates at which men and women commit suicide also differ. Women attempt suicide at a rate three times higher than that of males, whereas men succeed at a rate several times faster than that of women (Claassen & Knox, 2011). Every year, 19 out of every 100,000 men worldwide commit suicide; the suicide rate among women is 4 per 100,000 (Levi et al., 2003). Though various explanations for this distinction in sexual

inclination have been put forth (**Fiori et al., 2011**). One well-known one focuses on the different tactics that men and women adopt (**Stack & Wasserman, 2009**). Men will frequently use more violent tactics, such as shooting, injuring, or hanging themselves, whilst women would typically use less violent ones, such drug abuse. In the US, around 66% of male suicides involve firearms, compared to 40% of female suicides (**Maris, 2001**).

Suicide is likewise connected with social environment and conjugal status (**You et al., 2011**). About half of the individuals who had ended it all in one review did not have any close friends or family. Still fewer had comfortable ties to guardians and other family members. In a related line, studies have shown that single people commit suicide at a higher rate than married or cohabiting individuals (**Roskar et al., 2011**).

According to the study's second premise, societal stigma needs to be a strong indicator of suicidal thoughts and actions. Our notion is supported by our findings. Suicidal behavior among females is highly predicted by social stigma. stigma as a quality that has the power to seriously dishonor, devaluing entire persons in order to contaminate and limit others. In Goffman's formulation, the characteristic is initially viewed as the source of discreditation; nevertheless, later interpretations of stigma explicitly adopt a framework for social evolution (**Goffman, 1963**). For example, Herek defines stigma is defined as the unfavorable regard, inferior standing, and general weakness that society accords to people who belong to a particular group or class or who bear a particular brand (**Herek, 2009**). Discrimination avoids situations in which people or groups are denied consistency and act differently based on their social class. Discrimination may occur in relationships at the social point, as previously mentioned (**Frost, 2011**).

The adverse impacts of shame-based trauma on women and children, discovered to be true in a variety of social groups (**Chan et al., 2008**). However, the negative effects of stigma are mostly limited to those who are stigmatized; regrettable conclusions about stigma are often contingent and overt. Below is a summary of some of the key discoveries about the impact that shame-based traumas have on those who are stigmatized. Poor physical health is a result of discrimination based on race or gender. This finding's relationship to stressors—which are linked to shame and disgrace—is evident, and these stressors eventually contribute to cardiac illnesses (**Smart-Richman et al., 2010**). Stressors based on shame are associated with a higher number of clinical visits and poor physical health, especially for minority populations. Similarly, among gender-based minorities and gay men who have HIV positive features, these stressors are associated with worse physical wellbeing and higher rates of clinical visits (**Makadon et al., 2006**).

Due to their defamatory circumstances, people from misunderstood associations exchange experiences for all purposes and reasons (**Lehmiller & Agnew, 2006**). Misjudged associations tend to feel less shame-based distress than limited pairings do on a regular basis (**Frost, 2011**). Consequently, despite the fact that these three types of intimate partnerships typically have unusual strains, there are two

problems that are universal to many underappreciated partnerships. However, there is little data on patterns of shame-related pressure in specific pairs, and there is some evidence that traumas based on shame can have a significant impact on a person's ability to fulfill their affiliation and maintain their unchanging quality (Lehmiller & Agnew, 2006).

According to the study's findings, 68% of the female participants were between the ages of 16 and 30. This is the age group in which people start families and develop social lives. People in this age range struggle to live the lives they want, and many of them encounter failure and hardships that force them into shelter homes. An additional conclusion of this study showed that 41% of the female residents of shelter homes were divorced. Our civilization is fast and drastically becoming more and more divorced, and the ratio is rising daily. Many divorce-related events have hazardous repercussions, including the possibility of death, and in these situations, women are forced to live in shelter homes in order to preserve their lives in our society.

The study's other results showed that 58% of the women living in shelters came from cities. This conclusion is accurate when considering that most people live independent lives in cities and have the guts to make decisions on their own in a variety of spheres of life, including employment, family, marriage, and social interactions. Additional research revealed that the majority of women residing in shelter homes are part of the joint family system. While this system offers numerous benefits, there are drawbacks to living in such a lifestyle. Generally speaking, joint families have a negative impact on people's independence and give them no choice but to obey and follow the decisions of the family head. This is especially true for women, who are often suppressed and lack agency, which can result in running away from home, divorce, and suicidal thoughts and actions (Fazel et al., 2011).

According to the sheltered sample of another Pakistani study nearly one-third of the women reported having considered suicide at least once in the previous week, and over half reported having been raped by an intimate partner at least once. Suicidal thoughts was substantially more common in cases of intimate relationship rape. These results add to the body of research showing a link between suicide thoughts and actions and intimate partner abuse, both physically and emotionally (Golding, 1999). In a meta-analysis of previous research looking at the connection between physical abuse by intimate partners and suicidal thoughts and actions Golding (1999) discovered that the base rates of suicidality were significantly greater in crisis situations, and the only contexts where rates were higher were psychiatric ones. When considered collectively, these studies indicate that treatment planning should always include an evaluation of suicidal thoughts in shelter settings.

The present findings corroborate earlier research emphasizing the function of depression and PTSD as mediators of suicide conduct. Suicidal ideation assessment and

identification can focus preventative efforts on acting before the ideas turn into actions. A potential avenue for intervention is highlighted by recognizing these psychological symptoms as the means by which intimate relationship rape affects suicidality. Consequently, co-occurring suicidal ideation may be lessened by treatments for depression and PTSD that have empirical backing. The findings of this study may help in developing suitable procedures and strategies for providing this vulnerable population with more complete health care services. However, as the WHO notes, there are other cultural variables that contribute to suicide tendencies, resulting in variations throughout ethnic groups (**Krug et al., 2002**). Thus, in order to lessen this worldwide public health risk, suicide prevention initiatives must be culturally sensitive and involve the work of multidisciplinary teams, comprising primary healthcare providers, researchers, and government representatives.

**Jones and Pridemore (2016)** investigated the association between the lodging emergency and the incidence of explicit suicide by race and sex in 142 major metropolitan statistical regions in the United States between 2005 and 2009. The study found that variations in the severity of the lodging emergency at the metropolitan level did not significantly impact suicide rates at the metropolitan level, and that the invalid effects held true for several explicitly racially and sexually explicit groups. The surprising conclusion that none of the dependent factors had any invalid effects contradicted previous research on the link between suicide and difficult financial circumstances, suggesting that while financial hardships may be associated with a higher risk of suicide, pressure from rental contracts may not be. According to what the authors assumed, there was no impact of the lodging contract pressure file on the total, sex-, and race-explicit suicide rates at the metropolitan level, despite the fact that the lodging emergency was a major catalyst for the recent financial crisis and may have been linked to increased suicide rates or individual suicides.

According to published data, 81% of the women residing in shelter homes are educated from primary to metric levels. Low levels of education can occasionally be a barrier to making wise decisions in a variety of areas of life, including marriage, family, work, and social interactions. Typically, these people base their decisions more on feelings than on knowledge and logic, which causes them to suffer from a variety of issues and occasionally force them to live in shelter homes as a result of their choices. Additional research indicates that the primary causes of domestic violence, divorce, and running away from home among women residing in shelter houses in South Punjab (**Carver, 2010**).

Further research reveals a positive relationship between suicidal conduct, suicidality, and the stigma associated with getting treatment. This validates our theory that there is a positive correlation between these factors, suggesting that these problems are experienced by females residing in shelter families. It also shows how these variables relate to one another. All of these problems affect the female inmates of shelter homes in South Punjab (**Bearman et al., 2009**).

Suicidal ideation content may be further examined in order to learn more about the psychological processes that underlie these correlations. Suicidal thoughts, for instance, may be the result of a wish to end unbearable psychological suffering (**Jacobs et al., 1999**). There are some noteworthy limitations to the current investigation. Initially, a broad screening question was employed in this study to screen for suicidal ideation. Subsequent research endeavors ought to contemplate evaluating suicidal ideation by more comprehensive inquiries that appraise aspects like regularity, intensity, and substance. Second, inferences regarding the causal nature of the interrelationships between the phenomena cannot be made because the study is cross-sectional in character. Thirdly, it's a sheltered sample. Using a sheltered sample has the benefit of including greater base rates of more serious types of violence, such as rape associated to IPV (intimate partner violence) etc.

## Conclusion

The study concludes that the female residents of shelter homes face a multitude of social and personal challenges that contribute to mental health issues, such as suicidal thoughts and behaviors. Additionally, the social stigma that surrounds these issues makes it difficult for these women to integrate into society. Policies for the prevention of mental health issues among them must be created, and the public must be educated to accept them as valuable members of society rather than stigmatizing them.

## Recommendation

1. Research on the comparative cultures of various societies, such as those in Punjab and Sindh, is necessary.
2. A longitudinal study should be carried out to examine the impacts of a shelter-style household.
3. Independent research on the suicidal behavior, stigmatization, and suicidality among these ladies ought to be conducted.

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