

**EXPLORATION OF PREFERENCES FOR SUPPORT AND COPING STRATEGIES
FOLLOWING SUICIDE ATTEMPT AMONG ADOLESCENTS IN LIMPOPO
CAPRICORN DISTRICT**

by

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A mini-dissertation

Submitted in partial fulfilment of the requirements for the degree of

Master of Arts in Clinical Psychology

in the

Faculty of Humanities

(School of Social Sciences)

at the

University of Limpopo

(Turfloop Campus)

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2013

DEDICATION

THIS MATERIAL IS DEDICATED TO MY PARENTS

Mr. M.J. & Mrs. M.R. Rasodi

Who taught me discipline,

Humbleness and to be

responsible for my actions

and never to give up on

what I believe in.

ACKNOWLEDGEMENT

It has been a difficult and challenging times throughout the years; there were times when I wanted to quit, but Thanks to all those who made me focus and for that I wish to express my sincere appreciation and gratitude to the following people:

Prof. T-A.B. Mashego, for her all round skills in supervising me through the years and not giving up on me, her emotional support and patience is really something to draw a lot from. Her knowledge in this field and expertise always makes an impact.

My children, Mashadi and Katlego, the courage and energy I drew from you is amazing, with you in my mind I could move mountains. We couldn't spend much time together but I always know you loved me and I love you lots and thank you.

My parents, my late father Matome Joel Rasodi who taught me discipline and to be responsible for my actions and never to give up on striving for academic achievement, and always to strive for what I want no matter what. This has really helped me a lot to make it in life and I thank you for everything you did for me. My mother Mashadi Rosinah Rasodi believing and trusting in me and supporting me throughout the years without fail. It has been difficult years for us but now the rewards are greater. Thank you Mma Rasodi and I really love you all and have a special place in my heart.

My younger brother, Thabiso for always encouraging me not to give up on the research.

Special thanks to Mmmaditshikeng Flora Makwela for helping with printing of articles, and always been by my side through thick and thin. The love and support is amazing. You're special indeed.

Caroline Makwela you've been there throughout the journey, for your support and advises has enriched me, thank you

Lucas Morula Mokoeana for always encouraging me and his wise words of wisdom, and Thomas Khota for helping me with the necessary resources.

To all those who helped with data collection from all the hospitals involved, thank you for the efforts and time sacrificed

Great thanks to Andrew and Victor Netshidzivhani for helping with the data analysis.

And finally to the Almighty for driving me to where I am and without fail

DECLARATION

I declare that this dissertation hereby submitted by me to the University of Limpopo for the degree of Master of Arts in Clinical Psychology, has not been submitted before either at this university or at any other institution.

I also declare that it is my own work in all respect, and that all material has been acknowledged accordingly.

Signed at _____ on this day _____ of _____ 20 _____

Full names _____

Signature _____

Ngoako Matshukgane Rasodi

ABSTRACT

The aim of the study was to explore preference for support and the different coping strategies that are employed by adolescents' following suicide attempt in Limpopo Capricorn district. The sample comprised of 81 adolescents of both male and female who were admitted at public hospitals around the district and referred to psychology department for intervention. Using purposive sampling, data was collected through the use of a questionnaire which was divided into 1. Demographical information, 2. Multidimensional scale of perceived social support (MSPSS), 3. Ways of coping scale (WCS) which consisted of three subscales: active-cognitive, active-behavioural and avoidance strategies. Most participants reported not having support. Participants who expressed support from family, friends and significant others indicated that although family, friends and significant others were equally perceived to be an important source of support, family was more inclined to be the most preferred source of support. This preference differed according to gender as females perceived family to be the most important source followed by friends and lastly significant others, while males order of preference was friends followed by significant others and lastly family; indicating that males are more inclined to have their friends as the most preferred source of support than females. The findings of the study also indicated that suicidal adolescents used avoidance strategies followed by cognitive and lastly behavioural strategies. A significant relationship was established in the use cognitive strategies and coping by adolescents who viewed their support structures as supportive and also with active behavioural strategies. On avoidance strategies there was no significant relationship established highlighting the possibility that those adolescents who feel that they have no support use avoidance as a coping strategy. The recommendations made on the results from this study are that research in suicide should be a continuous process that keeps up with the changing family, political and cultural dynamics of our society. This is crucial since what is considered crucial support today for the adolescent, might not necessarily be viewed as relevant support for the adolescent in the future.

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CHAPTER I

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Suicide has become a public health concern said to be a major cause of death around the world. It is a third-leading cause of death for adolescents with an estimated 877 000 lives lost each year worldwide (Braquehais, Oquendo, Baca-Garcia & Sher, 2009). It thus becomes important that clinicians and researchers considered suicide to be a risky behaviour and make its prevention become a priority.

According to (Geller, 2003) psychiatric illness is a major contributing factor, and more than 90% of suicides meet the criteria for Diagnostic and Statistical Manual of Mental Disorder Fourth Edition Text Revision (DSM-IV-TR) i.e. major depressive disorder and bipolar disorder (Diagnostic and Statistical Manual of Mental Disorders, 2000). Of these disorders up to 60% were associated with suicide among adolescents. Other contextual factors can be viewed as predictors to suicide behaviour such as economic condition, lack of parental support, alcohol, sexual abuse to mention a few (McKeown, Cuffe & Schultz, 2006). These factors require much attention and perhaps by understanding them, there can be an effective intervention in preventing and treating suicide among these young adults.

Research studies have shown that the rate for suicide attempts is higher in boys than in girls (Centres for Disease Control and Prevention, 2003). This shows that adolescents are more likely to kill themselves and are accounting for an increased percentage of suicides.

Although risky behaviour is becoming common among adolescents, they are seen to be significantly less satisfied with the quality of social support they receive in whatever emotional turmoil they may be going through, from either friends, family or significant others (D'Attilio, Campbell, Lubold, Jacobson, Richard, 1992). Adolescence is a complex stage of development wherein peer advice is very important. It is thus important to note teenager's preference for support during this stage in order to avert suicide attempts during times of need for emotional support. Emotional need during suicide attempt require a close confidante to talk to, and peer group seems to be a much preferred choice for discussions during adolescence. It is thus important to determine adolescents preferred choice of support to avert suicide attempts.

1.2 STATEMENT OF THE PROBLEM

Suicide is a worldwide mental health problem and public health establishments and the mental health practitioners concern about suicide has risen drastically so as to try and reduce if not alleviate the risks associated with suicide or suicide attempt.

Adolescent suicide is a critical problem as it highlights how these young adults might be coping and managing their problems. As adolescents go through the developmental stage, they come across difficult and frustrating situations which might make them have momentary thoughts of harming themselves as they see no other way and they lack the means to cope with the stressors, These self- harming acts are never normal behaviours but only reflect pathological state of mind which need to be managed holistically, i.e. socially and emotionally through family, friends and/or significant others giving different kinds of support, psychologically through therapy and physiologically by medication .

According to Rassool (2000), South Africa has one of the highest suicide rates in the world, which can be seen as a result of unemployment, the use of cocaine, crack and heroin, and the incidence of HIV/AIDS. Again these young adults are still fragile and vulnerable that they may seek approval from their peers. They are therefore more easily influenced and once they are rejected they may either become substance abusers, rapist, or thieves so as to boost their self- esteem. These adolescents are most likely to have low-self esteem, unable to initiate things, which eventually results in depression.

According to Donson (2009) in 2008, there were 2904 cases of suicide recorded in South Africa and the youngest cases were in the 10- 14 age bracket with 40 cases and the most recorded was 479 cases in the 25-29 age bracket. In realizing that it is a complex problem; the researcher wanted to explore some of the dimensions involved in adolescents who have attempted suicide and look at their preference for support and their ways of coping and thereby trying to reduce the level of re-attempting and thereby the total number of completed suicide by making these adolescents aware of available support structures, and the importance of confiding in someone they trust.

Who the adolescent prefers to talk to about their psychological and emotional difficulties is an important point of departure towards assisting them with their problem. They need to feel comfortable to discuss their problems. This has to be someone they know and consider as a friend or a peer. This is viewed as an important cornerstone of the adolescent suicide, as adolescents spend extended time with their friends or peers either at school or home.

1.3. AIM OF THE STUDY

The aim of the study is to explore preferences for support system and identify the different coping strategies employed by adolescents following suicide attempt.

1.4. OBJECTIVES OF THE STUDY

- 1 To identify adolescents preferred choice of support following suicide attempt.
- 2 To outline the reasons for adolescents preferred choice of support following suicide attempt
- 3 To explore various coping strategies used by adolescents and its relationship to the preferred kind of support
- 4 To explore gender difference in terms of preferred support system

1.5. HYPOTHESES

Hypotheses 1: Adolescents who have attempted suicide prefer their peers for emotional support to other forms of support

Hypotheses 2: Adolescents who have attempted suicide and perceive their environment to be supportive cope more than the adolescents who do not perceive their environment as supportive.

Hypotheses 3: Adolescents use different coping strategies following suicide attempt and this differs according to the support they prefer to have.

1.6. SIGNIFICANCE OF THE STUDY

Suicide has reached an alarming proportion among adolescents, who are at this stage the most vulnerable to risk taking behaviours. The present research aims at exploring suicide attempts and preferred choice of support among adolescents. In most cases adolescent tend to have a

need for sense of belonging, they want to feel good and accepted by their peers and this could influence their choices. Their choice of a support system in this regard maybe easily influenced, in terms of decision making. The present research is aimed at looking closely at what influences the decision to attempt suicide among adolescents and who they prefer as a confidante as a way to inform intervention in suicide attempts and prevention.

1.7. OPERATIONAL DEFINITIONS

1.7.1. Suicide

The term Suicide is an act or engagement whereby an individual takes their life through engaging in a self-destruction mode by either hanging, drug overdose or gunshot, etc. This operational definition is also aligned with the definition as highlighted in literature; a suicidal act is any act of deliberate self damage which the person committing the act could not be sure of surviving (Stengel, 1970). According to Rosenberg, Davidson, Smith, Berman, Buzbee, Gantner, Gay, Moore-Lewis, Mills, and Murray (1988) they explain suicide as death arising from an act inflicted upon oneself with the intent to kill oneself.

Other concepts of suicidal behaviour derive from just thinking about ending one's life, in which one come up with a plan to commit the act, obtaining the means to do so, attempting to kill one self, to finally carrying out the act ("completed suicide").

Joe and Marcus (2003), mention that previous suicide attempt is the most significant determinant of whether an adolescent will complete suicide. Many adolescents who kill themselves have previously engaged in suicidal behaviour which, is usually preceded by suicidal ideation.

Adolescents are much less likely than adults to commit suicide; however, they are as likely as

adults to think about suicide and to attempt it (Kimmel & Weiner, 1995). It is during this life stage (adolescence) when these young adults are capable of designing and carrying out a suicide plan because of their cognitive maturity. Therefore in children younger than 12 years, cognitive immaturity becomes a protective factor which prevents them from committing suicide (Sadock & Sadock, 2003). This emphasize that the ability to commit suicide can be seen with an age appropriate towards executing a plan.

Research studies showed that up to 40% of attempters will continue to make more suicide attempts, moreover up to 10 to 14% die as a result of suicide (Garland & Zigler, 1993). Other research studies have shown that suicide attempters were six times more likely to make other suicide attempt as compared to non suicides (Pfeffer, Werman & Hurt, 1991). Therefore, previous attempts by these young adults should be carefully looked at, as they are a good indicator for future attempts, especially if no intervention is obtained after the first attempt.

The following concepts will give a clear understanding on suicidal behaviour manifested by adolescents.

1.7.2. Suicide attempt

The terms in this document means that an individual has made means and tried to kill themselves through acts of deliberate self harm.

Mashego, Peltzer and Madu (2003), referred to suicidal attempt as “an act, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences”.

1.7.3. Suicidal thoughts and threats

Suicidal threats or statements as made by adolescents often express a negative attitude towards life. Statements like that are concluded by most as a need for attention and often ignored.

Research studies revealed that understanding the thoughts of people who commit suicide is rather difficult, unless they made clear statements before their death, their ideation or left a note (Rosenberg, et al., 1988). The fact of the matter is that suicide does not occur without warning and that adolescents who completed suicide have either talked about it or given many clues regarding their suicidal intentions. In their study, Zimmerman and Asnis (1995), stressed that such statements should be taken into consideration as one may dismiss the behaviour of a person who is genuinely anxious and potentially suicidal.

1.7.4. Support

Any action or behaviour that the adolescent views as an act of helping them and that they feel to be able to deal with the problematic situation that they are faced with as a result of the help they are receiving from specific individual within their environment.

1.7.5. Social support

Social support involves the people in the immediate environment of the adolescent that the adolescent view as giving help or support to them. This would be the people that are viewed as giving support in the adolescent's environment.

1.7.6. Coping

Is the ability to deal with problems that are affecting the adolescent psychologically, emotionally and physically in a way that they feel to be in control of the situation and the

environment that they find themselves in and are able to live and manage the stressors caused by the problems.

1.7.7. Adolescent

Adolescents are individuals who are between the ages of thirteen (13) and twenty (20) years, being admitted to public hospitals in the Capricorn district of Limpopo after attempting suicide and referred to psychology unit for psychological intervention.

1.8. Scope of the study

The study will be based on adolescents in the Limpopo Province, Capricorn District. The reason for choosing Capricorn is that it provides a clear socio economic demarcation as Polokwane caters for mostly middle to higher income group and areas like Seshego and Mankweng provide lower to middle class income group and the rest of the district is generally low income area.

This research study will be focusing on adolescents who have already attempted suicide. The study further starts by investigating the most preferred method of support system by these adolescents and thus looking into coping strategies after they have attempted suicide.

The adolescents will have been referred for psychological intervention in general public hospitals as out-patients after being discharged in the Capricorn District public hospital

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter looks at the concept of suicide and its definition. It highlights the prevalence of suicide according to the world health organisation (WHO) and that of South Africa, and Limpopo including gender differences. Risk factors associated with suicide and the family dynamics are discussed. Difficulties of adolescents' stage and the psychosocial issues e.g. substance abuse, will be dealt with within this chapter.

2.2 Definition of suicide

The term "suicide" refers to the human act of self inflicting one's own life resulting in death from intentional self harm, including poisoning, hanging or suffocation, drowning, use of a firearm, explosive materials, sharp or blunt objects, motor vehicle crashes and other unspecified means (Caldwell, Jorm & Dear 2004). The concept suicide suggests direct reference to violence and aggressiveness expressed by these individuals, which is in a form of killing one self. Other concepts of suicidal behaviour derive from just thinking about ending one's life, in which one may come up with a plan to commit the act, obtaining the means to do so, attempting to kill one self, to finally carrying out the act ("completed suicide"). The following concepts will give a clear understanding on suicidal behaviour manifested by adolescents.

2.2.1 Suicide ideation

Rutter (1995) emphasized that suicidal ideation are thoughts, ideas, ramifications or fantasies about committing suicide or overt verbal threats to kill oneself. Suicidal ideation is one of the indicators of suicidal behaviour and is common in adolescents especially when the depressive disorder is severe (Sadock & Sadock, 2003). Barlow and Durand (1995), states that the first step down the dangerous road to suicide is thinking about it. This shows that adolescents being at a depressive state of mind not only put them at risk, but could be a precipitating factor in executing the thought to commit suicide.

According to Kovacs, Goldstone, and Gatsonis (1993) a number of adolescents who thought about killing themselves actually attempted it. Various studies have attempted to determine the rate of attempted suicide compared to completed suicide. According to Sadock and Sadock (2003), it is estimated that the rate of suicide attempts to completed suicide in young adults is 15 times greater than suicide completion. This shows that attempted suicide outnumbers completed suicides.

According to Krall (1989), suicide ideation is regarded as a desperate warning involving definite risks. He further indicates that it is difficult to differentiate between suicide attempt that is meant as a warning and the one meant to be successful. It is therefore essential that, all forms of adolescent self destructive behaviours be taken into consideration and be attend to.

2.2.2 Suicide attempt

Mashego, Peltzer, and Madu (2003), referred to suicidal attempt as “an act, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or

generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences”.

Joe and Marcus (2003), mention that previous suicide attempt is the most significant determinant of whether an adolescent will complete suicide. Many adolescents who kill themselves have previously engaged in suicidal behaviour which, is usually preceded by suicidal ideation. According to Goldsmith, Pellmar, Kleinman and Bunney (2002) suicide attempts increased from 7.3% to 8.8% in the past five years.

A study conducted among 130 adolescents between the ages of 13-18 years who were admitted in a psychiatric hospital following suicide attempt, revealed that 6% had made another suicide attempt within the next month, while 10% had re-attempted suicide during the subsequent three months (Spirito, Plummer, Gispert, Levy, Kurkjian, Lewander, Hagberg, & Devost. 1992). This forms the basis on which adolescents needs to be made aware of the support structures available to them and to know what to do in a stressful situation.

2.2.3 Suicidal thoughts and threats

Suicidal adolescents often make verbal threats that are seen as seeking attention and are usually ignored as a result. According to Juon, Ja Nam and Ensminger (1994), there is a myth that people who talk or threaten about committing suicide, will not complete it. Zimmerman and Asnis (1995) emphasised that these statements must be genuinely considered as one may dismiss the behaviour of an individual who is genuinely suicidal.

The best predictor for suicidal individuals are only those statements that they made as they are genuinely anxious and suicidal; as it is not easy to tell the specific individual who will commit and who will not commit suicide (Fallon, Laporta, Fadden & Graham-Hole, 1993).

This means that most people who have completed or attempted suicide have made their intentions known to somebody. The dismissal of such statements by who may be viewed as a confidante by the adolescent makes it even harder for them to cope and the problems escalates and finally they see no way out except to take their life.

Impulsiveness and lack of experience in dealing with stressful issues, contributes to the high risk of suicide in adolescents (Langlois & Morrison, 2002). It is important to note that suicide can be a risk taking behaviour which, can be expressed by poor impulsive decision making.

2.3 SUICIDE PREVALENCE

In the last few decades there has seen an increase in suicide to the rate of 60% and according to Schlebusch (Health24, 2011) World Health Organisation (WHO) estimates that approximately 1million people die from suicide per year and this figure may reach 1.5 million by 2020. Suicide rate for the world as a whole is estimated at 11.6 per 1000,000 inhabitants, and this amounts to 1.4% of the total mortality and 15% of injury mortality. Even though literature shows that males are succeeding in completed suicide to females, predominance of males over females has been relatively constant (3.6:1)

Househam, (2010) further states that for the last fifteen years, South Africa has experienced similar trends in chronic disease prevalence, and this forms an increasing component of the South African global burden of diseases. WHO estimates the burden of diseases from non-communicable disease in South Africa as two to three times higher than that in developed countries. Burden of non-communicable disease is rising in rural communities and it affects a disproportionate number of poor people in urban communities.

In South Africa, suicide range from 11.5 per 100,000 to a high of 25 per 100,000 in males, with an estimated fatal to non-fatal ratio of 1:20. About 11% of all non natural deaths are suicide related for all age groups. On average 9.5% of non-natural deaths in young people are due to suicide which is as high as adult suicide rate. Generally there are 20 or more attempts every hour and this is predominantly by males at 5:1 and non-fatal are predominantly female at 3:1.

According to Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana, Norman, Pieterse, and Schneider (2000) in Limpopo 89% of its population lives in non-urban areas, with 52.2% of the population being females and just over 40% of the population were younger than 15 years. In terms of the mortality profile in 2000 a total of 53 815 deaths were estimated for Limpopo and of those 26 404 (49.1%) were females and 27 410 (50.9%) were males. In terms of the causes of death, half of the deaths were group I causes which included HIV/AIDS, while 40% group II causes and 10% were injuries. Injury related deaths were very high in male adolescents and young adult men.

2.3.1 Premature Mortality in Limpopo

Bradshaw et al., (2000), states that leading causes of premature mortality was HIV/AIDS and it accounted for a third of the total years of life lost (YLL), 40% females and 28% males.

Diarrhoeal diseases were second leading cause of premature mortality among persons (7% of YLL). Injuries accounted for 7% and 19% of all YLL in females and males respectively. The top four causes of premature mortality accounted for over half of the total YLL, (51.4%) being HIV/AIDS, homicide, diarrhoeal and lower respiratory infections.

Suicide is ranked twelfth in males and accounted for 1.5% with 8686 YLL, and it was ranked

nineteenth (19) in persons (including both males and females) and accounted for 1.0% with 11 049 YLL. Females did not make the top twenty since they mostly only end with attempted suicide unlike males whereby because of the harsh methods used they end up killing themselves. For children less than fifteen (15) years leading cause of death in boys were road traffic accident, while for girls leading cause of death was HIV/AIDS. In males 5-14 years, suicide made 2.2% of the total population and above 14 years, from 15 years, suicide was ranked sixth highest and contributed 2.7% of the total population (Bradshaw et. al., 2000).

2.3.2 Gender differences

There are gender differences in adolescent's suicidal behaviour (Beautrais 2002); this means that suicide is prevalent in both genders. Barlow and Durand (1995) showed that males are observed to commit suicide more than their female counterparts. (Moller-Leimkuhler, 2003; Nevid, Rathus & Greene 1997) in their study expressed that, males in particular prefer far more violent methods such as guns and hanging whereas females would rely on less violent options like drug overdose and carbon monoxide which results in hospitalization when attempting suicide, this view is also held by Nevid, Rathus and Greene (1997) where they found females to be three times more likely than males to attempt suicide but males are more likely to succeed as they use more lethal means. Therefore males are more likely to die as a result of suicide, while females are likely to survive with severe bodily harm. Also it is observable that male suicidal adolescents always succeed in executing the plan of killing themselves unlike female suicidal adolescents.

Reasons why males engage in this risky behaviour can be complex. Research work by Moller-leimkuhler (2003) evidently showed that traditional masculinity is a significant risk factor for male vulnerability resulting into maladaptive coping strategies such as emotional inexpressiveness and reluctance to seek help. That is the manner in which males are

traditionally raised within society and that's how they deal with interpersonal issues and this appears to differ with that of their counterparts.

2.3.3 Suicide in South Africa

Pillay and Wassenaar (1997) stipulates that adolescent suicidal behaviour in South Africa is prevalent as it is in Western countries. Hence, the need to approach suicide behaviour as a mental illness should receive attention from therapist and researchers alike. In their study, Flisher and Parry (1994) revealed that close to 1.3% deaths in this country were as a result of suicide. They further indicated that suicide mortality rate was higher among whites, followed by Asians, coloureds and then blacks.

In adolescent's era, suicide attempts appear to be higher than that of completed suicides. In a study conducted in the Limpopo Province, the rate of attempted suicide among secondary school pupils was 17% for boys and 13% for girls of these 10.3% were admitted to general hospitals, whereas 17.7% of admissions were patients referred due to attempted suicide (Schlebusch, 1985).

A lot of "accidental" deaths such as those caused by guns, car accidents, and drug overdoses are thought to be suicides. It was therefore, suggested that the reason why adolescent suicides may be underreported is due to physicians and families covering up the true cause of death in an attempt to avoid the stigma that is often placed on the families of these adolescents.

Durkheim (1876) observed that suicide has a seasonal variation, which takes its peak in spring and summer. The same findings were found to be significant to most South Africans. In their study, Flisher, Parry, Bradshaw and Juritz (1997), found that suicide among adolescents reach its peak around spring or summer for all race and both genders. However

the suicide rate was found to be more prevalent among blacks and coloured South Africans (Flisher et al., 1997). This according to Mashego as cited in Masa: Turf Update (2004) is a season when matriculates obtain their exam results. She further indicated that suicide becomes increasingly high during this period, especially after the announcement of the results. This view is also held by Schlebusch (Health24, 2011) that most variations in time, day, and year happens mostly on weekends and on weekdays it is during 7am-8pm. The seasonal variations take it peak during exams at the end of the year. This became evident when one central lifeline call centre received suicide calls at the rate of 2500 calls per minute, which was higher than the previous years (Mashego as cited in MASA: Turf Update 2004)

2.4 RISK FACTORS ASSOCIATED WITH SUICIDE

2.4.1. Strained family relationships and stress

Family problems are present in about 75% of adolescent's suicide attempters; these problems may include family instability and conflict, parental abuse, neglect, rejection or disciplinary inconsistency. With these problems faced by the adolescents, stress surfaces this as will be preceded by a traumatic event that produces extreme stress or anxiety. This may be because of a break-up of a relationship with girlfriend or boyfriend, unwanted pregnancy, getting arrested or getting into trouble at school. Most will attempt or commit suicide within hours of expecting trouble or getting into trouble. Most adolescents seem to be able to cope with stressful events, but suicidal adolescents often become filled with anxiety and dread that they see no alternative to suicide (Nevid, et al., 1997). Such state of mind makes the adolescent develop less trust of his/her environment and thus become vulnerable towards making negative decisions that could have been averted. It is thus important to find out the preferred person they would rather talk to, in order for them to be ready to relook at the choice that they could make impulsively without thinking or checking with anyone.

2.4.2. Parental rearing and suicide

In a family environment where parenting is warm and high in control, adolescents tend to grow up being responsible, high self esteem and with emotional stability. Parenting significantly influences externalizing behaviour among adolescents. That is failure in providing that may result in risky behaviour (engaging in drugs) and psychological maladjustment (internalizing stress) later in life thereby making it more difficult to deal with psychosocial issues. Studies have shown that low parental monitoring is strongly associated with increased risk of suicidal ideation and attempts. Sharma and Sandhu (2006) on the other hand emphasized that the pattern of harsh, hostile relationship between parents and children leads to development and intensification of antisocial behaviour.

Cicchetti and Toth (1995) pointed that parenting that is inconsistent, with harsh discipline, inadequate parental monitoring, parent child conflict and low affective bonding can be a risk factor for adolescent behaviour problem, which may result in suicide. Research indicated that four broad parenting styles are associated with differential outcomes for adolescents and each of the styles entails varying degrees of parental warmth, control and involvement.

Authoritative parenting is characterized by high control and high warmth. In this parenting style, parents are responsive to the reasonable needs and desires of the child, but also make maturity demands appropriate to the child's age of development. Parents sets clear and well defined expectations and rules regarding the school performance, participation in household chores, and interpersonal behaviour with family members, peers, adults and authority figures. This was associated with positive outcomes such as positive academic achievement, social responsibility and positive peer relationships. As adolescents they will be able to deal with interpersonal crisis and life stressful events.

Authoritarian parenting is characterized by high control and low warmth. Parents are observed to be directive and over controlling and require unquestioning obedience to parental authority. If a child deviates from parental rules, punishment becomes harsh and is often physical. In this parenting children rarely participates in making choices and decisions, and do not learn from their own mistakes, and bad choices and decisions they made.

Permissive parenting is more characterized by high warmth and low control. This parenting provides adolescents with little structure and discipline. Parents, make few demands for mature behaviour, and tolerate even those impulses in adolescents that meet with societal disapproval.

Neglectful parenting style is characterized by low warmth and low control. Parents in this regard offer little affection or discipline, and parents show little concern in their parenting. Therefore, neglectful parents are neither responsive to reasonable needs nor demanding of responsible, age appropriate behaviour with respect to task or interpersonal relationships.

Research work thus far have shown that of the four parenting types, authoritarian and permissive parenting are most strongly related to externalizing problems such as aggression and substance abuse. Moreover, neglectful parenting is most strongly related to children's distress including symptoms of depression, then suicidal behaviour at a later stage (Luthar, 1999; Steinberg, Lamborn, Darling, Mounts & Dornbusch, 1994). Parental rearing is the outcome of the behaviour that is seen in most adolescents. Proper parenting style not only protects against suicidal behaviour, but also predicts psychosocial competence among adolescents, high self-esteem and internal locus of control (LOC)

2.4.3. Family psychopathology and suicide

Family psychopathology in a form of mental illness, family suicidality and substance abuse was found to be closely related to suicidal behaviour in most adolescence. In a research study among suicide adolescents and non suicide adolescents, findings revealed a high prevalence of family psychopathology particularly in suicidal adolescents (Yang & Clum, 1995). The prevalence of suicidal behaviour among adolescents needs to be looked at within a family context in which a lot of psychopathological factors may serve as a predictor towards a self destructive behaviour in these young adults. This self destructive behaviour would be preceded by inappropriate parenting style.

Reynolds and Eaton (1986) expressed that parental psychopathology may have a pivotal role in adolescents suicidal tendencies. According to Schlebusch (Health24, 2011) there is a significant link between suicide, homicide and blood alcohol concentration. In their study Tishler and McKenny (1982), found that fathers of suicide attempters had more depression and alcohol abuse than fathers of non suicide attempters, whereas mothers of attempters had more alcohol abuse and suicidal ideation. Adolescents growing within this family context are perceived to have lower levels of self esteem and an external locus of control (LOC). Adolescents by having low self esteem and external LOC may develop a pathological behaviour in dealing with the external world, in which suicide may come as a form of escape to whatever challenges they come across. This may imply that parental psychopathology may have a negative cognitive functioning and may impact on a child's development later in life with negative consequences of the adolescent not being able to draw support during the time of need. Family psychopathology makes it difficult for the adolescents to receive needed support at the time of suicide attempt, and at the same time they find it even more difficult to express and confide in someone they feel comfortable talking to at this time of need.

2.4.4. Child maltreatment and suicide

There seems to be a strong relationship between early life events which may predict suicidal tendencies later in life. Research findings stipulated that individuals exhibiting suicidal behaviour in most cases experienced childhood maltreatment, that is, childhood physical abuse, sexual abuse and neglect (Yang & Clum, 1996).

Factors that include having an abusive father were associated with suicidal tendencies among adolescents (Myers, Burke, & McCauley, 1985). They further showed that adolescents who experienced physical abuse were more likely to have a self destructive behaviour as compared to their normal counterparts. Consequently maltreatment may result to negative self esteem and high levels of hopelessness particularly in physically and sexually abused children (Culter & Nolen-Hoeksema, 1991; Allen & Tarnowski, 1989). According to Briere and Runtz (1986), child maltreatment as a result may have both short term and long term effects on suicidal behaviour, leaving the adolescent without anyone to trust within their environment and this may even perpetuate into adulthood as a long term effect, whereby one may find it difficult to adjust to societal values and standards.

2.4.5. Family instability and suicide

Family instability as a result of parental separation, divorce, absence, and death in the family, were related to suicidal behaviour (Yang & Clum, 1996). Factors such as losing a parent as a result of death before the age of eighteen were associated with adult suicidal behaviour. Kienhorst, De wilde, Van Den Bout, Diekstra, and Wolters (1990) on the other hand viewed that parental absence during child and adolescent development may also result to suicidal behaviour. This also reflects lack of monitoring on adolescents behaviour, which may have a negative impact; whereby they may associate with bad company leading to delinquency.

Early experiences of parental separation and divorce were among those factors common in depressed individuals. According to research studies early negative life events does have a negative impact on suicidal behaviour especially suicide attempt. As perceived by Beer (1989) family instability may result to low self esteem in most adolescents, i.e. resulting to externalized behaviour, anger and suicidal behaviour.

2.4.6. Cognitive- Behavioural factors

Beck (2011) identified distorted, negative cognition (thoughts and beliefs) as primary features of depression. He states that dysfunctional thinking which influences the individual's mood and behaviour is common to all psychological pathologies; this implies that people's emotions, behaviours and physiology are influenced by their perception of events (Beck, 2011).

According to Beck, Rush, Shaw, and Emery (1979), this is based on the rationale that an individual's affect and behaviour are largely determined by the way in which the individual structures the world around them. The individual's cognitions are based on attitudes or assumptions (schemas) developed from previous experiences, schemas provide the instructions to guide the focus, direction and qualities of daily life and special contingencies (Beck, Freeman, Davis, & associates, 2004). This leads the individual to develop a certain belief system that they adopt to deal with life events. These beliefs begin in childhood as people develop certain ideas about themselves, other people, and their world. Their central or core beliefs are enduring understandings so fundamental and deep that they often do not articulate them, even to themselves the person regards these ideas as absolute truths, as just the way things are.

According to Beck (2011) core beliefs are the most fundamental level of belief; they are global, rigid, and overgeneralized. Automatic thoughts the actual words or images that go through a person's mind, are situations specific and may be considered the most superficial level of cognition. Between the core beliefs and automatic thoughts are intermediate beliefs, core beliefs influence the development of intermediate class of beliefs, which consists of unarticulated attitudes, rules, and assumptions, e.g.:

Attitudes: "nothing works right for me"

Rule: "give up if a challenge seems too great"

Assumption: "If I try to do something difficult I'll fail. If I die, I'll be okay".

This is when the individual starts to consider suicide as an option and depending on how great the stressors are they might complete the act.

These beliefs influence the individual view of a situation, which in turn influences how they think, feel, and ultimately how they will react or behave.

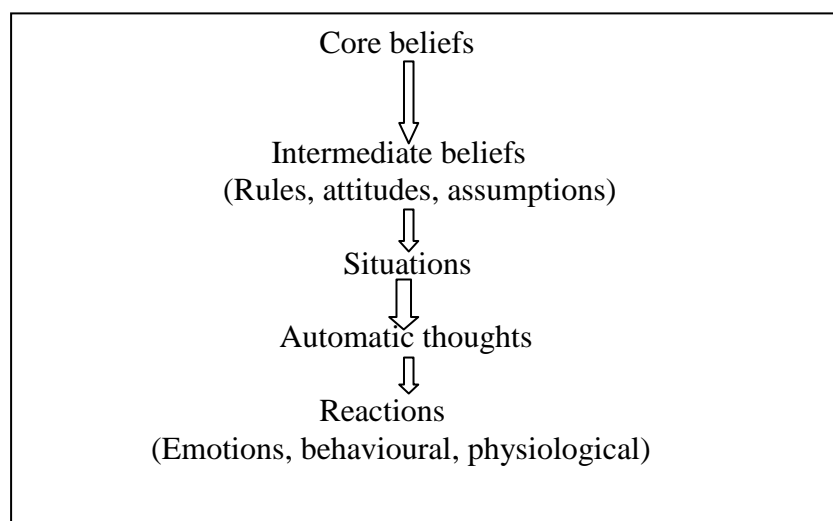


Fig 1: The relationship of behaviour to automatic thoughts (adopted from Beck and Beck (2011). Cognitive behavioural therapy basic and beyond)

Behaviourally emphasis is based on that behaviour is learned; and that learning takes place through observing, imitating and reinforcing (Garfield & Bergin, 1986. Nevid, Rathus, & Greene, 1997); According to Nevid et al., (1997) abnormal behaviour represents the learning of inappropriate maladaptive behaviour; they focus on two types of learning classical conditioning and operant conditioning.

In classical conditioning the environment is the stimulus with its stressors on the individual and the responses to these stressors is the behaviour the individual will give, these will be a learned response from the previous experiences and the schemas that have already been formed within the individual (Nevid, et al.,1997).

In operant conditioning individuals learn to emit learned behaviours because of the behaviour effects. This simply put implies that individuals manipulates the environment to produce certain effects, these effects are acquired by individuals as responses or skills that lead to reinforcements. Reinforcements can be either positive or negative. When the reinforcement is positive e.g. social approval of certain behaviour then, this boosts the behaviour and the individual is motivated to do more of the positive reinforcement. When the negative reinforcement is in place this could be said to be the reverse of positive reinforcement as in the same situation but when there is social disapproval of certain behaviour then there is pain, fear, anxiety, etc; these leading to individuals reframing to risky behaviours as they see no future for themselves and becoming hopeless and helpless to can achieve a positive state of mind (Nevid, et al., 1997).

These debilitating factors of suicidal behaviour are seen as an act committed by the individual due to respondent because of a negative event or operant conditioning in response to

punishment, or observational learning which is learning through modelling, this refers to the process of acquiring new behaviours and knowledge by observing others e.g. social contagion. According to Hawton (1986) learning through imitation refers to the point that suicidal adolescents imitate the behaviour of other family members and friends. In a study of adolescents who attempted suicide 44% knew of an actual or attempted suicide by one or more close friends or relatives and 25% of their mothers or fathers had previously attempted suicide (Weiner 1982).

2.5. RISK FACTORS ASSOCIATED WITH THE ADOLESCENT STAGE OF DEVELOPMENT

2.5.1. Body modification and suicide

Body modification in the form of tattooing and body piercing is becoming increasingly common and well accepted in western society (Carroll, Riffenburgh, Roberts, & Myhre, 2002). They further revealed that adolescents with at least one tattoo and body piercing have suicidal thoughts coupled with other disorders. Stuppy, Armstrong, & Casals-Ariet (1998) showed in their research work that 10% to 13% of adolescents' aged 12 to 18 have tattoos. A study conducted on adolescents showed that having many body modifications can be linked to having negative perceptions about one's body as well as symptoms of depression and personality trait (Carroll & Anderson, 2002).

According to a study on individuals who belong to a website for body modification, having body modifications (e.g., piercing, tattoos) was associated with a higher incidence of prior suicidality (i.e., suicidal ideation and attempted suicide) (Hicinbothem, Gonsalves, & Lester, 2006). The type of body constructions needs to be taken into consideration, as they may be an expression of inner feelings leading to suicide. These may be aggravated by lack of belonging

on the side of the adolescent and may feel to have no support from their peers as they are treated as outcast.

More findings continue to show that males with tattoos and females with body piercing are more likely to participate in physical fights, would receive medical care as a result of the fights, carry weapons and carry guns compared to their peers without tattoos and body piercing (Carroll & Anderson, 2002). A variety of pathological behaviours are seen to be prevalent among these adolescents hence findings indicated that females with tattoos were generally found to be at high risk for suicide thoughts, behaviours and attempts

2.5.2. Social contagion

Adolescent suicide sometimes occurs in clusters, especially when suicide receives publicity. When the adolescents receive this, they may romanticize suicide as a heroic act of defiance. These may be among siblings, friends, parents or adult relatives of suicidal adolescent. Suicide of a family member or school mate renders suicide a more realistic option for managing stress or punishing others. It may be that the other person's suicide gives the adolescent the impression that he or she has no way out but to commit suicide (Nevid, et al., 1997).

Studies showed that in an environment where a family member succeeded in committing suicide, other members tend to imitate similar behaviour as a way out from their misery (Brent, Kolko, Allan, & Brown, 1990). The circle of pathology therefore becomes dominant in children as they develop, and this leading the adolescent to not have second thought about committing suicide whenever they find themselves in a stressful situation and not having any reason to get support as they are not coping.

2.5.3. Sexual activity and suicide

There are some socio-economic factors that a child has no control over that influence the delay of initiation of sexual activities. These are having a two-parent family and high socio-economic status, residing in a rural area, performing better in school, feeling greater religiosity, not having suicidal thoughts, and believing parents care and hold high expectations for them (Raj, Silverman, & Amaro, 2000).

Sexual molestation, both in males and females, at a young age was seen to correlate with early age initiation of sexual activity, early and unwanted pregnancies, multiple partners and suicide (Raj, Silverman, & Amaro, 2000).

Research studies have documented the relationship between suicidality and risk behaviours like sexual activity (Patton, Harris, Carlin, Hibbert, Coffey, Schwartz, & Bowes, 1997; Walter, Vaughan, & Armstrong, Krakoff, Maldonado, Tiezzi, & McCarthy, 1995). Similar findings were found from a study conducted in Cape Town (Flisher, Ziervogel, Chalton, Leger, & Robertson, 1996). This behaviour is also regarded to be health threatening in that adolescents engage in having more than one sexual partner, condom non-use, using dangerous and addictive substances and contracting sexually transmitted diseases and HIV/AIDS. Adolescents therefore become vulnerable in dealing with the consequences which comes as a result of these behaviours. Therefore a diagnosis of a health threatening behaviour in their own right then becomes associated with increased risk of attempted and completed adolescent suicide (Brent, Perper, Moritz, Allman, Friend, Roth, Schweers, Balach, & Baugher, 1993; Shaffer, Garland, Gould, Fisher, & Trautman, 1988).

2.5.4. Poor peer relationships and suicide

Peer relationship is an important era during adolescent development. It is during this phase where they interact and develop a sense of belonging and learn from their peer group, learn problem solving skills, and peer nominations. Inability in attaining peer relationship may result to rejection by peers and low self esteem. Studies so far have linked poor peer relationship with suicidal behaviour in most adolescents (Yang & Clum, 1996). In their study; Rubenstein, Heeren, Housman, Rubin and Stecher (1989) expressed that positive peer relationship decrease the likelihood of adolescent suicide behaviour and boost a high level of self-esteem. Acceptance by peers among adolescents is essential in that feeling of rejection in some may result to suicidal tendencies or engagement in risk taking behaviours. However if the adolescent feels accepted and comfortable within their peers then they find it possible to open up and discuss their problems and this will bring about a sense of belonging and feel having support within his peers.

2.6. BIO-PSYCHOSOCIAL FACTORS

A number of bio-psychosocial factors may increase a person's vulnerability in developing suicidal behaviours. A combination of factors at times may interplay and increase the person's risk for suicide. Other than depression as a risk factor among these young adults, many adolescents who have attempted suicide engage in behaviour such as delinquency, drug use, physical problems, sexual promiscuity, or psychosomatic illnesses (Allberg & Chu, 1990).

2.6.1. Geography, Race and Age

Adolescents who stay in less populated areas unlike those living in congested urban areas are more likely to commit suicide, as in more rural areas of the United States have the highest suicide rate. And this is also increased by the population race as one will find that in a certain geographical area will live certain race. Suicide rates for African American, Asian American, and Hispanic American youth are about 30% to 60% lower than that of non-Hispanic white youth. White teens are more likely to kill themselves than Black teens and recently rates of suicide are rising fastest among Black adolescents males (Nevid, Rathus, Greene, 1997; Joe, 2006). Young adolescents in the late 15 to 24 years of age are at greater risk of suicide than other age groups, this might be fuelled by the complexity of life events as the adolescent grows and does not have the necessary skills to deal with the challenges they are faced with.

2.6.2. Substance abuse and suicide

The use of substances among adolescents has increased and they are easily accessible within their community. Adolescents mostly prefer to use substances in order to regulate their mood, feeling, behaviour and alter perception (Crombie, Pounder, & Dick, 1998). However, some resort to the use of these substances as a coping mechanism to stressors associated with adolescence. The use of alcohol plays an important role in the events leading to suicide among adolescents irrespective of psychiatric history (Crombie, Pounder, & Dick, 1998). Alcohol has a double effect on emotion, with low doses often improving negative affect, but higher doses producing central nervous system depressant effects (Hufford, 2001). The abuse may take place either in the adolescent's family or on their own (Nevid, Rathus & Greene, 1997).

According to Overholser, Freiheit and Difilippo (1997), suicide is a common means of violent death among alcoholics with an estimation of 18% dying as a result of suicide. The use of alcohol and drugs as coping strategy may be less effective and rather aggravate the stressful life-events- particularly interpersonal difficulties experienced by adolescent. As viewed by Overholser, et al., (1997) suicide and substance abuse may be regarded as maladaptive attempts by most alcoholics to escape from an intolerable situation; that is the effect provided by alcohol and drugs are temporarily and once the substance is out of the system reality still prevail. According to Kandel, Raveis, and Davies, (1991) suicide as a result can be seen as the only alternative especially if the drug approach is ineffective.

Research studies so far have suggested that alcohol abuse is related to emotional distress and suicidal behaviour among young adults (Kosky, Silburn, & Zubrick, 1990). Depression and alcohol consumption in combination as seen by many others can be more fatal (Overholser et al., 1997). In a study conducted, most individuals reporting depression along with secondary substance abuse reported increased risk of suicidal ideation or attempts when depressed (Grant, Hasin, & Dawson, 1996). Alcoholism as viewed by Overholser et. al., (1997) may contribute to suicide risk even after controlling depression. In most adolescents, the combination of substance abuse and having comorbid mood disorders may be strongly associated with risk of completed suicide (Brent, Perper, Moritz, Liotus, Schweers, Balach, & Roth, 1994), Many of those who attempt suicide have been found to be under the influence of alcohol at the time of their attempt. This could explain that depression may lead to alcohol abuse and dependency then suicidal tendencies and this pattern can be consistent and reciprocal in most young adults.

In a research study conducted worldwide, findings revealed a strong relationship between suicide and high level of alcohol consumption (Sher, 2006; Tatsuo, Motoki, Yosuke, & Shoichiro, 2006). This association according to Stack (2000) can be seen as a predisposing or a precipitating factor among these adolescents. There have been a number of questions on how the effect of alcohol is related to suicide in adolescence. Beck, Steer and Trexler (1989) emphasized that alcohol intoxication may have short term effects in that it may prompt sudden, impulsive suicide attempts.

It was further indicated that alcohol use may be related to an increased risk of suicidal behaviour because alcohol reduces inhibition, making individuals more likely to act on impulsive suicidal feelings and that as a result may lead to poor decision making (Overholser, et. al. 1997). Another significant association between alcohol and suicide was found in which a high rate (33%-69%) of positive blood alcohol concentration was found mainly among suicide completers (May, Van Winkel, Williams, McFeeley, DeBruyn, & Serna, 2002; Hufford, 2001; Cherpitel, Borges, & Wilcox, 2004). They further elaborated that alcohol intoxication increases suicide risk 90 times as compared to abstinence. This means that the use of alcohol in this regard is a risk factor and may worsen suicidal behaviour manifested by these young adults and the use of other lethal methods (e.g. firearm).

Hufford (2001) emphasized that in understanding alcohol in relation to suicidal behaviour, concepts such as 'acute risk factors', 'potentiating factors', 'proximal risk factors' should be examined since they describe the actual suicidal behaviour. He further emphasized that, 'predisposing factors', 'constant risk factors', and 'distal risk factors' also plays a major role in describing events distant from the suicidal behaviour. Therefore, suicide as the main objective in these adolescents, it is important that other external forces be considered since

they may be influential.

Adolescents have the tendency to act with forethought and therefore make impulsive decisions without considering the results after. Several studies have managed to come up with the definition of the concept impulsivity in understanding these individuals. It was shown that impulsivity and aggression are implicated in suicidal behaviour (Sher, Oquendo, & Mann, 2001; Mann, Waternaux, Hass & Malone, 1999). According to Vitacco and Rogers (2001) impulsiveness is the best predictor of externalized behaviours and that behaviours displayed by these young adults could be risky. Impulsivity as expressed by Sher (2006) is related to suicidal and self destructive behaviours within different psychiatric conditions, including alcohol, substance use and mood disorders. Predisposition to intake of alcohol and drugs can be due to mistrust of one's environment and it becomes important to identify the linkage of such behaviour to the adolescent's environment

2.6.3. Psychiatric disorders and suicide

Stressful life events are not the only contributing factors to suicidal behaviour. Psychiatric disorders like personality disorder, mood disorder and psychosis. According to Peltzer, Cherian, and Cherian (1998) psychiatric disorders are one of the most contributing factors to suicidal behaviour in Africa. However the effective management of these disorders in their early diagnosis may reduce the likelihood of suicidal tendencies.

Depression was previously described by researchers as a risk factor for suicidal behaviour. It was observed by others that depressed individuals with a history of alcohol dependence have higher lifetime aggression and impulsivity and were also more likely to report a history of suicide attempts, childhood abuse, and tobacco smoking as compared to depressed adolescents without alcohol dependence (Sher, Oquendo, Li, Huang, Grunebaum, Burke,

Malone, & Mann, 2003; Sher, Oquendo, Galfalvy, Grunebaum, Burke, Zalsman & Mann, 2005). Adolescence, because of their impulsiveness and their lack of experience in dealing with stressful issues, therefore, contribute to the high risk of suicide (Langlois & Morrison, 2002). It then becomes clear that adolescents in the mist of their depressive mood tend to make impulsive decisions which can be seen as a result of their behaviour.

2.7 CONCLUSION

Suicide is a self destructive behaviour which comes as a result of psychosocial pain that result from experience of distress by an individual. The individual does not plan to die, but due to lack of problem solving skills experienced at the time of experience of the pain, death becomes an unplanned option. The reduction of distress for the individual becomes the way out for reduction of lethality and a subsequent drop in the suicidal behaviour. Such reduction in distress requires multiple forms of intervention, of which support is of paramount importance. For the kind of support an individual who attempts suicide, is exposed to, to be effective in averting suicide depends on the individual's trust in the support. The section above indicated multifactorial and multidimensional factors influencing suicidal behaviour and in their nature indicates the influencing environmental factors which will be important to focus upon, to determine how best such impact can be reversed. The adolescent is influenced by family background, genetic predisposition, peer pressure and psychiatric problems to make a choice to end their lives. It is thus important to find out the preferred choice by the affected adolescent, to be assisted following suicide attempt.

CHAPTER 3

SUPPORT AND COPING STRATEGIES IN SUICIDAL ADOLESCENTS

3.1 INTRODUCTION

This chapter will focus on environmental systems, primarily on social support from family, elaborating on family structures, boundaries, peer relationships and significant others. Culture and religion will also be highlighted as well as the different types of social support, including the effects of such support on individuals.

A brief systemic overview will be given; with a discussion on dispositional factors and coping mechanisms for teenagers.

3.2 ENVIRONMENTAL SYSTEMS

Within the environment that adolescents find themselves, there are external life stressors and this includes environmental pressures individuals are faced with everyday of their lives. These pressures happen in the midst of external resources which include social relationships that a person has at their disposal in order to use to cope with life stressors (Diener & Fujita, 1995).

External resources include relationships with family, peers and significant others (including teachers, neighbours, priests, psychologists, etc) and these are the external resources where adolescents would turn to in times of need for support. According to Rutter and Behrendt (2004), social support is related to less feeling of isolation, healthier adolescent functioning, and higher levels of resilience. This would imply that when adolescents are within reach of what they feel as support within their environment, then they will perform and achieve better,

because of the support that they get from their environmental resources. Such support would mitigate the suicide behaviour that they may have at times when stressors are high. Unlike those adolescents whose environmental resources are not there; thereby heightening the suicidal behaviour in the adolescent without social support.

3.2.1. Support

According to Krantz, Baum, and Singer (1983) support is defined by the relative presence or absence of psychosocial support resources from significant others, while Baron and Byrne (1991) view support as help provided by friends and relatives who give physical and psychological comfort to an individual facing stress; they are for the view that those individuals having social support tend to be in better physical health and to be better able to resist stress than those without the support.

As suicidal adolescents go through life challenges, they turn to perceive certain types of support from certain people or peer groups as the type of support they feel comfortable with and would prefer those individuals to confide in them and be better able to cope with their life stressors

Adolescents who are preoccupied with suicidal tendencies often feel lonely, while on the other hand they can rely on various sources for support such as family and friends. The current study will attempt to identify various source of support and help seeking behaviours in attempted suicide.

3.2.2. Social support

Social support can be defined as an exchange of resources between two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient (Duffy & Wong, 2000).

Absence of social support is another factor that pushes teenagers to commit suicide because immediately the teenager finds no one to rely on; someone they can talk to about what is distressing them, then the alternative would probably be to seek refuge in committing suicide, as the only way out. This would be as a result of the overwhelming feelings of distress and them not being aware of the feelings and not being able to deal with it or not being sure what to do as they might be perceived as failures in life.

3.2.2.1. Family as a source of support

Adolescence is a transitional stage from childhood into adulthood. It is during this period when adolescent turmoil is experienced across various families. According to Stern and Zevon (1990) family plays an important part in influencing adolescent's responses to life stressors; therefore family operates as a protective external asset in adolescent development towards adulthood.

Most studies highlighted that family relationships are the most important source of support for adolescents. According to Morano and Cisler (1993) family support can act as a protective factor against external stressors. Recently, family structures are changing because of divorce, single parenting, and separation. Many adolescents lack sufficient support within the family when they need it most because of the various factors affecting family structures. Hawton (1986) states that family disruptions due to death, divorce, separation and unstable relationships have been a common factor in adolescent's suicide behaviour. With such

extreme changes within the traditional family structures, this would be considered as one of the main contributing factors to adolescent suicide.

The impact of family connectedness and parental perception on children and adolescents may be seen as a protective factor against suicide attempts (Borowsky, Ireland & Resnick, 2001). A warm, caring and understanding family is a good source of support for a young person in distress. Such individuals are seen to have a strong supportive system which they can cling onto. Research so far showed that poor family environment is a predictor of suicidal behaviour among adolescents. This was also supported by Garber, Little, Hilsman and Weaver (2002), they viewed that adolescent suicide symptoms in most instances is mediated by perceived family functioning.

3.2.2.2. Peer groups as a source of support

Peer groups are an important feature of the social world from childhood, as will be realised in school children who always play together. During the adolescent years this kind of interaction changes in significance and structure. According to Steinberg (1993) four specific developments stands out. Firstly, during adolescence there is an increase in the amount of time that is spend with peers as against the time they spend with parents. That is, well over half of adolescents waking time is spent with peers and only 15% with adults and parents. At this period, adolescents list of significant others in their life would be composed of people who are most important to them as people of the same age. Besides parents other adults account for less than 25% of the adolescent's social networks, these are the people the adolescent interacts with most regularly.

Secondly, adolescent peer groups, unlike with younger children, they turn to be independent and without any supervision from adult authority, they rely on significant others (Steinberg

1993). Thirdly, during the adolescence more contact with peers of the opposite sex is made, unlike in childhood where sex-segregation is high. An increasingly larger proportion of the adolescents significant others are opposite-sex peers. Finally, because of the adolescents time spend with significant others, this generates the emergence of larger collectives of peers or crowds (Steinberg 1993). These crowds serve as reference groups for the adolescent and they provide identity for them. This makes it easier for other people to understand the type of person the individual is, only by understanding the type of group they belong to.

Steinberg (1993) suggests that these changes in peer relation have their origin in the biological, cognitive, and social transitions of adolescence.

It therefore suggests that peer groups are an important part of an adolescent under “normal” conditions an adolescent will be receiving the necessary support from significant others and social networks, with the necessary responsiveness and demand. Should the adolescent lose his group identity, or relationship with significant others, they may develop psychological problems if the environment is not conducive and this could result in depression which may lead to attempted or completed suicide.

According to Steinberg (1993) the increase in intimacy between adolescents and their peers is not accompanied by a decrease in intimacy towards parents. In other words though the adolescents start seeing their friends as important sources of emotional support, they do not stop to be in need or use of their parents as well for the same needs. As adolescents begin the process of individuation, they may seek intimacy outside the family as a means of establishing an identity beyond their family role. Intimacy with parents provides opportunities to learn from someone older and wiser; intimacy with friends provides opportunity to share experiences with someone who has similar perspective and degree of

expertise.

The different groups between peers and parents are important as they can provide different functions of social support at times of life threatening events, by buffering adolescents against the potential negative effects of stress.

Steinberg (1993) summarises the above point concisely by stating that adolescents who have intimate friendships typically have better mental health than their peers. Intimacy, as it provides social support enhances adolescents' well-being, it is also likely that psychologically healthy adolescents are better able to make and maintain close relationships with others.

3.2.2.3. Religion as a source of support

Religion is an important although a complex aspect of human culture and may serve as a protective factor against suicide. Religious affiliation is associated with less suicidal attempts in most depressed adolescents (Kendler, Gardner & Prescott, 1997). Studies are of the opinion that individuals who are religiously bound have a close network family relationship, while those without a religious background lack family relationship (Kendler, Gardner & Prescott, 1997). As a result they were observed to rely on friends and others for support; hence they are vulnerable to suicidal behaviour due to the lack of family support.

Many young adults find themselves in various denominations for spiritual wellbeing but many still finds themselves in risky activities such as the abuse and use of substances. Affiliation to a religion, irrespective of a denomination in relation to suicidal behaviour was not yet established by other previous research work. However it was concluded that being part of a religious affiliation regardless of a denomination is essential. Rather, lack of affiliation may be a risk factor for suicidal acts (Dervic, Oquendo, Grunebaum, Ellis, Burke,

& Mann, 2004). It does not necessarily mean that those who are religious affiliates do not experience depression, rather being part of an affiliation serve as a buffer against stressful events, depression and hopelessness.

Aggression, impulsive traits, anger are related to suicidal behaviour and can therefore, predict future suicidal behaviour particularly in boys. Literature has based this on the fact that boys display many externalizing behaviour and use more dangerous methods than females. Religion in this regard has been reported to be associated with lower hostility, less anger, and less aggressiveness. Religious affiliation in its context becomes a regulator in lowering aggression and anger which may predict suicide. In a study conducted by Boomsma, de Geus, van Baal and Koopmans (1999) emphasized that being brought up in a religious background may reduce the influence of genetic factors on suicidal behaviour.

In chapter two it is clearly outlined that, attempted suicides experience extreme feeling of emptiness and to some extent they develop antisocial behaviour which predicts suicidal behaviour. According to Koenig, Mc Cullough and Larson (2001), religious affiliation does not only target suicidal prevention, but also promotes social ties and reduces alienation. By referring to social ties in this study we refer to close family networking, having friends and relatives of the same affiliation, which also provide emotional support, nurturance, and reassurance of worth. Individuals always know that whenever they have difficulties they can get help and that they are not alone. Religious commitment on personal adjustment provides a buffer effect against all odds.

Research studies stipulated that the relationship between religious affiliation and aggression among depressed individuals serve as a therapeutic intervention for suicidal behaviour (e.g. deliberate self harm). Linehan, Heard, and Armstrong (1993) evidently reported that anger

reduction leads to reduced parasuicidal behaviour. Through religious beliefs individuals benefit and develop a skill of coping with stressful events and support for moral objection to suicide. Thus every time when these individuals come across stressors in life they will not resort to suicide as a solution to their problems.

3.2.2.4. Culture as a source of support

Culture as viewed by Early and Akers (1993), put emphasis on that we are cultural beings of all species, therefore we require cultures to make life worth living. Culture embodies a lot of aspects such as values, norms, beliefs and identity. Such values can contribute to how people respond and deal with life stressful events. Triandis, Gelfand and Canton (1996) on the other hand stressed that values are influenced by individualism and collectivism. In cultural context, individualists regard themselves as independent individuals with personal goals which ultimately influence their social behaviour, unlike collectivists which, stresses an interdependent self. According to Early and Akers (1993) suicide among black is relatively low due to culturally inspired resilience.

Research studies were of the opinion that culture shape our daily lives (Early & Akers, 1993), in their study they showed that individuals who come from a community that still take efforts in preserving and rehabilitating its own culture, are observed to have lower rate of suicide among its adolescents. Further, social support is likely to provide adolescents with coping mechanisms with not only everyday problems but major life events. Suicidal behaviour in adolescents for example has been associated with lower level of social support (Eskin, 1995). Social support as a result becomes a source of measure that reduces the impact of stress in these young adults.

It is argued that Blacks and Whites have different ways of dealing with life stressors and yet respond differently to those. Whites are more distressed by economic strain, while Blacks are more affected by interpersonal strain. Due to collectivism within the black culture, social support is further obtained from family, church and the community. Extended family network with strong ties, functions as a buffer against suicide for its members (Nisbert, 1996).

In African communities most of these aspects are still in existence however the influence of western culture is increasingly dominating ways of doing things and the way people think. As a result, young adults tend to overlook the significance of what culture can do for them when they approach stressful life events. The cultural way of doing things has been neglected and undermined mostly by young adults due to the adaptation of western culture. This according to Mashego et al., (2003) suicide in an African culture is forbidden. This same study found that in certain areas of South Africa, bodies of individuals who die as a result of suicide and other non-natural causes (i.e. stabbings and gunshots), are not brought home for night vigil. The reason behind this concept is that there is fear that the same behavioural pattern will repeat itself.

Trust also appeared to be an important factor in help-seeking behaviour and greater cultural distrust was associated with a more negative attitude towards seeking help (Nickerson, Helms, & Terrell, 1994). Acculturation was also associated with help-seeking in international students. Gim, Atkinson and Whiteley (1990) stated that more acculturated students had more positive help-seeking attitudes; this was consistent with traditional oriental culture where there is a negative perception of psychiatric services. Counsellors thus need to pay close attention to acculturation issues when working with Asian students (Atkinson, Thompson & Grant, 1993).

Culture referred to the shared patterns of life that define social groups. This usage tended to portray cultures as bounded, fixed entities, neglecting crucial differences among and within groups, and it risked reducing culture to an autonomous variable among others. But culture is not a thing; it's a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habitus and physiological reactions, the understanding of what is at stake in particular situations, the development of interpersonal connections, religious practices, and the cultivation of collective and individual identity. Culture is inextricably caught up with economic, political, psychological, and biologic conditions.

3.2.2.5. Therapeutic intervention as a source of support

Many research studies examining suicidal behaviour have primarily focused on the role of general practitioners, mental health specialists, and other health care providers as the source of support against suicide. It is estimated that from 24% to 69% of those who committed suicide have made contact with psychiatrists or general practitioners in the month prior to death. (Barnes, Ikeda & Kresnow, 2001). This suggests that contact with clinicians is common among suicides.

The increasing number of suicide among adolescents pose a challenge in knowing if these young adults are seeking professional help regarding their emotional problems. In a study conducted among suicides, it was revealed that, patients from the age of 35 and older had a contact with a clinician prior to suicide than younger case patients. This explains that young adults are less likely to seek professional help about interpersonal crises. Part of the reason why adolescents do not seek professional help is that adolescents find it easier to confide in other adolescents- friends and peers rather than adults about their suicidal behaviour, or any

other problems they are faced with.

The other reason is that young adults are afraid of confrontation and shy to speak loud about their problems. Freud indicates that young adults are not fully developed; they are therefore still controlled by the Id which is the subconscious mind therefore the Ego which is the conscious mind plays a lesser role during this stage of development. Seeking professional help for them might be an embarrassment. The id forces young adults to think that what they are doing is absolutely correct. They may also not know where to go or how to access professional (mental health) help.

Non-professional consultants i.e. family, friends and other community helpers are important in the prevention of suicide particularly in those who cannot access health care. This according to Gerland and Zigler (1993) will establish and strengthen families and communities in the strategy against suicide.

Other method of consultation frequently used by adolescents is the use of telephone hotlines. This is the most preferred service because it is anonymous, easily accessible, appealing to adolescents and young adults.

There is a great need for intervention for those at high risk for suicide to seek assistance. Therefore educational programs which aim at promoting help seeking behaviour to those at risk and destigmatise suicide, and reducing barriers to health care and mental health service should be made available in preventing suicidal behaviour (Barnes et al., 2001).

According to the South African Depression and Anxiety Group (SADAG) (August 2012) the issue of suicide is a preventable tragedy and the increase in technology like cell-phones, and

social media forums has shifted the trend of suicide notes to notes being sent via short message services (sms) or posted on social forums like facebook. According to SADAG (news24.com, 2012) reported on an article that appeared in the Volksblad newspaper, that a 14 year old girl from Heidedal in Bloemfontein left a message on her new cell-phone before committing suicide, the message read “I’m sorry mom; I don’t want to live anymore. I want to be with mama euna and dad ni (Nico)”. Recently SADAG (April 2012) has joined the facebook suicide prevention agency to connect facebook users to crisis intervention and counselling services. From these services SADAG has been receiving contacts from individuals who are depressed and others being suicidal. The site also helps to identify those who might be in need of such services either by friends or family.

The government should also play a role of paternalism towards assisting the young adults by making available programmes that will cater for youths. Those programmes should be in such a way that they will keep young adults preoccupied such that they don’t have ample time to think destructively. One of the reasons why young people think to commit suicide more often is that they want to see things happening within the blink of an eye and according to their way, this therefore gives pressure to young adults and lead them to undesirable behaviours.

Different stakeholders in collaboration with the government should work on an integrated approach and embark on campaigns that will assist in eliminating this social problem.

3.2.2.6. Commonly used coping strategies by adolescents

Coping strategies involve techniques that are used by adolescents to adapt to daily life stressors that they are faced with everyday, these include:

Defence mechanisms

Adolescents will usually turn to have a negativism which is an active, verbal way of expressing anger as a way of trying to be in charging using the “so what” attitude as if they don’t care about anything said by anyone (Sadock & Sadock, 2003) and this would more often be accompanied by acting out as a way of adapting to the problems. The behavioural strategy is found to be more common among adolescents’ reaction to their environment.

Cognitively, adolescents will use different strategies with repression as they try to block those anxiety evoking ideas from awareness and continue as if nothing is happening (Nevid, et al., 1997) will rationalise the situation so that it is suitable to them as they see it.

According to Sadock and Sadock (2003) Peer groups, through school experiences accelerates separation from families. As adolescents live in the world of their own understanding that is unfamiliar to parents, home is treated as a base to reorganise themselves and school becomes their real world where important relationships develop with persons of similar ages and interest.

3.3. Types of social support

There are different types of social support and each serves certain and unique purpose that is embraced by the individual:

1. Social embeddedness: this is the kind of support whereby the number or quantity of connections an individual has to significant others who might offer assistance. A socially embedded individual has many friends, family members, and associates upon whom he can draw when seeking social support.

2. Enacted support: or the availability of actual support refers to the very real actions others perform when they render assistance. An individual may have a large network of friends or

be socially embedded, but the friends might not actually give support. The number of available supportive friends, then, is less than the number who actually supports the needy individual.

3. *Perceived social support*: it is the perception of how available and how adequate social support is. An individual might have many friends who offer support, but the support is useless or not consistently given (Duffy & Wong, 2000).

Therefore the kind of support that an individual will receive will highly depend on the level of actual support that the individual will receive as and when it is needed and this needs to be consistent and make the needy individual feel and understand that the support or help that is given at that given moment is real and mitigates the real situation of them finding themselves in a stressful situation that might lead to suicidal ideation, attempts and completion. Therefore this implies that social support does not depend on the large number of networks one has but the real actions that people are prepared to make and sacrifice their resources to help others achieve their goals, and this may be one or two people within the larger groups of one's network.

3.4. The effects of social support

a. *The direct effects*: of social support mean that interpersonal contact and assistance directly facilitates healthier behaviour. E.g. when friends encourage an ill individual to stick to his medication and eat healthy food.

b. *The indirect effects*: of social support mean that social support influences an individual's well-being by decreasing the perceived severity of stressful events. E.g. when parents convince a child that a difficult math class is a challenge rather than a stressful event.

c. *Interactive effects or buffering effects*: social support is interpreted to mitigate or ameliorate the adverse effects of stressful events, by influencing the recognition, quality, and

quantity of coping resources. E.g. a friend points out that the distressed individual is coping as well as or better than others in the situation or that the distressed individual has many caring friends

d. Boostering effects: in which social support actually enhances the beneficial effects of positive life events, the social support points out the life-enhancing effects of some positive experiences (Duffy and Wong, 2000).

3.5. Social integration and suicide

Gibbs cited in (Abrahamson, 1990) argues that the different types of suicide classified by Durkheim all have in common a concern with social integration, i.e. anomic suicides are a function of low integration while altruistic suicides are a function of excessively high integration. Gibbs argued that in the final analysis, integration involved the strength of individual's ties to society. Such ties are a function of the stability and durability of social relationships.

According to Jacobs (1992) most people who kill themselves are mentally ill at the time, in addition to depression; the most frequently diagnosed disorders are substance abuse (or dependence) and schizophrenia. The presence of both depression and substance abuse appears to be an especially lethal dual diagnosis. Identification and effective treatment plan of these disorders, especially depression, continue to be the most important strategy for preventing suicide.

Beck and Steer (1989) found that out of 10 (ten) clinical and demographic characteristics (i.e. sex, race, marital status, employment status, presence of a depressive diagnoses, presence of a schizophrenia diagnosis, a previous suicide attempt, and age), only a diagnosis of alcoholism

predicted the eventual suicide of patients who had previously attempted it.

Individuals should be integrated in society moderately as those with low integration might have problems with establishing relationships and may feel isolated, while highly integrated individuals may lead to being easily disappointed and the ultimate result in both integrations is suicidal behaviour as they feel that they are very much disappointed with the society they find themselves in.

3.6. Personal systems

Personal systems include individual stressors and protective factors that may influence the vulnerability of an individual to engage in suicidal tendencies. These protective factors include among others demographics like gender and race, but as this has already been dealt with in the previous chapter, we will only concentrate on dispositional factors, which make part of the personal systems

3.6.1. Dispositional factors

Dispositional factors refer to the unique characteristics each individual has that influence their level of resilience to stressors (Compton, 2005), as cited in Loots, (2008). According to Loots (2008) the presence of factors that increase the individual's resilience, contribute to the overall well-being of the individual, while other factors or the absence of certain factors might hinder the process of successful coping and increase vulnerability. Factors that increase or decrease resilience in adolescents include:

a) **Hardiness**

Hardiness as a contributing factor to resilience includes commitment, control and challenge, when faced with problems. Adolescents perceived to be in control and use the challenges they face as a learning platform and grow from the challenge, are better able to cope with life stressors and have a sense of well-being than adolescents who lack hardiness (Beasley, Thompson & Davidson, 2003).

b) **Internal Locus of Control**

Though this was touched on in the previous chapter, this refers to individuals perceiving their behaviour as the determinant of the outcome of events. When individuals perceive events as being controlled by external factors, including fate and luck they will be perceived as having an external locus of control (King, Schwab-Stone, Flisher, Greewald, Kramer, Goodman, Lahey, Shaffer & Gould, 2001). In learning and implementing an internal locus of control, alleviates learned helplessness and decreases the risk of developing depressive symptoms and ultimately the risk of suicide tendencies.

c) **Self efficacy**

This is the way individuals perceive their ability to perform. High efficacy can contribute to the individual's willingness to take challenges and promote effective performance, and a low self efficacy can discourage an adolescent to accept a challenge making them to believe that they would not be able to negotiate or complete the task at hand.

d) **Optimism**

Optimism is the expectation that future outlook is positive despite the current problems that one might be faced with and this has been highlighted as an important factor in individuals

who display resilience, while the opposite which is pessimistic is associated with inappropriate coping skills (Carver, Scheier, & Weintraub, 1989)

Optimistic individuals are better at gathering support and pushing themselves to achieve because of the positive expectations and this alleviates potential threads to suicidal tendencies.

e) Sense of coherence

This is the individual's perception of their environment as understandable, manageable and meaningful. When adolescents are better able to make sense of the problems or challenges they are facing and be able to learn from them, this will ultimately help them to better be able to decrease their susceptibility to suicidal risk

f) Self-esteem

Self-esteem affects how individuals think, act and even how they relate to other people. Self-esteem allows individuals to live life to their full potential. Low self-esteem means poor confidence and that also causes negative thoughts which means that one is likely to give up easily rather than face challenges and it has a direct bearing on one's happiness and well-being. Negative stress and low self-esteem are significant predictors of suicidal ideation; Adolescents with low self-esteem have been found to be predisposed to depression and other psychiatric pathologies (Wilson, Stelzer, Bergman, Kral, Inayatullah & Elliott, 1995).

g) Neuroticism

This is the tendency to experience negative emotions, like anger, anxiety, or depression; sometimes called emotional instability. Neuroticism is linked with low tolerance to stress and

individuals are vulnerable to stress. Individuals are more likely to interpret ordinary situations as threatening and minor problems as hopelessly difficult. Their negative emotional state tend to persist for extended period of time, and this leaves them in a negative mood, preventing them from thinking clearly or making decisions and cope effectively with stress. This view is also supported by (Bridge, Goldstein & Brent, 2006; Fergusson, Woodward & Horwood, 2000). Adolescents who are neurotic will tend to contemplate suicide or even attempt it just soon after they find themselves faced with problems, especially if it's a serious problem in their view.

h) Depression

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behaviour, feelings and physical well-being. Individuals may feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable or restless, and tend to lose interest in activities that once were pleasurable and ultimately they may attempt suicide. According to Fergusson et al., (2000), several studies have identified depression as the most common psychiatric factor related to suicidal risk.

i) Hopelessness and helplessness

According to Nevid, Rathus, and Greene (1997) hopelessness refers to the expectation that regardless of one's attempt, efforts, positive desirable events are unlikely to occur and negative, undesirable events are likely to happen. Depression, helplessness, hopelessness, low self esteem, poor self concept are psychological syndromes which leads to suicide in most suicidal patients and individuals with these traits are most likely to be depressed and yet do not value life. Hopelessness cognition are believed to cause a distinct subtype of depression called hopelessness depression, which is characterised by features like low motivation and

energy, feelings of sadness, apathy, suicidal thinking, difficulty concentrating, and a general slowing down of psychomotor behaviour. The individual basically sees ultimate futility of their actions and stops trying to achieve desired outcomes.

According to research body, there is evidence supporting the idea that hopelessness is a major psychological factor leading to suicide more than depression, poor self concept, and low self esteem (Goldney, 1981). Other studies outlined that the level of hopelessness is a strong predictor of attempted and completed suicide than the level of depression (Beck, Steer, Kovacs & Garrison, 1985). In this regard it becomes clear that not all depressed individuals necessarily think of killing themselves, rather feelings of hopelessness may put an individual at a vulnerable state towards suicidal tendencies.

Suicidal individuals can be observed as having limited coping strategies and mechanisms towards their stressful life events. Zimmerman (1995) therefore suggested that suicides learned to have ego defense mechanisms which are observed to be less effective and that as a result left them without adequate tools to confront their life situations. Suicides once they realize that they cannot deal with their personal issues, they become frustrated and therefore resort to life threatening measures as a way out.

Maris (1981) stated that a depressed and suicidal person at some level tend to struggle with existential issues and therefore question the meaning of life. They regard life as not worth living for. Nothing seems to be worth it. Most suicides see life as being short, painful, fickle, and often lonely and anxiety generating (Maris, 1981). Suicidal individuals often view living as an empty exercise, however they don't realize that by committing suicide they will never come back.

From this perspective, adolescent's suicidal behaviour is generally considered a result of their inability to adapt to stress and this manifest in hopelessness and despair. According to Shneider (1993) hopelessness is the most predominant feeling preceding a suicidal behaviour, in his view the more hopeless an individual feels about his life situation, the more likely they will give up trying and use suicide as a means of escaping the situation. This is again exacerbated when the hopelessness and depression is combined with low self- esteem; this becomes a high risk factor for suicide among adolescents (Nevid, et al.,1997).

j) Substance abuse

This aspect has been dealt with extensively in the previous chapter. What could be of interest is that substance abuse could facilitate transition from suicidal ideation to suicide attempt to completed suicide (Bridge et. al, 2006)

3.7. Conclusion

In this chapter we dealt with different dynamics of support and the types of support involved in dealing with adolescents who have attempted suicide. Sources of support have been highlighted in peer groups, religious groups, culture and the family has been extensively discussed in terms of the preferences.

Dispositional factors that contribute to resilience or not contribute, the presence or absence of these factors like self-esteem, hardiness and optimistic contribute positively to the well-being of the individual. Contrary to depression and substance abuse as these factors can only affect adolescents negatively and perpetuate the increased risk of adolescents engaging in suicidal behaviour.

CHAPTER 4

THEORETICAL CONCEPTUALIZATION

4.1. INTRODUCTION

This chapter will look at the theoretical perspectives around suicidality from the different schools of thoughts. This will include the psychodynamic approach the biological perspective, the cognitive behavioural approaches, sociological, and the Bronfenbrenner's theory; and lastly the theoretical framework will be outlined.

Different theoretical perspectives have attempted to explain the factors associated with completed suicide and attempted suicide behaviour, though no single model has been found to account for the significant patterns of suicidal behaviour in adolescents. Aetiological factors are complex and professionals have attempted to understand them from biological, psychological and social models. These theories are not mutually exclusive but could be found in the same individual at the same time.

4.2 THEORETICAL PERSPECTIVES

4.2.1 The Psychodynamic perspective

Psychoanalysts such as Freud, Jung, Menniger, Kohut and Wolf, were the first to come up with theoretical analyses of suicidal behaviour among adolescents. The theory is based on the following psychodynamic issues which were found to be prevalent in most adolescents contemplating suicide (Sadock & Sadock, 2003).

4.2.1.1. **Inner conflict and hostility**

According to Menniger (1938) suicidal individuals have inner hostility towards themselves and this may result in having suicidal tendencies and wishes. In this view, adolescents have certain expectations from certain individuals; and once they do not acquire those expectations, feelings of anger with subsequent development into rejection develop. Such continued rejection becomes internalized. By projecting these feelings, impulses are turned inwards and there is a wish to punish or force affection from significant others.

Manifestation of these feelings as explained by Menniger (1938) makes suicide individuals have suicidal fantasies in a form of a wish to kill, wish to be killed and the wish to die. Menniger (1933) explains the three wishes as the three unconscious elements of suicidal fantasies. These wishes may dominate one another and may only become worse once adolescents experience stress. Suicidal behaviour therefore becomes a pathological behaviour of releasing aggression and acting out on wishes and impulses.

4.2.1.2. **Rebirth**

Being born again is regarded as playing an important role in suicidal behaviour. Suicidal adolescents in the mist of their own intrapersonal dilemma may have a wish to escape and start all over again. Suicidal individuals become preoccupied with a fantasy to commit suicide. Such fantasies as explained by Menniger (1933) include wishes of revenge, power, punishment, rebirth rescue, reunion with the dead, or a new life.

According to Zimmerman, (1995), suicide reflects an unconscious need for spiritual rebirth. He views suicide as a possible second chance in which a person struggles to deal with life issues. Suicidal behaviour presents itself in that the self may be regarded as a problem and

therefore wishes the problem may go away and that he\she gets a second chance and even better mechanisms in dealing with the problem.

Adolescents with suicidal tendencies in most cases are fascinated with death and thus perceive it as a peaceful refuge. To them self-destructive behaviour becomes a meaningful transportation there. View for suicide replicate a desire for renewal or resurrection to a different and better life. Suicide behaviour therefore, is seen as a magical and omnipotent act of regression towards rebirth of a new self (Zimmerman, 1995).

4.2.1.3. Object Relationships

According to Sadock and Sadock (2003) for individuals to be able to form mutually satisfying relationships is by internalizing early interactions with family and significant others. This is made possible as a function of the ego since satisfying relatedness depends on the ability to integrate both positive and negative aspects of others and the self and be able to maintain an internal sense of others even when they are not around.

The mind is a relational component and the object is the goal of the relation. The object can be people (family, friends, significant others) or things like toys and the objects become attached. As we form attachment with the objects, they are internalized from early developmental experiences and are introjected onto the self.

Suicide is a desperate intrapsychic act aimed at protecting internalized “good” objects from death instinct (Zimmerman, 1995). Suicidal tendencies may be evoked by feelings of rejection when individuals are disappointed by significant others.

4.2.1.4. **Self fragmentation (Self psychology)**

The psychodynamic approach to suicidal behaviour requires the understanding of the self or individual and the act in itself. According to this perspective psychopathology and its symptoms of depression develop from a fragmentation in the self structure (Kohut & Wolf, 1978). In their view they see self fragmentation among suicidal adolescent occurring as a result of less cohesion, more permeable boundaries, diminished energy and vitality, and lack of internal balance. Lack of a supportive structure by individuals may result to internalized pain in which individuals may wish to avoid it in all cost.

Self identity and closeness between members of the family is significantly important for most adolescents. As stated by Henry, Stephenson, Fryer-Hanson and Hargett (1993). Adolescents are at a particular risk for suicidal behaviour because puberty is a crucial period for development which goes alongside destructive tendencies. Undergoing destructive emotions in this path may cause inner pain to these individuals and that may evoke suicide impulses.

4.3. **Sociological perspective**

The prominent French Sociologist, Durkheim (cited in Watson, Milliron, Morris, 1995), looked at sociocultural factors that influence suicide. He argued that an individual alone is not vulnerable to self destruction, rather, forces within the society influence individual's decision to commit suicide. Also psychological issues are not the only factors that contribute to an individual in committing suicide.

In this theoretical concept the idea to kill oneself is dependent on social circumstances, in which people find themselves. Society's influence on individuals may result in increased suicide rate and this will differ according to the various cultural measures of social

attachment and integration, (Eckersley & Dear, 2000). Society, cultural norms and values have a significant influence on the thoughts and actions of individuals. Durkheim (1897) suggested four different species of suicide, which are egoistic, altruistic, fatalistic and anomic suicide.

4.3.1. Egoistic suicide

There are three types of societies which can influence suicidal behaviour and these are religious, domestic and political society (Durkheim, 1897). Religious society provides integration and meaning for its members by giving a unified society with strong belief. If this fails and there is no support then individuals may develop life threatening behaviour like suicidal tendencies.

Domestic society includes marriage, this can reduce suicidal behaviours as it provides individuals with shared sentiments and memories and this brings along with it positive attitude towards life and give meaning to life and living. When individuals do not find these fulfilling sentiments they may develop risky behaviours (Henry, Stephenson, Fryer-Hanson, & Hargett, 1993).

This risky behaviour will be since individuals find it difficult to integrate into society and connect with the community. This risky behaviour is particularly relevant in South African adolescents especially among blacks schooling in predominantly white school. Exposure to different cultures can, with some individuals, lead to the development of feelings of isolation known risk factor for suicidal behaviour in adolescence (Loots, 2008)

4.3.2. Altruistic suicide

According to Corr, Nabe and Corr, (1997), altruistic suicide is the over integration between the individual and society where they feel no sacrifice is too great for the well-being of the society e.g. suicide bombings especially in Palestine and Israel. The individual's personal identity is overpowered by the identification with the welfare of the larger society and the individual finds meaning outside themselves.

4.3.3. Anomic suicide

This type of suicide is accounted for by the society's regulation of its members. And, individuals need to regulate their desires. When society is unable to help regulate the individual's desires then the individual may develop risky behaviours including suicide. When individuals are in a crisis, the change in relationships between themselves and the society causes even more unbearable stress. If the individual is unable to resolve the problem they may resort to suicide as they see it as the only way out to escape the problem (Corr et. al 1997).

4.3.4. Fatalistic suicide

This is caused by high societal control and regulations that prohibits an individual to be free within society. With such strict regulations the individual sees no freedom in the future and becomes hopeless and may resort to suicide. According to Pillay and Schlebusch (1987) Indian South African adolescents are the most vulnerable because of their societal strict regulations.

4.5. Bronfenbrenner's theory

According to Bronfenbrenner's theory, the interaction between an individual and the environment is as a result of the different systems that present certain behaviour because of the different systems. He identifies different social systems that individual's are part of, namely:

- a) *Microsystems* is the complex of relations between the developing person and environment in an immediate place with particular physical features in which the participants engage in certain activities in particular roles e.g. being a daughter, parent, teacher, etc. for a particular period of time.
- b) *Mesosystem* is the interrelations among major settings containing the developing person at a particular point in their life. For an adolescent, mesosystem would embrace interactions among family, school, and peer groups for others it might include church and camps.
- c) *Exosystem* represents settings in which the individual is not directly involved but is indirectly influenced, this is an extension of the mesosystem including specific social structures both formal and informal, that do not themselves contain the developing person but encompass the immediate setting in which that person is found and influence, delimit or even determine what goes on in the system.

This include major institutions of the society like work environment, neighbourhood, mass media, government etc.

- d) *Macrosystem* includes the institutional patterns of the culture or subculture, such as the economic, social, educational, legal and political systems, which micro, meso, and exo systems are the concrete manifestations.

Macrosystems are conceived not only in structured terms but are carriers of information and ideology that provide meaning and motivation to particular agencies,

social networks, roles, activities, and their interrelations. What place or priority children and those responsible for their care have in such macrosystems is of importance in determining how a child and his or her caretakers are treated and interact with each other in different types of settings (Bronfenbrenner, 1977).

This theory focuses on an individual as someone who is taking part in that they have to absorb pressures from the different systems and with the support of the system at the same time be able to cope within the very same system. When the individual struggles to adapt or cope to the systems demands they might be vulnerable to risk factors associated with suicidal behaviour and finally may attempt suicide.

4.6. Biological perspective

Biological changes are associated with completed and attempted suicide. Researchers so far came to an agreement that biological changes particularly in central nervous system (CNS) does play a significant role in what we see as suicidal behaviour among these young adults. Goldsmith, Pellmar, Kleinman, and Bunney (2002) evidently showed that abnormal functioning of the hypothalamic-pituitary-adrenal (HPA) axis, which is a major component of adaptation to stress, has shown to promising for the prediction of future suicides, but not for suicide attempt.

Other research studies showed that deficit in serotonin may be a crucial determinant in major depression (Stockmeier, Shapiro, Dilley, Kolli, Friedman and Rajkowska (1998). In their study they observed an increase in serotonin- 1A autoreceptors in the midbrain of suicide victims with major depression. What happens in the brain of a suicide individual is that, these receptors inhibits the firing of serotonin neurons and diminishes the release of this neurotransmitter in the prefrontal cortex.

The use of antidepressant as a method of treatment has been suggested by psychiatrists. According to Goldsmith. et. al (2002) antidepressants reduces serotonergic function and at the same time alters noradrenergic function in the central nervous system of both suicide attempters and completers.

Several lines of studies including the adoption, twin, and family studies hypothesized the link between genetic inheritance and risk of suicide (Goldsmith. et. al, 2002). Having the first degree relative who completed suicide increases the chance of an individual's risk of suicide 6-fold.

4.7. Theoretical framework

4.7.1. Family systems approach

A family is a system that operates within a certain transactional pattern. A structure is an invisible set of functional demands in which a pattern of interaction between family members is well observed. Through this interactional pattern information about how the family is organized manifest itself (Minuchin, 1996). Repeated transactional patterns therefore describe how, when, and to whom members within the family should relate.

According to Watson and Protinsky (1988) family is the most important social context for adolescents and also contributes to their development. A family structure therefore becomes an important predictor of the psychological adjustment of individual family members (Minuchin & Fishman, 1981). The role, function and identity of every family member become functional and individuals know how to relate to each other.

The structural family therapy emphasizes the importance of family structure in the functioning of a family as a unit and well being of its members. It also focuses on

maintaining a balance within family organization. A significant body of empirical literature suggests that suicidal behaviour in the teenage years is associated with family processes. Henggeler, Melton, and Linda (1992) gave a considerable attention to the roles of extra familial system in the development and maintenance of adolescence difficulties. They stressed that family has an influence on youth behaviour and provides guidelines for intervening when these influences are contributing to identify problems. In such cases, creating an effective family interface with a family system is crucial to achieving favourable outcomes.

Parents should be accommodative of changes relative to the developmental needs of their children. Adolescence being a transition from childhood into adulthood means that adolescents, during this period of development, tend to experiment a lot and often inclined to making impulsive decisions. Failure in accommodating their needs, which are characterized by independency and responsibility, will result in them seeking acceptance from their peers to achieve their goals.

In parental subsystem, parents become role models and continue to nurture their children, which enable them to be able to deal with stressful issues. The pattern of harsh aversive hostile interchanges between parents and children leads to development and intensification of antisocial behaviour. The nurturance provided in the parental subsystem serves as a buffer effect against suicidal ideation and attempts.

The sibling subsystem is a social laboratory in which children can experiment with peer relationships. In this subsystem, children learn to negotiate, compete, support and also learn from each other (Minuchin, 1996). The effective functioning of this subsystem is dependent on the well being of the spousal and parental subsystem.

As viewed by Hetherington and Clingempeel (1992), sibling subsystem is the first domain of social understanding. As the sibling subsystem interacts they learn new skills. They learn to be caring, sensitive and to interact socially (Anderson, Hatherington, Reiss, & Howe, 1994). According to Erikson's psychosocial developmental stages, people undergo phases in life in which physical, cognitive, instinctual, and sexual changes may trigger internal crisis which may result in either psychosocial regression or growth and development of specific virtues (Sadock & Sadock, 2003). This may result in adolescents becoming vulnerable and maladjusted, leading to suicidal behaviour.

In families where there is hostile environment and rejection, sibling aggression and sibling rivalry becomes prevalent, in that they aggressively demand attention from their parents or harm themselves in order to gain attention. Negative relationship between siblings may result in adjustment problems as well as externalized problems (Hetherington & Clingempeel, 1992). In consequence, family cohesion is important for sibling relationship and can prevent suicidal tendencies.

Anderson et al., (1994) talks of interparental relationships and sibling relationships, which may have a positive effect on children's relationships. Aspects such as family collectiveness and nurture are essential for the well being of children, in that they will know that even if they have difficulties they have the support from their families. Exposure to the external world may put pressure to developing adolescents, however having support from the immediate family will act as a mediator from stressful events, peer pressure, substance use and self destructive behaviour.

4.7.2. Boundaries

Minuchin (1996) describes a boundary as an invisible line that separates people or subsystems from each other psychologically. It is a thin line that defines the level of interaction process between members in a system and within subsystems. The family has both internal and external boundaries and both play a significant role. External boundaries to the nuclear family differentiate it from its social milieu. Internal boundaries, serve a function of differentiating the subsystems from one another. These boundaries differentiate and regulate the interaction between the nuclear system and the inter-generational networks.

Boundaries may reflect both flexibility and rigidity and this is required for an effective normal functioning of the system. Therefore boundaries should impose a mixture of rigidity and flexibility, depending on the circumstance.

Dysfunctional boundaries emerge as a result of enmeshed family relations. Aspects such as dysfunctional marital relationships and poor mother child relationship may have a negative impact on members of the family (Minuchin & Nichols, 1993).

Parental warmth was associated negatively with McCabe, Clark (1999) Suicidal behaviour in adolescents for example has been associated with lower level of social support received more social support when experiencing major life events rather than daily hassles. In addition, parenthood has been suggested to be protective against suicide. Thus, for instance, parental support has consistently been shown to predict self-esteem, families can be protective factors because those young people whose families spend time together and are emotionally involved were significantly less likely to be suicidal (Rubenstein et al., 1989).

4.8. Cognitive behavioural approach

Cognitive behavioural approach of Beck offers a more pathological explanation to suicide (Weishaar, 1993). This framework is used in the study to try and give theoretical clarity on suicide. Cognitive theorists' postulate that; suicidal behaviour occurs because of the distorted perceptions that individuals have about their worldview. Suicidal tendencies are not viewed as a disease, but rather as a symptom of an underlying problem (Rutter, Taylor & Hersov 1994). From this approach the aim is to try and understand what goes on in the mind of an individual who attempted suicide.

Depressed individuals have a pattern or tendencies to self talk and this perpetuates suicide tendency, these patterns are also called schemas. These are cognitive structures that hold core beliefs about certain thought, the person is usually not aware of the schemas until when triggered by a life event at which time they emerge accompanied by strong emotions.

From a behavioural approach, suicide can be seen as an act by the individual either in response to a negative life event or operant conditioning in response to punishment or even observational learning copycat suicide.

4.9. Conclusion

This chapter has highlighted a number of theories and points out that suicide can be understood from different perspectives, therefore it is vital that one understands these theories as a collective as there is no one theory that has proved to be adequate enough to explain suicide and its complexities.

CHAPTER 5

RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter deals with the research methodology used in the study including study design, participants, procedure and the type of instruments used for data collection and statistical methods used to analyse data. Ethical issues have been noted and considered.

5.2 Research design

Explorative design was used in the study. The researcher's aim was to understand adolescents who attempted suicide and their preferred type of support and coping strategies they use.

5.2.1 Participants

A total of 81 participants consisting of adolescents from 13 to 20 years both males and females of all races took part in the research. The inclusion criteria was to target suicidal adolescents that have attempted suicide and have been admitted in a hospital and referred for psychological intervention, irrespective of the kind of method used to commit the act

5.2.2 Procedure

Participants were individuals who attempted suicide and admitted in hospitals in Capricorn district. These were individuals who were referred for psychological intervention following suicide attempt. The individuals who agreed to take part in the study following discharge, were chosen for the study. On agreeing to participate, the study was explained to them and if they were still willing to participate, a consent form requesting permission to conduct a

research survey was handed out to participant who were minors; they were informed of the reasons of the research and consent form were issued out to their parents since they were minors. The project leader or researcher could not administer the questions himself because of ethical reasons including confidentiality of doctor-patient relationship. Data was therefore collected through counsellors or psychologists who did have a face to face contact with the participants.

5.2.3 Sample

The sample population was drawn from 100 (n =100) adolescents who attempted suicide in all hospitals i.e. Polokwane, Seshego, Mankweng, Helene Franz, Lebowakgomo. The researcher used purposive sampling which is a type of non-random sample in which the researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult to reach population.

5.2.4 Instruments

The questionnaire had 3 parts i.e. Section A (Biographical data), Section B was the Multidimensional Scale of Perceived Social Support, and Section C was the Ways of Coping scale.

5.2.4.1. Demographical Information

A questionnaire was used to collect demographical information which include age; gender; grade; religion, race, etc.

5.2.4.2. Multidimensional Scale of perceived Social Support (MSPSS)

Multidimensional Scale of Perceived Social Support (MSPSS) as developed by Zimet, Dahlem, and Farley (1988) was used, the items were divided into three factor groups relating to the source of social support, namely family (fam), friends (fri), or significant others (SO). The items were to be responded to by using a likert scale of 1 to 5 where 1 was strongly disagreeing 2: Disagreeing, 3: Neutral; 4: Agreeing; 5: Strongly agreeing .Subjects included 136 females and 139 males university undergraduates. The three subscales, addressing a different source of support, were found to be having a strong factorial validity.

The psychometric properties of the scale were investigated and a high internal consistency was demonstrated, and the factor analysis confirmed the three subscales of the MSPSS: family, friends, and significant others (Canty-Mitchell & Zimet, 2000).

5.2.4.3. Ways of coping scale

Ways of coping scale as developed by Billings and Moos (1981) was also used to measure coping strategies used by the participants. There were 32 items which measured three types of coping viz, active behavioural strategies (13 items), active cognitive strategies (11 items), and avoidance strategies (8 items) (Holahan & Moos, 1987).

The items were rated on a scale from 'not at all' to 'sometimes' and 'regularly'. The score for each set of coping strategies is the sum of the scores for the items indicative of that strategy. Research shows that the validity of each set of coping items as follows (Billing & Moos, 1981; 1885). Chronbach alpha of 0.62 for the active cognitive coping; 0.74 for the active behavioural coping, and 0.60 for the avoidance coping. This reflects an acceptable internal consistency.

5.3 Data collection

Through purposive sampling, all participants were made aware of their rights to participate and to terminate at any given time. As some of the participants were still minors, guardian or parental permission was needed to have the individuals participating in the research process. Data collection was through individual appointment with those participants who were still minors and had to wait for parent or guardian permission. For those who were above eighteen (18) years, the purpose of the study was explained to them and this took place at the consulting rooms of the psychologists or interns psychologists. A trained research assistant or clinician helped to administer and explain the questionnaire through.

5.4 Quantitative data

Quantitative method of collecting data was used by issuing questionnaires to individuals referred for psychological intervention after they have attempted suicide, the questionnaires will help the researcher to remain focused by asking only specific questions with the aim of specific outcome on the proposed study.

5.5 Statistical methods used

The Statistical Package for Social Sciences (SPSS) was used to analyse the data with Chi-square test and Analysis of variance (ANOVA).

5.6 Ethical consideration

University of Limpopo Ethics committee approved the study and permission was granted by Limpopo Health Department to interview patients that were admitted following suicidal attempt in the hospital around Capricorn district.. It was of outmost importance to guarantee

confidentiality to all participants and that no harm either physically or psychologically by way of participating in the study.

After obtaining permission, participants were made aware of the purpose of the study, and their rights to participate and that they can opt to withdraw at any time during the process. The participants were also made aware of the confidentiality and anonymity of the process.

Since participants were minors permission from their parents was requested before proceeding with the research, not excluding issues of confidentiality.

5.7. Conclusion

The methodology in this chapter was discussed including study design, participants and instruments used. All the necessary procedure for data collection and the statistical methods used were highlighted. Ethical issues were finally discussed and taken into consideration.

CHAPTER 6

RESULTS AND INTERPRETATION

6.1. Introduction

This chapter focuses on presenting the results and interpreting the analysis of data collected. Participant's biographical details are explained. Data is been presented in numerical form. Using descriptive statistics to describe and interpret the numerical information in frequency distributions and tables.

6.2. Demographical data

Biographical data is presented in frequencies, for eighty one participants (N = 81). A total of hundred (100) questionnaires were distributed, nineteen (19) of the returned questionnaires were either spoiled or incomplete.

Table 1: Demographic Details

Variables		Frequency	Percent
Age	14-17	23	28.3
	18-21	57	70.4
	22-26	1	1.2
	Total	81	100.0
Gender	Male	32	39.5
	Female	49	60.5
	Total	81	100.0
School Grade	8	5	6.2
	9	3	3.7
	10	9	11.1
	11	12	14.8
	12	28	34.6
	Post matric	22	27.2
	Total	79	97.5
	Missing	2	2.5

Religion	Christianity	57	70.4
	Islam	3	3.7
	African Traditional Religion	18	22.2
	Other Religion	3	3.7
	Total	81	100.0
Racial Group	Black	73	90.1
	White	2	2.5
	Indian/Asian	4	4.9
	Other	2	2.5
	Total	81	100.0
Ethnic group	Northern Sotho	45	55.6
	Southern Sotho	8	9.9
	Tsonga	8	9.9
	Venda	10	12.3
	Zulu/Xhosa	6	7.4
	Other ethnicity	4	4.9
	Total	81	100.0
Residential types	Urban/City	23	28.4
	Semi	23	28.4
	Urban/Township	34	42.0
	Rural/Village		
	Total	80	98.8
	Missing System	1	1.2
	Total	81	100.0
Parent's Marital status	Married	22	27.2
	Never married	30	37.0
	Divorced/Separated	20	24.7
	Deceased	9	11.1
	Total	81	100.0

Participant's Living with	Both parents	25	30.9
	Mother only	22	27.2
	Father only	4	4.9
	Grandparents	22	27.2
	Guardian/Stepparents	8	9.9
	Total	81	100.0
Birth order of participant's	First born	33	40.7
	Second born	21	25.9
	Third born	13	16.0
	Last born	8	9.9
	The only child	6	7.4
	Total	81	100.0
Number of children in participants' family	1	13	16.0
	2	13	16.0
	3	18	22.2
	4	11	13.6
	5	6	7.4
	6	7	8.6
	7	5	6.2
	8	4	4.9
	9	2	2.5
	10	1	1.2
	Total	80	98.8
	Missing System	1	1.2
	Total	81	100.0

6.2.1. Age of participants

Table 1 above details the demographic information on the age, gender, etc. For a total of 81 respondents (N = 81). The respondents' ages ranged as 14-17 years interval (n=23) (28.3%), 18-21 years (n= 57) (70.4%). Age 22-26 years (n=1) (1.2%)

As most frequencies were observed in the eighteen (18) to twenty (20) age groups, this shows that most attempted suicide in adolescents takes place during the exit years of adolescents unlike when the adolescents are still fourteen or fifteen years where the frequencies are still low.

6.2.2. Gender of participants

The table shows that from the eighty-one (81) participants, (39.5%) were males (n=32) and (60.5%) were female (n=49). This indicates that there were more female participants than male participants.

6.2.3. Educational level of participants

The participants in the different grade levels were as follows: (6.2%) were in grade 8 (n=5); (3.7%) were in grade 9 (n=3); (11.1%) were in grade 10 (n=9); (14.8%) were in grade 11 (n=12); (34.6%) were in grade 12 (n=28); (27.2%) were post matric (n=22) and this included among others, technikons and universities. (2.5%) did not respond to the question (n=2).

6.2.4. Religious affiliation

The table indicates that most participants (70.4%) were Christians (n=57), (3.7%) belonged to Islam (n=3), (22.2%) were African Traditional Religion (n=18) and (3.7%) belonged to other religion (n=3).

6.2.5. Racial group

The table displays the racial groups, showing (90.1%) were Blacks (n=73); (2.5%) were White (n=2); (4.9%) were either Indians or Asians (n=4); and (2.5%) belonged to other racial groups (n=2).

6.2.6. Ethnic group

The table indicates that (55.6%) were Northern Sotho (n=45); (9.9%) were Southern Sotho (n=8); (9.9%) were Tsonga (n=8); (12.3%) were Venda (n=10); (7.4%) were either Zulu or Xhosa and (4.9%) belonged to other ethnic groups. The Northern Sotho speaking individuals (55.6%) were the most participants for this question and this could be because of the area's most hospitals are found in, since the study was around Capricorn district and it's where most Northern Sotho individuals are found.

6.2.7. Residential types

The table above indicates that (28.4%) came from urban or city residential (n=23); (28.4%) came from semi urban or township (n=23); (42.0%) came from rural or villages (n=34) and (1.2%) did not respond to the question.

6.2.8. Parent's marital status

(27.2%) of the participants parent's were married (n=22); (37.0%) were never married (30); (24.7%) were either divorced or separated (n=20); and (11.1%) were deceased (n=9).

6.2.9. Participants' living with

(30.9%) of the participants were living with both parents (n=25); (27.2%) were living with mother only (n=22); (4.9%) were living with father only (n=4); (27.2%) were living with grandparents (n=22); and (9.9%) were living with either guardian or stepparents (n=8).

6.2.10. Birth order of participants

The table shows that (40.7%) of the participants were first born (n=33); (25.9%) were second born (n=21); (16.0%) were third born (n=13); (9.9%) were last born (n=8); and (7.4%) were the only child (n=6).

6.2.11. Number of children in participants' family

The number of siblings, reflects that (16.0%) were the only child (n=13); (16.0%) were only two (n=13); (22.2%) were only three in the family (n=18); (13.6%) were four in the family (n=11); (7.4%) were five in the family (n=6); (8.6%) were six in the family (n=7); (6.2%) were seven in the family (n=5); (4.9%) were eight in the family (n=4); (2.5%) were nine in the family (n=2); (1.2%) were ten in the family (n=1), and (1.2%) did not respond to the question (n=1).

6.3 FINDINGS

The findings will be presented in a way to describe participants expression of support by family, friends and significant others. The demographic differences will be highlighted about such expression of support and preference for support by the participants. The data will also include the respondents' ways of coping.

6.3.1. Expression of feeling supported (Perception of support)

A multidimensional scale of perceived support was used to measure perception of support.

The results obtained were used to compare the feelings of support by gender and age of participants using a t-test.

The results obtained indicated that 48% felt supported and 52% felt they were not supported as shown in table 2 below.

Table 2: Multidimensional Scale of Perceived Social Support

	Frequency	Percent
No Support	42	51.9
There is support	39	48.1
Total	81	100.0

6.3.2. Adolescents' perception of support

Differences in the adolescents' perception of support were done using t-test (one sample test).

The adolescents' perception of support by family, friends and significant others indicated significant differences for family support ($t = 30.648$, $df = 80$, $p = .000$), friends ($t = 30.335$, $df = 80$, $p = 0.000$) and significant others ($t = 25.634$, $df = 80$, $p = 0.000$). This indicated that adolescents prefer family support first ($X = 17.79$) followed by friend's support ($X = 17.77$) and the least preferred support is from significant others ($X = 17.63$). It is clear from these findings that although the family is the most preferred source of support, friends and significant others are still and equally important as sources of support (see table 3).

Table 3: T-Test: Adolescents' perception of social support

	N	Mean	T	df	p
family	81	17.79	30.648	80	.000*
friends	81	17.77	30.335	80	.000*
Significance others	81	17.63	25.634	80	.000*

* Significant at $p < 0.05$

6.3.3. PERCEPTIONS OF SUPPORT BY GENDER

The chi-square test was used to test perceived sources of support by gender. The results indicated that there was no significant association between gender and perceived sources of support ($X^2 = .525$, $df = 1$, $p = .469$) (See Table 4).

There was however, some pattern where females were inclined to show more perception of support by family ($X = 18.45$), friends ($X = 18.06$) and significant others ($X = 17.98$) than their male counterparts who showed a different order of preference for support as they perceived friends ($X = 17.31$) first, followed by significant others ($X = 17.09$) and lastly, family ($X = 16.78$).

This indicates that although the family is the most preferred source of support between the genders ($X = 17.79$) followed by friend ($X = 17.77$) and the least being significant others

($X=17.63$) (See Table 5), perceptions by gender indicates that males are more inclined to have their friends as the most preferred source of support than females.

Table 4: Chi-square test results of gender and social support

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.525 ^a	1	.469		
Continuity Correction ^b	.247	1	.619		
Likelihood Ratio	.525	1	.469		
Fisher's Exact Test				.503	.310
Linear-by-Linear Association	.518	1	.472		
N of Valid Cases	81				

Table 5: Perceived sources of social support by gender

		N	Mean
Family	Male	32	16.78
	Female	49	18.45
	Total	81	17.79
Friend	Male	32	17.31
	Female	49	18.06
	Total	81	17.77
Significant others	Male	32	17.09
	Female	49	17.98
	Total	81	17.63

6.3.4. PREFERENCE FOR SOURCES OF SUPPORT

Multidimensional scale of perceived social support (MSPSS) was used to measure preferences of support. Results indicated that family (33.5%) was the first preferred source of support, followed by friends (33.4%) and then, significant other (33.1%). This indicates that family and friends are most perceived as supportive, with the significant others being the last preference (See table 6 below)

Table 6: Preferred sources of support in percentages

		Total score obtained on MSPSS	Percent
Sub- scales	Family	1441	33.5
	Friend	1439	33.4
	Significant Others	1428	33.1
	Total	4308	100.0

6.3.4.1 Differences in the adolescents' preferences for source of support

Analysis of variance was used to determine the adolescent's preferred source of support between family, friends and significant others. Results showed no significant difference found for family preference as source of support ($F=1.997$, $df=79$, $p=.162$), as well as friends as source of support ($F=.388$, $df=79$, $p=.535$) and significant others ($F=.393$, $df=79$, $p=.532$) (See table 7). This indicates that there is no significant difference in adolescents preference for either family, friends or significant others for support.

Table 7: ANOVA: Adolescent's differences in preferences for support

		Sum of Squares	df	Mean Square	F	Sig.
Family	Between Groups	53.841	1	53.841	1.997	.162
	Within Groups	2129.591	79	26.957		
	Total	2183.432	80			
Friend	Between Groups	10.852	1	10.852	.388	.535
	Within Groups	2211.691	79	27.996		
	Total	2222.543	80			
Significant others	Between Groups	15.191	1	15.191	.393	.532
	Within Groups	3049.698	79	38.604		
	Total	3064.889	80			

6.4 STRATEGIES OF COPING BY ADOLESCENTS IN THE PRESENT STUDY

Ways of Coping scale was used to measure strategies for coping. The scale consists of three subscales: cognitive, behavioural and avoidance.

The results indicated that adolescents use more avoidance as a coping strategy (n=48)

followed by cognitive strategy (n=46) and lastly by behavioural strategy (n=43) (See Table 8 below)

Table 8: coping strategies used by adolescents

	Frequencies	
	Coping	Not coping
Cognitive	46 (56.8%)	35 (43.2%)
Behavioural	43 (53.1%)	38 (46.9%)
Avoidance	48 (59.3%)	33 (40.7%)

6.5. Relationship between ways of coping and perceived social support

6.5.1. Active - Cognitive Strategies and perceived social support

Table 9: Active - Cognitive Strategies and Perceived Social Support

		Multidimensional Scale Of Perceived Social Support		Total			
		No Support	There is support		X ²	df	p
Active-Cognitive Strategies					20.941	2	.000*
	Not at all	9	26	35			
	use	33	13	46			
Total		42	39	81			

*significant at $p < 0.05$

X² was used to compare the use of active-cognitive strategies and perceived social support.

The results show that there is a significant association between the use of cognitive strategy for coping and perceived support ($X^2 = 20.941$, $df = 2$, $p = .000$)

6.5.2. Active - Behavioural Strategies and perceived social support

Table 10: Active - Behavioural Strategies and perceived social support

		Multidimensional Scale Of perceived social support		Total			
		No Support	There is a support		X ²	df	p
Active-behavioural strategies					7.889	2	.019*
	Not at all	14	24	38			
	use	28	15	43			
Total		42	39	81			

* Significant at $p < 0.05$

X² was used to compare the use of active-behavioural strategies and perceived social support.

The results showed that there is a relationship between active-behavioural strategies and the kind of perceived social support ($x^2 = 7.889$, $df = 2$, $p = 0.019$) (see table 10),

6.5.3. Avoidance strategies and perceived social support

Table 11: Avoidance strategies and perceived social support

		Multidimensional Scale Of perceived social support		Total	X ²	df	p
		No Support	There is support				
Avoidance strategies					.453	2	.797*
	Not at all	16	17	33			
	Regularly	26	21	45			
Total		42	39	81			

*significant at $p < 0.05$

Chi-square was used to compare the use of avoidance strategies and perceived social support, results showed that there is no significant relationship between avoidance strategies and the kind of perceived social support ($\chi^2 = 0.453$, $df = 2$, $p = .797$) (see table 11).

6.6 Relationship between gender and coping strategies

6.6.1. Gender and Active- Cognitive Strategies

Table 12: Gender and Active - Cognitive Strategies

		Active - Cognitive Strategies		X ²	df	p
		use	Not at all			
Gender	Male	18	14	.103	1	.950*
	Female	28	21			
Total		46	35			

*significant at $p < 0.05$

Chi-square was used to check on the relationship between gender and active-coping strategies and the results showed that there is no significant relationship between the two ($\chi^2 = 0.103$, $df = 1$, $p = 0.950$) (see table 12).

6.6.2. Gender and Active- Behavioural Strategies

Table 13: Gender and Active - Behavioural Strategies

		Active - Behavioural Strategies		X ²	df	p
		use	Not at all			
Gender	Male	18	14	.221	2	.895*
	Female	25	24			
Total		43	38			

*significant at p<0.05

Chi-square was used to sought the relationship between gender and active- behavioural strategies and the results showed that there is no significant relationship between gender and active- behavioural strategies ($x^2 = 0.221$, $df = 2$, $p = 0.895$) (see table 13).

6.6.3. Gender and Avoidance Strategies

Table 14: Gender and Avoidance strategies

		Avoidance strategies		X ²	df	p
		Use	Not at all			
Gender	Male	22	10	4.786	2	.091*
	Female	26	23			
Total		48	33			

*significant at p<0.05

Chi-square was used to check on the relationship between gender and avoidance strategies and the results showed that there is no relationship between gender and avoidance strategies ($x^2 = 4.786$, $df = 2$, $p = .091$). In this study table 12 indicates that more females use avoidance strategies more than their male counterparts.

7. CONCLUSION

In this chapter perception, preferences and strategies were investigated and results were presented and interpreted in tables, the demographical details showed that there were eighty one (81) participants with 39.5% of the participants being males and the other 60.5% being females. Participants were from grade 8 to post matric, most were Christians who belonged to the Black racial group speaking Northern Sotho. They came from urban, city and township areas; and more than forty percent were 1st borns' in the family.

The findings showed that perceptions of support by gender showed no significance towards the two groups (males and females), but females scored more in all subscales of family, friends and significant others. They showed to have an inclination to perceive family first, followed by friends and significant others were they last. Unlike males were they scored low compared to females in all categories and they had different sequence compared to females as they preferred friends, followed by significant others and lastly family.

The adolescents' preference for sources of support was established using ANOVA and no significant was established in the source of support for all the different subgroups being family, friends and significant others.

In this study coping strategies used by adolescents showed that more used avoidance, followed by cognitive and lastly behavioural. There was a significant association established in the use of cognitive strategies and coping as these adolescents viewed their source as supportive and this was also true with active-behavioural strategies, the adolescents viewed their support structure as supportive. On avoidance strategies there was no significant relationship established and this implies that these adolescents view their world outlook as not having any support.

The relationship between gender and coping strategies showed that there is no significant relationship among, active, behavioural and avoidance strategies.

CHAPTER 7

DISCUSSION

7.1. Introduction

This chapter deals with the results from the previous chapters on statistical analyses, an in-depth discussion is presented considering the various hypothesis that were put forward; limitations of the study and recommendations would be made in terms of directing and assisting future research on the topic.

7.2. Demographical data

From the data in the previous chapter, participant's age ranged from fourteen to twenty years of age. A larger proportion of the participants 70.4% were in the 18-21 years range. More females than males participated in the study and this is also confirmed by literature that more females engage in suicide attempt than males as males turn to complete the act (Nevid.et. al. 1997).

Most of the participants who engaged in suicidal attempt were in grade twelve and others obtained post matric qualifications. Christianity in terms of religion had the most participants and together with African traditional religion. Literature highlighted that religion is an important aspect of support in that individuals who have closely knit ties with their religion, find support within the church and turn to cope better with life stressors and challenges, and are at a lesser risk of committing suicide or even to have suicidal thoughts (Dervic et al., 2004).

Racial group with the most frequency was found among blacks and further broken down to

ethnic group with more Northern Sotho speaking participants which could be attested to the fact that Limpopo has a large percentage of Northern Sotho people like KZN with the majority of Zulu speaking people.

The demographical data suggest that those living in urban areas and those living in semi urban or township areas were equal in participation and the rest came from rural areas. This could have been influenced by the geographic area where the hospitals are situated as the research only took place in Capricorn district and it is only around Polokwane where it's urban and the rest of it is rural.

Participants parental marital status was that most were never married as compared to those that were married and those that were divorced or separated, and only a small statistic showed that the rest were deceased though limited to not saying either both parents or only one as the father or mother was deceased.

Majority of the participants were found to be living with both parents and this is fundamental for a stable and healthy upbringing of a family and by the participants engaging in suicidal behaviour that would imply that family relations are not grounded and that family boundaries are not rigid there by making these to be enmeshed leading to the participants feeling that they have no support.

Others were either living with mother only or with grandparents only and with single parenting it also lacks the support of either parents and this may at times translate to some individual not coping with the absence of one or the other parental figure in their lives.

The birth order of participants in their family showed that most of the participants who

engaged in suicidal behaviour were first born followed by second born. What is noticeable about the birth order is that the frequency of participants decreased as the order increased to the last born.

7.3. Perceptions of perceived social support

The following discussion will be focusing on integrating the results as presented in the previous chapter and to consider the hypotheses indicated in the study. Duffy and Wong (2000) consider perceived social support as one of the type of social support that looks at how available and adequate social support is. An adolescent might have numerous sources of support and may feel that the support is either useless or inadequate or sometimes even inconsistently provided.

Therefore Duffy and Wong (2000) actually emphasized that the kind of support that an individual receives is dependent on the level of actual support that an individual can receive as and when needed and this needs to be consistent to be considered adequate.

7.3.1. Adolescent's perception of support

Most of the individuals who participated in the study reported to having no support as compared to those who said they have support. This would imply that most of the individuals who have attempted suicide perceive their immediate environment as providing no form of support.

Hypothesis 1, stated that 'adolescents who have attempted suicide prefer their peers for emotional support to other forms of support' the findings indicated contrast to the hypothesis in that Adolescents who attempted suicide prefer their family as the first line of support and peers or friends are considered second to family, while significant others are the least perceived source of support. Adolescents perception of support by the three sources being

family, friends and significant others indicated that there is a significant difference between family, friends and significant others. Adolescents perceived the family as the most important source of support among the three groups, then friends and finally significant others.

As most adolescents who have attempted suicide indicate that they have no support within their immediate environment and would still prefer family for support to other forms of support. This would imply that though adolescents may feel good or bad about their families, they do prefer to have them as their first line of support and this indicates that where family environment and parenting are warm, accommodating and high in control, adolescents will grow up being responsible, having high self esteem and with emotional stability and this is often only brought to the conscious once the adolescent has been through a turmoil and realises that what has been imparted to them is what they really need and the family is the first environment to provide that (Sullivan, 2001). And because of that, they start to externalize their behaviour and feel they can share their problems and find better solutions. Stern and Zenon (1990) highlighted that family environment plays an important part in influencing adolescent's responses to life stressors; Sullivan (2001) viewed the family as a protective factor in the adolescents developmental stage.

Shama and Sandhu (2006) are also of the view that harsh, hostile relationship between parents and children leads to the adolescent developing antisocial behaviour and the adolescent finding themselves being estranged from the family. As was also pointed out that parenting that is inconsistent, with harsh discipline, inadequate parental monitoring, family conflict and low affective bonding can lead to risk factors for adolescents resulting in suicide (Cicchetti & Toth, 1995).

7.3.2. Perception of support by gender

In the present study more females participated in the research and this was in line with what most literature highlighted that more females attempt suicide than their male counterparts (Nevid, Rathus & Greene,1997). Even though there were more females than males, the results on sources of perceived social support by gender among the participants, highlighted that there was no significant relationship between gender and perceived sources of social support. This implied that even if there is support or no support, this does not depend on any gender specification. This would also imply that there are other factors that would influence support and that gender is not one of those.

Females, they were more inclined to perceive the family as the most preferred source of support, followed by friends and the last being significant others, while males showed a different pattern to that of females. They perceived the friends as the first source of support followed by significant others and lastly family.

This different order of preference by the males may be due to cultural aspects that as a man one might need to show their masculinity and be closer to their friends than family, unlike females where they are expected to spend most of their time at home. This as might be brought about by the sense of trying to belong to a group of friends and ultimately; having to prove that element of masculinity and be accepted within the group. Triandis et.al., (1996) stressed that individualism and collectivism are the two aspect that are important in culture and from the result within the study it shows that males were more inclined to be collectivists and be more interdependent self and ultimately influence their social behaviour thereby ultimately them viewing friends as more important, these aspect of collectivism is embodied in culture as some of the aspects include values, norms, beliefs and identity; which gives the adolescent that sense of belonging and feeling accepted within the group

7.4. Preference for sources of support

Adolescents showed no significant difference in terms of preference on the source of support for either family, friends, and significant others. Though there was no significant difference the family was more inclined to be the first in order of preference and followed by friends and lastly significant others.

The family as highlighted by the adolescents turns to be the most important institution that adolescents rely on for support in many circumstances. As was documented by Stern and Zevon (1990) family environment is important in that it plays a vital role in influencing adolescent's responses to difficult situations they are faced with. Steinberg (1993) elaborated further that actually different groups are important to provide support because they perform different roles of support at times of stress. Friends and parents do provide different forms of support for adolescents; and the adolescent might need them both for different reasons. Therefore this would mean that an adolescent might seek help with their family on issues relating to school as to where to attend school and academic difficulties as the school will also communicate first with the parents when need be. This relationship between the school, parents and adolescents is crucial so as to help the adolescent to achieve that which is important and that's performing well at school.

While on the other hand the adolescent may relate better with their friends on relationship matters, this might be because the adolescent feels that their friends are of their same age and experience problems of the same level and that they might be in a better position to understand them and that they might be talking of problems that their friends know about and can be better of in giving solutions. With this in mind it wouldn't mean that the preferred friends are capable of solving nor have the experience to help their friend but instead it might

be more of feeling comfortable talking to friends than family about such matters as family might discourage or even reprimand them for the problems they are facing.

Steinberg (1993) explains that the increase in intimacy between adolescents and their friends is not accompanied by lessened intimacy towards family or parents, spending more time with friends. From family the adolescent will have an opportunity to learn from someone wiser and older, while from friends it's an opportunity to share experiences with someone who has similar perspective and degree of expertise

7.5. Coping strategies used by suicidal adolescents

Hypothesis three stated that 'adolescents use different coping strategies following suicide attempt and this differs according to the support they prefer to have'. Coping strategies was measured using (Ways of Coping Scale (WCS), which has subscales of coping by active-cognitive, active-behavioural and avoidance.

The results highlighted that there were those who reported that they were coping and those who reported that they were not coping. What is significant for those who reported coping is that most used avoidance as a coping strategy and followed by cognitive strategy and the least was behavioural. While those who reported not to cope were more inclined to use behavioural and this was followed by cognitive strategy and the least used was avoidance.

What stands out from the different strategies is that while cognitive strategies are second in terms of the total adolescents using the strategy for those who are coping and those who are not coping, behavioural and avoidance are the two strategies that are alternated when comparing those who are coping and those who are not coping.

Most adolescents who reported to be coping used avoidance strategy more than the others and

this was followed by cognitive as indicated above and behavioural was the least used; while for those who reported not to cope, most adolescent used behavioural strategies to can cope and the least used by adolescents was avoidance

In avoidance strategies most participants expressed avoiding the problem they are faced with regularly. These strategies that adolescents made were more debilitating or risk taking as they exposed the adolescent to taking more alcohol, more smoking, tranquilizers, be withdrawn and projecting their feelings onto other people, etc. These strategies are as a result of what Beck (2011) referred to as distorted negative cognition (thoughts and beliefs) and these are the primary features of depression that ultimately leads to suicide attempts if not completed suicide.

According to Beck (2011) dysfunctional thinking which influences the individual's mood and behaviour is common to all psychological pathologies. Implying that people's emotions, behaviour and physiology are influenced by their perception of events as they are faced with at that moment.

This is based on the rationale that an individual's affect and behaviour are largely determined by the way in which the individual structures the world around them (Beck 2011), so the adolescent will structure their immediate problems as one's they can't manage and by so doing try and avoid them through actions or strategies mentioned earlier.

7.6. Relationship between ways of coping and perceived social support

There was a significant association established with active cognitive and active behavioural strategies and the ways of coping among adolescents in terms of how they were coping in relation to their perceived social support, while there was no significant relationship between

avoidance strategies and perceived social support.

This implies that those adolescents who were actively involved in thinking about their problems and those who actively physically did something to cope with their problems, perceived the environment as having support.

7.7. Relationship between gender and coping strategies

There was no significant relationship found between gender and the coping strategies; and although the results pointed out no significant gender relationship with coping strategies, females, more than males turn to use active-cognitive and active-behavioural strategies. Both genders were found to equally use avoidance strategies.

In general it has been established that with all the strategies that participants have deployed in dealing with the day to day life challenges gender has no relation in terms of the support that the individuals perceive to receive in return. This implies that whether an individual is a male or female, the kind of support that they receive does not in any way depend on their gender

7.8. Conclusion

The aim in this study was to explore preferences for support structures that adolescents prefer following suicide attempt and to identify the different coping strategies employed by suicidal adolescents specifically for the Capricorn district in Limpopo.

In all eighty one participants were recorded from around the district and there were more females than males in the study. The study results presented and discussed in the chapter indicate that most adolescents, especially those at the exit years of adolescence are the ones most involved in the suicidal tendencies with females having the most frequencies.

In this study results indicate that adolescent suicide attempt takes its peak during matric, and this was also highlighted by Mashego (2004) when she explained that most matriculants are stressed by the pressures of matric exams and the results more often take their toll on these adolescents.

With the coping strategies no significant relationship was established on gender and the kind of coping strategies that individuals employed. There was however, indications that females used active-cognitive and active-behavioural strategies as a means to coping more than the males and both genders equally use avoidance strategy to cope.

Therefore the results also indicate that adolescents will use different coping strategies and avoid the situation most of the time, this making it more difficult for them to cope. The family as viewed by the adolescent is always an important group to receive support, though the other groups are still recognised as such but would follow after the family.

7.9. Limitations of the study

The study aimed at exploring preference for support and identifies the different coping strategies employed in dealing with these stressors.

- Suicide is a sensitive issue which is limited by the information received from participants and to collaborate or explore further from friends and family or significant others is not always possible due to confidentiality issues.

- Due to limited resource the research was based on a small sample from only a limited number of hospitals, thereby most of the possible participants have definitely filtered through from other hospitals and as it was confined to Capricorn district.

- More information could have been retrieved on participant's family dynamics which could have put more insight into how and why these adolescents act or behave as they do.
- Most participants were Northern Sotho speaking and this limited the research to one group and excluded other cultures
- As much as the study looked at support and coping in adolescents, there are other factors that still needs to be explored that would cut across the age range and look beyond adolescent's stage.

7.10. Recommendations

The study with the results and taking into account its limitations; the following recommendations are outlined:

- The demographical data highlighted that most participants were at the exit period of adolescents, therefore effective coping strategies should be taught from an early age, this would include tolerance thereby reducing the amount of frustration that may occur as a result of the stressors they face.
- Schools should be routinely involved in workshops and other activities that highlight the importance of support and coping strategies in an effort to alleviate suicide.
- But beyond workshops, mentors should be established that will focus one on one with individuals support in helping the adolescents to understand the dynamics involved in a support system and why it is important to have one.

- Adolescents should also be made aware of the importance of being mindful and aware of their immediate feelings and emotions about the here and now situation they are faced with through mentors and other significant individuals.

- More resources should be channelled at matriculants and post matriculants since they are the most vulnerable according to the results of the present study. Resources of this nature will help adolescents get involved in projects to keep them busy and not idle. The resources will also equip them with life skills to enhance their positivity to their environment; commit to activities that will prepare them for future endeavours and not become continuously consumed in negative behaviour with subsequent development of helplessness that breed suicidality.

- Research in suicide should be a continuous process that keeps up with the changing family, political and cultural dynamics of our society. This is crucial since what is considered crucial support today for the adolescent, might not necessarily be viewed as relevant support for the adolescent of today may change for the adolescents in the future.

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APPENDIX A

INFORMATION TO PARTICIPANTS

WELCOME!

We are conducting a research on the preferences of support on adolescents who have attempted suicide in the past twelve months. We are grateful for your participation and your time.

This questionnaire consists of 6 pages including the cover page. On the following pages we will be asking you to answer a number of questions. Please realize that there are no right or wrong answers to these questions, you need only choose one option from each question, we are interested in your individual response. **Your responses are completely anonymous.** The results will only be used for this research purpose, and under no circumstances will you be identified.

The questionnaire will take you about forty-five (45) minutes to complete. We would greatly appreciate it if you would take your time and answer each question with care and honesty. Please try and make sure that you answer all the questions.

We thank you very much again for your participation. When you're ready, you may turn the page and begin to answer. If you have any questions as you are completing the questionnaire, please do not hesitate to ask for clarity.

Appendix B

UNIVERSITY OF LIMPOPO
(Turfloop Campus)

PROJECT TITLE: Exploration of Preferences for Support and Coping
Strategies following Suicide Attempt among Adolescents in Limpopo Capricorn District

PROJECT LEADER: Ngoako M. Rasodi

CONSENT FORM

I, _____ understand that the services rendered at this unit are for _____ purposes only and hereby voluntarily consent to participate in the project and that the following was made clear to me by the researcher/ research assistant:

1. The research deals with exploring preferences for support and coping strategies following suicide attempt among adolescents and that the information will be used solely for research purposes
2. No client names will be used nor file numbers of clients. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research
3. Participation is completely voluntarily and you have the right and are free to withdraw from the project at any time
4. The content of the questionnaire has been explained to me

Signature of research participant

Signature of parent/ Guardian

Signature of researcher

Thus signed at _____ on this _____ day of _____ 20_____

APPENDIX C:
BIOGRAPHICAL INFORMATION

**EXPLORATION OF PREFERENCES FOR SUPPORT AND COPING STRATEGIES
FOLLOWING SUICIDE ATTEMPT AMONG ADOLESCENTS IN LIMPOPO CAPRICORN
DISTRICT**

Do not write your name on this survey. The answers you give will be kept private. No one will know what you wrote. Answer the questions honestly. Make sure to read every question.

Thank you very much for your participation!

BIOGRAPHICAL INFORMATION

1. Complete the following information by checking the appropriate box with an X

Please answer the questions below as honestly as possible, by marking the answer that applies to you most.

1. Age: _____

2. Gender: Male Female

3. School Grade: _____

4. Religion: Christianity Islam African Traditional Religion

Other (specify)

5. Race: Black White Asian/Indian

Other ethnic group

6. Ethnicity: N. Sotho S.sotho Tsonga Venda Tswana

Zulu/Xhosa Other (specify)

7. Place of residence: Urban/City Semi Urban/ Township

Rural/Village

8. My parents are: Married Never Married

Divorced/Separated Deceased

9. I am living with: Both parents Mother only Father only
 Grandparents Guardian/stepparents
10. In my family, I am the: First born second born Last born the
 only child other (specify)
11. Number of children in your family (including yourself) _____
12. Mother's education: No education Primary education
 secondary school education tertiary education
 (university/technicon/etc) other (specify)
13. Father's education: No education Primary education
 secondary school education tertiary education (university/technicon/etc)
 other (specify)
14. Guardian/stepparent's education: No education Primary education
 secondary school education tertiary education university/technicon/etc)
 other (specify)
15. Father's employment: unemployed Labourer
 Technical work civil servant/clerical work businessperson
16. . Mother's employment: unemployed Labourer
 Technical work civil servant/clerical work businessperson
17. Guardian/stepparent's employment: unemployed Labourer
 Technical work civil servant/clerical work businessperson

APPENDIX D

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

The following questions are about people in your environment who provide you with different forms of help or support.

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement by circling the appropriate box

Circle the “1” if you **Very Strongly Disagree**

Circle the “2” if you **Strongly Disagree**

Circle the “3” if you **Mildly Disagree**

Circle the “4” if you are **Neutral**

Circle the “5” if you **Mildly Agree**

Circle the “6” if you **Strongly Agree**

Circle the “7” if you **Very Strongly Agree**

1	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2	There is a special person with whom I can share my joys and sorrows	1	2	3	4	5	6	7	SO
3	My family really tries to help me	1	2	3	4	5	6	7	Fam
4	I get the emotional help and support I need from my family	1	2	3	4	5	6	7	Fam
5	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7	I can count on my friends when things go wrong	1	2	3	4	5	6	7	Fri
8	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10	There is a special person in my life who cares about my feelings	1	2	3	4	5	6	7	SO
11	My family is willing to help me make decisions	1	2	3	4	5	6	7	Fam
12	I can talk about my problems with my friends	1	2	3	4	5	6	7	Fri

APPENDIX E

WAYS OF COPING SCALE

Here are a number of options to choose from when dealing with problems. You have probably been coping with your problems in the past by handling it or dealing with it in a certain way. We would like to learn how you deal with your problems.

If you think the statement is describing how you *regularly* deal with a problem, make an X in the box labelled regularly. If you think the statement is describing how you *sometimes* deal with the problem, make an X in the box labelled sometimes on the answer sheet. The same goes for *not at all*. If you think the statement is not applicable to how you deal with a problem, make an X in the box labelled not at all.

Please be sure to answer every statement.

Instructions: Tick under appropriate response

ACTIVE – COGNITIVE STRATEGIES				
		Not at all	Sometimes	Regularly
1	Prayed for guidance and /or strength			
2	Prepared for the worst			
3	Tried to see the positive side of the situation			
4	Considered several alternatives for handling the problem			
5	Drew on my past experience			
6	Took things a day at a time			
7	Tried to step back from the situation and be more objectives			
8	Went over the situation in my mind to try to understand it			
9	Told myself things that helped me feel better			
10	Made a promise to myself that things would be different next time			
11	Accepted it, nothing could be done			

ACTIVE - BEHAVIOURAL STRATEGIES				
		Not at all	Sometimes	Regularly
12	Tried to find out more about the situation			
13	Talked with spouse or other relative about the problem			
14	Talked with friend about the problem			
15	Talked with professional person (e.g. doctor, lawyer, clergy)			
16	Got busy with other things to keep my mind off the problem			
17	Made a plan of action and followed it			
18	Tried not to act hastily or follow my first hunch			
19	Got away from things for a while			
20	I knew what had to be done and tried harder to make things work			
21	Let my feelings out somehow			
22	Sought help from persons or groups with similar experience			
23	Bargained or compromised to get something positive from the situation			
24	Tried to reduce tension by exercising more			
AVOIDANCE STRATEGIES				
		Not at all	Sometimes	Regularly
25	Took it out on other people when I felt angry or depressed			
26	Kept my feelings to myself			
27	Avoided being with people in general			
28	Refused to believe that it happened			
29	Tried to reduce tension by drinking more			
30	Tried to reduce tension by eating more			
31	Tried to reduce tension by smoking more			
32	Tried to reduce tension by taking more tranquilizing drugs			

This is the end of the survey. Thank you for your participation.