A Qualitative Investigation into the Risk and Protective Factors that mediate Non-Fatal Suicidal Behaviour in Indian Adolescents

by

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DECLARATION

Submitted in partial fulfilment of the requirements for the degree of Master of Social Science, in the Graduate Programme in Counselling Psychology, University of KwaZulu-Natal, Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Social Science in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other university.

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ABSTRACT

Considering the escalating rate of suicidal behaviour in adolescents, not much is known about the risk and protective factors that mediate non-fatal suicidal behaviour among this group. This study has focused on exploring the subjective worlds of Indian adolescents who have engaged in non-fatal suicidal behaviour in order to identify such factors, which are crucial in the designing of effective intervention programmes.

The sample consisted of 10 adolescent patients who were admitted to R.K. Khan Hospital in Chatsworth, Durban after non-fatal suicide attempts. The emergent risk and protective factors were conceptualised according to Bronfenbrenner's (1979) Social Ecology Theory, which facilitated an understanding of the multiple levels of risk and protective factors that mediate NFSB in adolescents. The results of this study highlight the collective influences of individual, familial, cultural and societal factors on adolescents' decisions to engage in non-fatal suicidal behaviour.

A number of clear priorities for prevention programmes emerged from the results of this study. As such, recommendations were made to facilitate prevention and intervention programmes at a site, familial, peer and community level.

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CHAPTER ONE

INTRODUCTION

1.1 Background and Rationale for the Study

Globally, approximately one million people commit suicide annually (Bertolote, 2001). The World Health Organisation estimates that based on current trends, approximately 1.53 million people will commit suicide by the year 2020 and 10-20 times more people will attempt suicide worldwide, representing an average of one death by suicide every 20 seconds and one attempt every 1-2 seconds (Bertolote & Fleischmann, 2002).

In keeping with global trends, suicide rates in Africa have been found to be significantly higher than was previously believed (Schlebusch, 2005a). Meehan and Broom (2007) report that South African suicide rates are higher than the global average (17.2 per 100 000 compared to 16 per 100 000). According to statistics provided by the National Injury Mortality Surveillance System (NIMSS), of the large metropolitan areas in South Africa, (Cape Town, Johannesburg, Pretoria and Durban), the suicide rates for Durban (14 per 100 000) was found to be the second highest, after Johannesburg (15 per 100 000) (Naran, cited in Schlebusch, 2005a). Durban has the highest proportion of Indians in South Africa, and the suicide rate for this group has been higher for both males and females than in other metropolitan areas in South Africa (Burrows & Laflamme, 2005).

Over the past decade or so, there has been a shift in suicide rates, from the elderly towards younger people, making suicide among the top five causes of death in young people (Schlebusch, 2005b). According to NIMSS statistics, the highest rate of suicidal behaviour occurs in the 15 to 19 year age group (Matzopoulos, Cassim & Seedat, 2003). This 'ungreying' phenomenon presents a serious public health concern, as several South African studies have noted that approximately one-third of all non-fatal suicidal behaviours (NFSB) involved children and adolescents (Schlebusch, 2004). Currently, more suicides are committed by people aged 5-44 years than by people aged 45 and above (Bertolote & Fleischmann, 2002).

The prevalence of NFSB has been found to be alarmingly high among adolescents across different cultures (Sidhartha & Jena, 2006), which is also the case in South Africa. The incidence of NFSB is on the increase in South Africa (Moosa, Jeenah & Vorster, 2005); with the child and adolescent age group being identified by the Durban Parasuicide Study (DPS) as the second-most at-risk group for NFSB (Schlebusch, 2005a). This indicates that the prevention of such behaviour should be a priority. In light of these facts, this study aimed to identify those factors that place adolescents at risk for suicide, as well as those factors that may protect them against such behaviour. It is imperative to identify such factors, which are fundamental to the designing of prevention programmes.

Despite the magnitude of research conducted in the field of suicide and suicidal behaviour, there are still apparent limitations in previous research. Most previous studies have employed a quantitative methodology, which, although necessary to gain statistical data, have not provided in-depth information on NFSB. Several researchers have stressed the need for more qualitative studies to understand the contextual experiences of suicidal adolescents especially in relation to the risk and protective factors for suicide (Bostik & Everall, 2007).

An exploration into the subjective worlds of adolescents who have engaged in NFSB will aid in the identification of the factors that place adolescents at risk for suicide, and those factors that may protect them against such behaviour. Such information is fundamental in the formulation of effective suicide prevention and intervention programmes.

Due to the exploratory nature of the study, a qualitative methodological approach was employed, as such methods allow for the in-depth investigation of selected issues (Kaniki, 2002), such as, in this case, the risk and protective factors for adolescent suicide. Qualitative research was deemed appropriate for this study, as it attempts to understand individual human experience in great depth (Becvar & Becvar, 2000), in line with the aims of this study.

This study has been seated within the area of ethnographic inquiry, as it aimed to develop an understanding of NFSB in adolescents, as seen through the eyes of the participants

(Fetterman, cited in Potter, 2002). According to Fetterman (1998), 'ethnographers assume a holistic outlook in research to gain a comprehensive and complete picture of a social group' (p.19). This orientation can assist the researcher discover the interrelationships among the various systems and subsystem in the community under study, mostly by contextualising the data (Fetterman, 1998). This has been deemed appropriate in the current study in order to ascertain the different levels of factors in the community that either place one at risk for, or protect one against engaging in suicidal behaviour.

Accordingly, a multi-levelled theoretical approach has been employed, in order to get a holistic understanding of the risk and protective factors that mediate NFSB in adolescents. Bronfenbrenner's ecological model, in particular, presents an ideal theoretical framework for this study, as it enhances the understanding of the individual by taking their larger environmental context into account (Kidd, et al., 2006). Bronfenbrenner's Social Ecology Theory relates to the influences on mental well-being which are believed to operate proximally and distally within four systems - the microsystem, the mesosystem, the exosystem and the macrosystem (Petersen & Govender, 2007). This framework has been considered to be ideal as it takes into account different levels of factors that play a role in NFSB.

In summary, the main aim of this study was to investigate the risk and protective factors that mediate NFSB in adolescents, drawn from the Psychology Out-patient unit at R.K Khan Hospital in Chatsworth, Durban.

Chapter two provides a critical overview of pertinent literature in the field while Chapter three details and justifies the methodology used in this study. Following a thematic analysis of the interview transcripts in Chapter four, Chapter five offers a synthesis of findings from a theoretical standpoint. Finally, a range of conclusions and recommendations are detailed in Chapter six, together with a critical appraisal of the limitations that constrained this study.

CHAPTER TWO

LITERATURE REVIEW

2.1. Terminology

As this study aims to explore the risk and protective factors that mediate adolescent NFSB, it is pertinent to define the key terms that will be used.

2.1.1. Non-Fatal Suicidal Behaviour (NFSB)

In this study, the term non-fatal suicidal behaviour (NFSB) will be used to indicate self-harm that did not succeed in ending the victim's life.

2.1.2. Adolescence

Adolescence, according to Erikson, occurs between the ages of 12 and 18, and is described as a time of transition between childhood and adulthood - a time for testing limits, breaking dependant ties and for establishing a new identity (Corey, 2005). Major conflicts at this time, according to Erikson's psychosocial stages of development, centre around the clarification of self-identity, life goals and life's meaning (Corey, 2005). As the Penguin Dictionary of Psychology, defines adolescence as 'the period of development marked at the beginning by the onset of puberty and at the end by the attainment of physiological and psychological maturity' (Reber & Reber, 2001, p.13), there is no general consensus on what age range constitutes adolescence. For purposes of this study, an adolescent will refer to an individual aged 12 to 20, inclusive.

2.1.3. Risk Factors

Risk factors are those factors that are believed to be associated with or lead to suicide; indicating that people who possess such factors are at a greater potential for suicidal behaviour (Suicide Prevention Resource Centre [SPRC], 2001). Hendin, Maltsberger, Lipschitz, Haas and Kyle (2001) define suicide risk as 'the presence of any factor empirically shown to correlate with suicidality - including age, sex, psychiatric diagnosis and past suicide attempts' (p. 256).

2.1.4. Protective Factors

Protective factors are those factors that reduce the likelihood of engaging in risk behaviours or of adverse outcomes from having engaged in them, and serve as buffers against exposure to risk factors (Jessor, 1998).

2.2. Non-fatal Suicidal Behaviour, Parasuicide and Attempted Suicide

Although the terms *parasuicide* and *attempted suicide* have often been used synonymously with NFSB, there are core differences. According to Schlebusch (2005a), attempted suicide refers to NFSB where there is a 'fortuitous survival of the intended suicide' (p.6) while parasuicide refers to 'non-fatal suicidal behaviour without the intention to die' (p.6). He further states that parasuicide is usually seen as a 'cry for help'; and such self-harm is believed to be used as an inappropriate problem-solving skill (Schlebusch, 2005a). Procter (2005) concurs with this definition, viewing parasuicide as a 'cry for help' where such behaviour is believed to be an expression of disconnection and dysfunctional relationships. This view is also shared by Kreitman (1997), who regards parasuicide as a form of communication, and specifically, a cry for help. O'Connor, Armitage and Gray (2006), on the other hand, define parasuicide as any act of deliberate self-harm, irrespective of intention to die.

Attempted suicide has generally been considered as a simple failure to complete a suicidal act, regardless of the reason (Kreitman, 1977). An intention to kill oneself, either explicit or implicit, is considered to be an important feature of an attempted suicide, according to Sidhartha and Jena (2006).

Both parasuicide and attempted suicide fall under the broader category of NFSB. For purposes of this study, NFSB will refer to suicidal acts that the person has survived, in accordance with Canetto (1997).

2.3. Non-fatal Suicidal Behaviour in South Africa

The South African ratio of fatal compared to non-fatal suicidal behaviour is thought to be 1:20, or higher (Schlebusch, 2004). Accordingly, the rate of attempted suicide among adolescents is much higher than completed or fatal suicides (Grøholt, Ekeberg &

Haldorsen, 2006). These statistics are alarming, considering that the true incidence of fatal and non-fatal suicidal behaviour is much higher than the reported figures (Koen, 2004). It is worth noting that most research on the prevalence of adolescent NFSB have been based on hospital presentations, which indicates that the rate of NFSB is much higher than actually documented, because not all cases of NFSB are reported or managed in hospital (Evans, Hawton, Rodham & Deeks, 2005). This assertion is supported by Fotti, Katz, Afifi and Cox (2006), who believe that the estimation that the rate of suicide attempts is at least 20 times greater than that of completed suicide is, rather, an underestimation, as many attempts are unknown and undocumented.

It is estimated that between 137 860 and 160 000 or more South Africans engage in NFSB annually, which means that there are approximately 438 non-fatal suicide attempts per day (Schlebusch, 2004). Considering the average household size (of about 4.4) in South Africa, up to 700 000 or more members of households are directly affected by NFSB annually or about 1900 per day (Schlebusch, 2005a, p.51). Bostik and Everall (2007) have conceptualised adolescent suicide as a personal and social tragedy, which affects families, schools and communities. These findings highlight the need for primary prevention, as well as secondary prevention and intervention at an individual and familial level.

2.4. Gender Differences in Adolescent Suicidal Behaviour

Several studies have shown that while males have higher suicide rates (Oquendo, et al., 2001); females are at a higher risk for suicide attempts (Wunderlich, Bronisch, Wittchen & Carter, 2001).

Two South African hospital-based studies (Deonarain & Pillay, 2000; Pillay, Wassenaar & Kramers, 2000) have found female to male ratios of NFSB to be 2.5:1. The male to female ratio was found to be 3:1 for South African Indians and 4:1 for White South Africans (Gangat, 1988). A Pietermaritzburg study by Wassenaar, Pillay, Descoins, Goltman and Naidoo (2000), found the male to female ratio to be 5.8:1 for Blacks, 5.3:1 for Whites and 4.3:1 for Indians. According to Pillay and Pillay (1987), South African

research has identified females between the ages of 16 and 25 as being most susceptible to suicidal behaviour.

2.5. Risk Factors in Adolescent Suicide

It is believed that identifying adolescents, who are at the greatest risk of engaging in suicide-related behaviours before such behaviours become fatal, would reduce the incidence of such behaviour (Gutierrez, 2006). While risk factors for suicide have been identified in previous studies; these are generic and not specific to the group being researched. Determining how to identify at-risk teenagers is believed to pose a huge challenge (Gutirrez, 2006). Accordingly, this study aimed to identify those risk factors that are specific to adolescents.

Certain behavioural, psychological and demographic factors are believed to increase one's risk of suicide. The SPRC (2001) have identified the following categories of risk factors for suicide:

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide, that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behaviour
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide (SPRC, 2001, p.2)

As these risk factors are generic, this study aimed to identify the contextual factors that put adolescents at risk for suicide.

Many studies have identified the roles of depression, substance use disorders and physical/mental illnesses as important risk factors for depression. These will be looked at in further detail.

2.5.1. Depression as a Risk Factor for Suicide

Depression is one of the most common psychological disorders associated with suicidal behaviour (Schlebusch, 2005c). According to Cantor (1998), depression carries a lifetime risk for suicide of 15%, with Major Depressive Disorder being the most common diagnostic correlate of suicidality. This holds true for South Africa as well, as reported by Schlebusch, Vawda and Bosch (2003), who found depression to be the most common diagnosis, present in nearly two-thirds (63.9%) of the non-fatal suicidal patients treated in a large academic hospital. In a South African study involving suicidal patients seen in general practice by Cassimjee and Pillay (2000), psychiatric disorders, particularly depression were identified as a prominent cause of suicide, along with relationship problems, financial problems, family problems, stress and education-related problems.

The U.S. Department of Health and Human Services (2001) estimates that 2-15 % of individuals diagnosed with major depression die by suicide. They report that suicide risk is highest in depressed individuals who feel hopeless about the future, those who have

just been discharged from the hospital, those who have a family history of suicide and those who have made a suicide attempt in the past. They also state that individuals who suffer from depression at the same time as another mental illness (specifically, substance abuse, anxiety disorders, schizophrenia and bipolar disorder) are at a particularly high risk for suicide. People who die by suicide are frequently suffering from undiagnosed, under-treated, or untreated depression. One of the reasons for under-diagnosis is that cultural factors can modify the expression of depressive symptoms in some groups (Schlebusch, 1990).

According to the Depression and Bipolar Alliance (2002), people who have been hospitalised for depression are most likely to consider or reconsider suicide 6-12 months after hospitalisation. Carter, Lewin, Stoney, Whyte and Bryant (2005) report that individuals with Major Depressive Disorder are likely to engage in suicidal behaviour during or soon after episodes of depression. Jacobson (1998) asserts that regardless of the duration and severity of the depression, the highest risk period for suicide is generally within the first three months of any specific major depressive episode and within 5 years of the lifetime onset of depression.

Schlebusch, Bosch, Luiz and Levin (1986) state that severely depressed people often do not have the cognitive or physical capacity required for suicide due to their low energy levels and slowed down functioning. A danger period to look out for is an increase in their motivation levels as the depression responds to treatment, as the patient has not recovered completely, but has the energy to carry out suicidal acts.

Miller and Taylor (2005) note that depression has also been correlated with adolescent suicidality. South African studies have also found a high incidence of depression in suicidal school children (Schlebusch, 2004).

Peruzzi and Bongar (1999) identified eight critical risk factors pertaining to suicide in individuals diagnosed with major depression. These are: the medical seriousness of previous suicide attempts, history of suicide attempts, acute suicidal ideation, severe

hopelessness, attraction to death, family history of suicide, acute overuse of alcohol and loss and/or separations.

The link between depression and suicidal behaviour is very clear, indicating the importance of detecting, treating and managing depression before it leads to fatal outcomes.

2.5.2. Substance Use/Abuse as a Risk Factor for Suicide

Psychological autopsy studies have found an over-representation of drug misuse in people who commit suicide (Appelby, 2000). According to Jacobs (1998), abusers of alcohol/drugs comprise 15 - 25% of all suicides. Drug misuse is reported more commonly in suicides that occur in urban populations and in young people (Isometsa, et al. 1997; Rich, Young & Fowler, 1986).

Meehan and Broom (2007) report that the fastest growing age group for attempted suicide in South Africa are people under the age of 35. This has been attributed to an increase in substance abuse in this age group.

Resnick et al. (cited in The Status of Youth Report, 2005) note two important trends related to substance abuse (i.e. tobacco, alcohol and drug use). Firstly, substance use is increasing among young people. Secondly, gender differentials in substance use are narrowing; i.e., substance use amongst girls is increasing very fast and, amongst certain groups, the rates of substance use among young men and women are indistinguishable.

According to the Substance Abuse and Mental Health Services Administration (2002), youth who consume alcohol and other illicit drugs were more likely than other youth to be at risk for suicide.

In a review of literature on suicide, Stack (2000) found that 55 out of 89 studies done in 17 countries, showed that the greater the alcohol consumption, the greater the suicide rate. Recent NIMSS figures (cited in Schlebusch, 2005a) show that alcohol was a factor in about one-third of all suicides. Suokas and Lonnqvist (1995) found a more significant association between alcohol and suicidal behaviour in younger age groups by

investigating blood alcohol measurements in suicide attempters. While there has been comparatively less research in developing countries, the studies that have been done indicate that alcohol use among young people is increasing (Acunda, 1986). Jacobson (1998) reported that alcohol levels indicating intoxication have been found in almost half of all adolescent suicides.

A university study by Birkett (2001) found that approximately 10% of students had used marijuana during the last month, and the same percentage had used one of a number of drugs including mandrax, ecstasy, cocaine, psychedelics, barbiturates and amphetamines. In all cases, more White youth reported using drugs than African or Indian students. Gender differences were also found to be minimal, with as many, or more, young women using drugs as young men. According to Mościcki (1998), cocaine abuse has been identified as a significant contributor to completed suicides and as an independent risk factor for attempted suicide.

In general, substance abuse is associated with greater frequency and repetitiveness of suicide attempts, more medically lethal attempts, more serious suicidal intent and higher levels of suicidal ideation (Mościcki, 1998). The apparent link between substance use/misuse and suicide presents a great concern, especially considering the increase of substance use/abuse among adolescents. This could essentially indicate that an increase in substance use/abuse could lead to an escalation in suicidal behaviour among adolescents.

2.5.3. Impact of Health and Mental Health on NFSB

Various physical and mental illnesses have been implicated as risk factors for suicidal behaviour. Hendin (1998) notes that, ‘terror, depression and a wish to die are the first reactions of many people who learn that they have a deadly illness’ (p.541).

Numerous studies have found an association between suicidal ideation or behaviour and poor physical health /disability, after controlling for other risk factors (Dubow, Kausch, Blum, Reed, & Bush, 1989; Gartrell, Jarvis, & Derksen, 1993; Grossman, Milligan, & Deyo, 1991; Rey Gex, Narring, Ferron, & Michaud, 1998). Some studies suggest an association between suicidal behaviour and specific chronic illnesses, such as diabetes and epilepsy (Brent, 1986; Goldston, Kovacs, Ho, Parrone, & Stiffler, 1994).

Medical conditions shown to be associated with high suicide rates include cancer, HIV/AIDS, peptic ulcer, Huntington's chorea, head injury and renal disease, with prevalence rates ranging from 25-50% in patients with select chronic illnesses. (Kelly, Mufson & Rogers, 1998).

Local findings are in accordance with international reports which state that cancer patients are at increased risk for suicide. The incidence of suicidal behaviour in cancer patients ranges from being 2-10 times as frequent (or more) as for the general population (Schlebusch, 2005a).

The link between AIDS and suicide was first documented with epidemiological evidence by Marzuk et al. (cited in Jacobs, Brewer & Klein-Benheim, 1998) in 1988. They found that men aged 20-59 with a diagnosis of AIDS were about 36 times more likely to commit suicide than matched controls in the general population of New York. Jacobs, et al. (1998) has made an interesting observation that despite the high correlation between suicide and AIDS, an increased risk of suicide is not found in patients who are HIV positive.

Although the correlation between HIV/AIDS and suicide has been under-researched in South Africa, certain ad hoc studies have shown a high suicide risk for this group (Schlebusch & Noor Mahomed, 2004). An increased risk of suicide among those with HIV/AIDS has been found to be related to antibody testing and learning of a seropositive status, the diagnosis of full-blown AIDS and the latter stage of the disease, which may be characterized by pain and dementia (Schlebusch, 2005a).

The strong connection between HIV/AIDS and suicide is a major concern in South Africa, due to the soaring HIV rate in this country; and particularly among younger people.

Gould, et al. (1998) investigated the following risk factors for suicide: being female, psychopathology, substance abuse/dependence, previous suicide attempt, suicidal ideation, hopelessness, poor coping skills, impulsivity, recent life events, sleep disturbances, chronic disease, family history of psychiatric disorders and suicidal

behaviour, family conflict and dysfunction and poor academic performance. Among these, they recognised psychopathology to be the strongest predictor of suicidal behaviour.

The U.S. Department of Health and Human Services (2001) reports that although most people who suffer from a mental illness do not die by suicide; having a mental illness certainly increases the likelihood of suicide. According to this department:

- An estimated 2 - 15 % of people diagnosed with major depression, die by suicide.
- An estimated 3 - 20% of people with bipolar disorder die by suicide.
- An estimated 6 - 15% of people diagnosed with schizophrenia die by suicide. Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Between 75% and 95% of these individuals are male.
- Also at high risk are individuals who suffer from depression comorbid with another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at a greater risk for suicide.
- People with personality disorders are approximately three times more likely to die by suicide than those without. Between 25% and 50% of these individuals also have a substance abuse or major depressive disorder.

A study of rural Chinese adolescents by Liu, Tein, Sandler and Zhao (2005) found that 73% of adolescents who attempted suicide suffered from elevated psychopathology. On the other hand, South African studies of suicidal Indian adolescents have generally found an absence of severe psychiatric disturbance among this group (Pillay & Schlebusch, 1987; Wassenaar, 1987).

The high correlation between physical and mental illness and suicide highlights the importance of early screening, detection, treatment and management of these illnesses.

As Burrows (2005) has stated, the identification of risk factors on the societal, community, familial and individual levels is essential in designing effective intervention

programmes. Therefore, this study has set out to identify the risk factors that predispose or precipitate NFSB in adolescents.

2.6. Protective Factors in Adolescent Suicide

While several studies have investigated the risk factors for suicidal behaviour, very little emphasis has been placed on the identifying specific, contextual individual, family and community factors which may protect against the development of suicidal behaviour, especially in relation to adolescent NFSB (Beautrais, 2000). Research into protective factors is still in the beginning stages (Brown, 2001). While it may be believed that protective factors are environmental in nature, Wasserman (2001) notes that they are also in the minds of people.

Some of the factors that are believed to protect against suicide as stated by the Suicide Prevention Resource Centre (2001) are:

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and non-violent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

As is the case with risk factors for suicide, these protective factors are generic and are not necessarily applicable to adolescents. The role of these factors in protecting against adolescent suicidal behaviour was therefore investigated in this study.

The probability of adolescents engaging in suicidal behaviour can best be determined by the combination of risk and protective factors unique to each adolescent (Gutierrez, Osman, Kopper and Barrios, 2000).

2.7. Review of NFSB identified in Indian Adolescents

According to Pillay and Wassenaar (1995), adolescents from the minority Indian community (comprising about one-million people; i.e. approximately 3% of the South African population), who reside mainly in KwaZulu-Natal appear to be particularly vulnerable to suicidal behaviour, judging from the high suicide rates among this group.

Wassenaar, van der Veen and Pillay (1998) argue that young Indian women are particularly affected by suicide, as they are most vulnerable to the stresses of cultural transition. Bridge, Goldstein and Brent (2006) have also acknowledged the link between cultural transition and suicide. Assimilation and loss of traditional cultural practices can increase alienation, intra-generational conflict, and create a situation in which an individual does not feel strongly affiliated with either the traditional or the alternative culture (Bridge, et al., 2006). The combined, concurrent stressors of adolescence and socio-cultural transition are believed to contribute to the peak of suicide mortality in young Indian females (Wassenaar, et al., 1998).

Flisher and Parry (1994) found the highest fatal suicide rate within the South African Indian female group to be those in the 15-24 year age range, judging from the over-representation of this group at a general hospital under study. The suicide rate among this group was found to be markedly higher than Indian females in other age groups. This finding has been supported by Burrows (2005); whose review of South African literature also found Indian females aged 15-24 to be at a high risk for suicidal behaviour. Pillay (1987) states that there is lack of parasuicide research among Blacks, Coloureds and Indians in South Africa. Flisher and Parry (1994) have stressed the need for further research into the relatively high suicide rate among Indian females within the 15-24 year age group. This has formed part of the current study.

2.8. Limitations of Previous Research

While the domain of adolescent suicide has been the subject of much empirical investigation, there exists a paucity of qualitative research on the topic. Most of the studies in South Africa have tended to administer self-report measures, which do not provide any in-depth or descriptive data. Some of the commonly used self-report

measures in South Africa are The Hopelessness Scale (Pillay & Wassenaar, 1991), The Family Satisfaction Scale (Pillay & Wassenaar, 1997), The Brief Psychiatric Rating Scale (Pillay & Wassenaar, 1995), Beck Scale for Suicidal Ideation, Suicidal Ideation Questionnaire, The Suicide Probability Scale, The Reasons for Living Inventory and the Self-Harm Behaviour Questionnaire (Gutierrez, et. al., 2000; Gutierrez, 2006).

While self-report measures appear to be the most economical instrument in terms of cost and administration, self-report data, especially from adolescents has been found to be questionable (Gutierrez, 2006). Kendall, Cantwell and Kazdin (1989) have noticed a tendency for young people to endorse fewer symptoms in such reports, compared to their parents or clinicians.

Several researchers have emphasised the urgent need for qualitative research to provide increased understanding of the experiences of suicidal adolescents (Cutcliffe, 2003; Cutcliffe, Joyce & Cummins, 2004). As such, this study which explored the subjective world of suicidal adolescents has elicited valuable information, such as the factors that lead them to suicidal behaviour as opposed to other coping mechanisms; and has helped establish the impact of contextual factors that put adolescents at risk for suicide, as well as those factors that could have prevented such drastic behaviour. Such information has been found to be extremely valuable in the formulation of prevention programmes and may even assist in designing interventions aimed at individuals who have previously attempted suicide.

As stated by Bostik and Everall (2007) there is a dire need to ascertain what could help post-suicidal teenagers through the process of healing. Coggan, Patterson and Fill (1997) acknowledge that despite the extensive body of literature relating to adolescent suicide, the quantitative nature of most of these studies do not incorporate the 'voice of the youth' in designing prevention programmes. In order to overcome this limitation, the present in-depth study has helped identify contextual risk and protective factors that are useful to inform interventions.

Previous studies have consistently found a link between suicidality and social support. It has therefore been regarded as pertinent in the current study to understand adolescents' perceptions of interpersonal relationships (Bostik & Everall, 2007) in relation to NFSB.

2.9. Decision-making processes in relation to NFSB

It has been envisaged that gaining insight into the experiential world of adolescents who have attempted suicide would assist in the identification of the decision-making process that led to the non-fatal suicidal act. More specifically, this study aimed to identify:

- precipitants that led to NFSB
- what alternatives were considered
- why NFSB seemed like the best option
- whether non-fatal suicidal adolescents spoke to anyone before resorting to such behaviour
- how they planned and carried out the act; and
- the consequences of NFSB

2.10. Adolescents Perceptions of Crisis Lines

Pillay (1987) stresses the need for adolescents to be made aware of the roles of crisis centres and other such organisations in supporting distressed teenagers. The present study has attempted to establish whether adolescents do make use of such support centres that are available to them, and whether they perceive them to be helpful. As far as crisis hotlines are concerned, it has been found that despite awareness of them, fewer adolescents make use of them, as compared to other sources of help (Gould, Greenberg, Munfakh, Kleinman & Lubell, 2006). The main reasons for not making use of hotlines include feelings of shame, self-reliance (trying to solve the problems on their own), distrust of advice provided by such services and the feeling that their problems would not be solved by hotlines (Gould, et al., 2006).

However, this was not found to be the case in South Africa. Meehan and Broom (2007) conducted a study to analyse and evaluate the South African suicide crisis line - a toll free line - which was established in 2003, in conjunction with the Department of Health and

the South African Depression and Anxiety Support Group. Their specific aim was to determine the demographic characteristics of the callers.

A key finding of the study was that adolescents make up the majority of callers to the South African suicide crisis line; and a link was found between areas where suicide prevention programmes were conducted and the volume of calls from those areas (Meehan & Broom, 2007). This highlights the importance of prevention programmes, which have been shown to increase help-seeking behaviour among adolescents.

Most callers to the crisis line are females, indicating that they take a more active role in mental health and are more open to discussing problems than males. The majority of callers also tended to be high school students in the 16-18 year age group. This study has also highlighted the need for awareness campaigns of support structures, especially via the media, as they found that most youth who called the crisis line had learned about it from television or radio (Meehan & Broom, 2007).

2.11. Methods of NFSB

Bosch, McGill and Noor Mahomed (1995) found that although diverse methods were employed in NFSB, the overdose of medication is one of the most common methods, specifically in younger age groups. The DPS, which spans some 26 years, has found that overall, approximately 90% of non-fatal suicide attempts are made by overdosing, while the remaining 10% resort to self-harm (Schlebusch, 2005a). Schlebusch (2005a) further states that in the case of overdose, the most common substances ingested are over-the-counter painkillers, prescription-only tranquillisers and anti-depressants, followed by household poison and utility products.

Bosch, et al. (1995) have noted that the overdose of medication may be a common method due to its availability, compared to other methods. This view is also supported by Bhamjee (1984), who states that the choice of method is greatly influenced by availability. More recently, Brown (2001) has reported that access to the means to engage in suicidal behaviour is a risk factor that is on the rise in young people. For example,

pesticides have been found to be a common method in China due its accessibility, just as firearms are a popular method in the United States of America (Brown, 2001).

In a study of Indian adolescents who were hospitalised for self-destructive behaviour, Pillay (1988) found that 93.1% of them had ingested medication belonging to family members. Indian South Africans have been found to be much less aggressive in their methods of self-destructive behaviour compared to other South African groups (Pillay, 1982). While there is a tendency to attribute the method of choice to the level of intent, it is important to bear in mind that many young people are unaware of the toxicity of ingested substances (Pillay, 1988). Another avenue that was explored in the present study is how the participants acquired the means to engage in non-fatal suicidal behaviour.

2.12. Factors Precipitating NFSB in Indian Adolescents

Various factors have been found to precipitate NFSB in Indian adolescents. Some of these factors will be discussed briefly.

2.12.1. Parental expectations of academic achievement

Meer (1976) maintains that the parental ambitions that are imposed on children are a common factor in adolescent suicide. She found parental expectations of high academic achievement to be a significant problem, particularly among Indians in Durban. This could very well account for the fact that the incidence of suicide tends to increase at the end of the year (Schlebusch, 2005c), when final examination results are released.

2.12.2. Parental Opposition to Romantic Partners

Parental opposition to the choice of marriage/romantic partners is also believed to provoke suicides in young Indians (Meer, 1976). While this particular finding was made over thirty years ago, recent findings by Wassenaar, et al. (1998) noted that arranged marriages still occur in some Indian families, where the autonomous choice of a marriage partner based on romantic love is forbidden. It is apparent that the level of acculturation of young Indians is a source of major conflict between adolescents and their orthodox parents. The present study has investigated parental opposition to romantic relationships and its role in NFSB.

2.12.3 Authoritarian parenting

Dysfunctional family relationships have often been implicated in adolescent suicide attempts. A study of Indian adolescents who had engaged in NFSB found that the majority of the respondents experienced conflicts with their parents before resorting to NFSB (Pillay & Wassenaar, 1997). The major conflicts in this case revolved around parents being too authoritative and not allowing their children to engage in age-appropriate behaviours such as socialising with partners and friends. Pillay and Pillay (1987) also found authoritarian parenting and the conflicts resulting from it to be a significant precipitating factor for suicidal behaviour in the 16-25 year age group. A major factor has been the parental forbiddance of unsupervised socialisation and the maintenance of steady intimate relationships.

2.12.4. The Impact of Communication, Cohesiveness and Intra-familial Connectedness in NFSB

Kerfoot (1980) states that adolescent suicidal behaviour cannot be understood without careful consideration of family background and relationships. Adolescents who engage in self-destructive behaviour have been found to grow up in families characterised by greater conflict and turmoil than non-suicidal adolescents (Kerfoot, 1980; Kienhorst, De Wilde & Diekstra, 1995). Adolescents who attempt suicide often do so within the family setting, in response to family stress (Kerfoot, 1980). Pfeffer (1986) maintains that suicidal behaviour often represents a final effort 'to escape a miserable and unbearable family situation'; while Fergusson, Woodward and Horwood (2000) hypothesise that the risk of suicide is increased by poor parent-child relationships.

Bostik & Everall (2007) found that adolescents with a history of suicidal behaviour generally reported parental unavailability, low levels of care and high levels of overprotection, low security of attachment to parents and the lack of an emotionally available parent. According to the American Academy of Child and Adolescent Psychiatry, mutual positive involvement in the family may protect one against suicidal behaviour (Groholt, et al., 2006). Pillay and Wassenaar (1997) have acknowledged the lack of empirical research into the family dynamics of suicidal adolescents. While the present study has not isolated the role of family dynamics in adolescent NFSB, it has,

however been an important focus of the investigation. The urgent need to include parents in suicide prevention and intervention programmes cannot be ignored.

2.13. Rationale

Despite the magnitude of research conducted in the field of suicide and suicidal behaviour, there are still apparent limitations in previous research. As noted above, most previous studies have employed a quantitative methodology, which, although necessary to gain statistical data, have not provided in-depth information on NFSB. Several researchers have stressed the need for more qualitative studies to understand the contextual experiences of suicidal adolescents especially in relation to the risk and protective factors for suicide (Bostik & Everall, 2007).

An exploration into the subjective worlds of adolescents who have engaged in NFSB has therefore been embarked upon, in order to aid in the identification of the factors that place adolescents at risk for suicide, and those factors that may protect them against such behaviour. Such information is fundamental in the formulation of effective suicide prevention and intervention programmes.

2.14. Key Questions to be addressed

Guided by a review of the available literature on NFSB among adolescents, the current study set out to address the following:

- The context-specific factors that put adolescents at risk for suicide
- The context-specific protective factors that can prevent NFSB
- The help-seeking behaviour of adolescents prior to the suicidal attempt
- The decision-making process prior to the attempt
- The impact of NFSB in relation to future/past problem-solving
- The means used to engage in NFSB and it's acquisition
- Adolescents' perceptions of family and social support.

Summary

This chapter has provided an overview of the literature reviewed on NFSB, both internationally and locally. From the literature reviewed it is apparent that NFSB is a

serious public health concern, due to the escalation in the rates of suicide and NFSB, especially among adolescents. Due to the fact that most previous research has been quantitative in nature, in-depth, qualitative investigations into the phenomenon of NFSB in adolescents is deemed to be essential in order to identify the risk and protective factors that mediate NFSB in this group. The identification of such factors is believed to be crucial in designing intervention and prevention programmes.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter comprises an overview of the aim and the research methodology used in this study. With regard to the methodology, a rationale for the use of qualitative methods is provided, followed by an overview of the research design, data collection techniques, method of analysis and ethical considerations for the study.

3.2. Aim

This study aims to provide an in-depth understanding of the risk and protective factors that mediate NFSB in adolescents.

3.3. Research Design

3.3.1. Qualitative Research

Due to the exploratory nature of the study, a qualitative methodological approach was employed. Qualitative methods allow for the in-depth investigation of selected issues (Kaniki, 2002), such as, in this case, the risk and protective factors that mediate adolescent NFSB. Qualitative research is appropriate to the current study, as it attempts to understand individual human experience in great depth (Becvar & Becvar, 2000), in line with the aims of this study.

Qualitative research lays down its claim to acceptance by arguing for the importance of understanding the meaning of experience, action and events as these are interpreted through the eyes of participants, researchers and sub-cultures, and for a sensitivity to the complexities of behaviour and meaning in the contexts where they typically or 'naturally' occur (Richardson, 1996). Qualitative methods are privileged within the qualitative paradigm, because they are thought to address a number of reservations concerning the uncritical use of quantification, in particular, the problem of inappropriately fixing meanings where these are variable and renegotiable in relation to their contexts of use.

According to Richardson (1996), from an epistemological standpoint, the gathering, analysis and interpretation of data should always be carried out within a broader understanding of what constitutes legitimate inquiry and warrantable knowledge.

Qualitative methods are inherently inductive; they seek to discover rather than test explanatory theories, they are naturalistic, favouring in vivo observation and interviewing of respondents over the decontextualizing approach of traditional scientific enquiry (Padget, 1998). As such they imply a degree of 'closeness' and an 'absence of controlled conditions' that stand in contrast to the distance and control of scientific studies. According to Manicas and Secord (1982), qualitative research is predicated on an 'open systems' assumption where the observational contexts (and the observer) are part of the study itself. In contrast, quantitative research favours a 'closed system' approach where every effort is made to neutralise the effects of the observational context (including the observer) (Padget, 1998).

Qualitative studies seek to convey the complex worlds of respondents in a holistic manner using 'thick description' rather than particularistic categories and variables. Padget (1998) goes on to say that, "doing qualitative research requires an unparalleled degree of immersion by the researcher as the instrument of data collection" (pg.3).

3.3.1.1. Generalisablity

Morse (1997) argues that theory derived from qualitative research is different from theory derived from quantitative research, in that qualitatively derived theory has been 'tested' in the process of development and is therefore more representative of reality and involves less conjecture than quantitatively derived theory. Because of this important fact, qualitatively derived theory may move directly towards implementation, and in doing so does not test theory per se but components of theory. Morse (1997) suggests that this has important ramifications for the evaluation of qualitative research and its role in knowledge development. While it was previously considered that qualitative research was so context-bound that it was not generalisable, it is now evident that qualitative research is generalisable according to its level of abstractness (Morse, 1997).

Morse (1997) emphasises that the aim of a qualitative researcher is ultimately to make links, or to help the reader make links, between what he or she has observed in one situation and what is occurring in other situations. Qualitative researchers investigate naturally occurring phenomena and describe, theorise and analyse them contextually in the 'real world' rather than in controlled situations, thereby yielding important findings for practice (Morse, 1997).

3.3.1.1 Applicability

Morse (1997) is of the view that researchers who conduct qualitative research in the health sciences should understand that the state of knowledge development is such that research results may well find their way into clinical applications regardless of the researchers' explicit assumption about their origins. This factor inherently alters a health science researcher's disciplinary responsibility in such a way that it extends beyond the reach of traditional evaluative criteria and into the domain of how findings might reasonably be interpreted or even used (Morse, 1997). Thus, a critique of qualitative research within the health sciences properly extends beyond the mere consideration of adherence to the methodical rules to an examination of the much more complex question of what meaning can be made of research findings.

Qualitative health researchers therefore cannot put forward their findings with the comfortable assurance that no one will apply them to practice before they become scientifically 'proven'. Researchers in this field are obliged to consider their findings 'as if' they might indeed be applied in practice (Morse, 1997). Since qualitative research is based on assumptions that are socially constructed, they are likely to be shared by others in the field, as well as by research participants. Therefore qualitative research serves to re-create them 'as if' they were factual. Since there is no absolute standard against which to measure qualitative research so as to account for the notion of truth or representativeness within the real world, or ensure confidence that research findings are indeed entirely valid, qualitative research accepts that there is value in recognising that some kinds of knowledge exist as 'probable truth'. Morse (1997), points out that qualitative research endeavors not to seek truth, but to create meaning, to construct

images from which people's fallible and tentative views of the world can be altered, rejected, or made more secure.

3.3.2. Ethnography

This study is seated within the area of ethnographic inquiry, as its main aim was to develop an understanding of the NFSB in adolescents, as seen through the eyes of the participants (Fetterman, cited in Potter, 2002). 'Ethnography yields empirical data about the lives of people in specific situations' (Spradley, 1979, p.13).

According to Fetterman (1998), 'ethnographers assume a holistic outlook in research to gain a comprehensive and complete picture of a social group' (p.19). This orientation can assist the researcher discover the interrelationships among the various systems and subsystems in the community under study, mostly by contextualising the data (Fetterman, 1998). This is appropriate in the current study in order to ascertain the different levels of factors in the community that either place one at risk for, or protect one against engaging in suicidal behaviour.

A focal point of most ethnographic research, according to Petersen (2000), is the use of emic and etic data (insider and outsider perspectives of reality). This is considered to be vital in the process of analysis since the emic perspective takes into account participants' views of situations, whilst the etic perspective addresses the researcher's interpretation of this reality (Petersen, 2000). Finally, the role of emergent data, apart from relying on theory and literature, allows the researcher to refute or develop new hypotheses where necessary (Petersen, 2000).

3.3.3. Theoretical Framework

Suicidal behaviour is a complex phenomenon and cannot be attributed to a single cause. It involves intricate interactions between psychological, social, cultural and biological variables (Schlebusch 2005c). In recent years there has been an increasing interest on the impact of social relations on adolescent suicidality (Kidd, et al., 2006). Beautrais (2000) stresses the need for research to focus on the identification of individual, family and community factors which may protect adolescents from engaging in suicidal behaviour.

Due to the multi-factorial and multi-dimensional nature of the causes and risk factors of suicidal behaviour (Schlebusch, 2005a), it was deemed appropriate to seek to understand the risk and protective factors for adolescent suicidal behaviour by employing a multi-levelled approach.

Bronfenbrenner's (1979) ecological model, in particular, presents an ideal theoretical framework for this study, as it enhances the understanding of the individual by taking their larger environmental context into account (Kidd, et al., 2006). Bronfenbrenner's Social Ecology Theory relates to the influences on mental well-being which are believed to operate proximally and distally within four systems – the microsystem, the mesosystem, the exosystem and the macrosystem (Petersen & Govender, 2007).

The microsystem is defined as any context in which the individual has immediate experience and direct personal interaction (Bronfenbrenner, 1979). In this study, this could include family interaction, peer group interactions, etc.

The mesosystem refers to the relationships between microsystems. Bronfenbrenner (1979) proposes that development will be enhanced if the different microsystems are strongly linked. E.g. if the values acquired at home and through peer groups are consistent, the adolescent is likely to embrace those values. However, if these are not consistent, they may become confused.

The exosystem refers to those systems with which the individual has no contact, but may affect his/her experience. It describes the community-environment level (Bronfenbrenner. 1979). For example, a parent's job dissatisfaction may have an impact on his entire family.

Finally, the macrosystem refers to 'distal influences of a cultural and structural nature' (Petersen & Govender, 2007). It includes the attitudes and values of people and policies that govern behaviour, economic trends, gender roles, cultural values, etc (Visser, 2007).

Bronfenbenner's ecological model emphasises the importance of reciprocal relationships between individual factors (such as hopelessness and depression) and contextual factors (such as family, peers and school) in study of adolescent mental health (Kidd, et al., 2006).

Considering that ecological models have are being increasingly applied to the study of adolescent risk factors (Kidd, et al., 2006), this particular model has been deemed to be appropriate in the identification of risk and protective factors for adolescent suicidal behaviour, as it will take into account the different levels of factors that play a role in influencing such behaviour.

3.4. Description of Study Site and Participants

The risk and protective factors that form the basis of this study have been identified through interviews with adolescents treated for NFSB at the R.K. Khan Hospital in Chatsworth, south of Durban in KwaZulu-Natal. The Group Areas Act, which is now obsolete, restricted members of specific racial and cultural groups to particular residential areas (Pillay & Wassenaar, 1995). Accordingly, the majority of the population of Chatsworth is comprised of Indians, leading to participants in this study being solely representative of this racial group.

The participants have been selected via non-probability convenience sampling, a method commonly used in in-depth qualitative research (van Vuuren & Maree, 2002). Due to the sensitive nature of the topic under investigation, a convenience sample, where participants are selected on the basis of their ability, seemed most appropriate. The participants in this study were identified by mental health professionals within the hospital's Social Work Department. The reasons for choosing a clinical sample are: (i) they are easier to access; (ii) they are in a controlled setting; and (iii) they are under treatment.

According to Kelly (2002), about 6 to 8 participants will suffice for an in-depth study with a homogenous sample. Accordingly, the sample for this study consisted of 10 participants. A prerequisite to participation in this study was participants' ability to speak English.

3.5. Data Collection

In order to gain an in-depth understanding of the experiential world of non-fatal suicidal adolescents, data was collected using in-depth interviews as a qualitative data collection tool. According to Terre Blanche and Kelly (2002), interviewing gives the researcher an opportunity to get to know the participants quite intimately so we can really understand how they think and feel.

The interviews were semi-structured, which, according to Layder (1993), requires a list of topics or questions that need to be covered - but are flexibly adhered to, depending on what the interview situation demands. Semi-structured interviews allow the researcher to alter the wording and order of questions, omit questions that seem inappropriate and introduce new questions or topics (Davies, 1999). Basically, cues have been taken from participants and their responses to questions. The semi-structured interview has been designed to allow participants to respond in any way they choose, which allows for their own interpretations and meanings to emerge (Layder, 1993).

3.5.2. Procedure

3.5.2.1. Phase 1: Consultation

Key experts in the fields of research methodology and suicidal behaviour were consulted in order to devise a conceptual framework for the study, including the Head of Department of Psychology at R.K. Khan Hospital. In addition, a comprehensive literature search was undertaken utilising the Proquest, EBSCO Host and Academic Search Premier databases.

The medical superintendent and Head of the Psychology Department of R.K. Khan Hospital were consulted in order to appraise them of the purpose and perceived benefits of the study, as well as to negotiate suitable fieldwork times.

3.5.2.2. Phase 2: Instrument Development

A review of the literature helped identify the key content areas that are of relevance in understanding risk and protective factors that mediate NFSB among adolescents. This was used to devise a semi-structured interview schedule to address the objectives of the

study. Core themes to be covered in the interview were developed on the basis of a review of relevant empirical literature and consultation with identified experts in the fields of research methodology and suicidology.

Given that the methodological constructs of the study were based on the ethnographic approach, the semi-structured interview was relatively open-ended. The strength of using such an approach is that it provides valuable insight into human behaviour as it is understood and experienced within a specific context.

3.5.2.3. Phase 3: Implementation

The interview was piloted on two participants in order to identify any changes that may have been necessary. Following this, ten individual, in-depth interviews, each lasting approximately 30-minutes, were conducted with adolescents who had been treated within the hospital for NFSB. All the interviews have been audio-recorded and transcribed verbatim. The value of the recording interviews has allowed the researcher to get a full record of the interview, without being distracted or distracting the participant by detailed note-taking (Terre Blanche & Kelly, 2002).

3.6. Data Analysis

All interviews were audio-taped and transcribed verbatim. Recordings were also subjected to random quality assurance checks, wherein sections of the recording were compared to their transcripts. The transcriptions were analysed thematically in order to identify commonalties and variances among the responses of participants. The interview transcripts were read in great detail, and relevant notes were be made.

The resultant data has been categorised according to the four levels of Bronfenbrenner's (1979) ecological model. Specifically, the factors identified have been slotted into one or more of the multiple levels. This has allowed for the identification of the different levels of factors that put adolescents at risk for suicidal behaviour and those factors that protect them against it. It has also allowed for the identification of how these different levels interact with each other to bring about specific behaviours in adolescents.

3.7. Ethical Considerations

Written consent to conduct the study was obtained from the Medical Superintendent at R.K. Khan Hospital. In addition, ethical clearance for the study was obtained from the University KwaZulu-Natal's Ethics Committee. Informed consent was obtained from each participant, who was alerted of their right to withdraw from the study at any stage, should they have wished to do so. As none of the participants were under the age of 14, it was not necessary to obtain consent from their parents/caregivers/guardians. Participants were assured of their anonymity, and that no identifying characteristics would be included in the final report. Pseudonyms have been used to disguise the identity of the participants.

As the interviews were audio-recorded, permission was sought from participants before proceeding with the recording.

CHAPTER FOUR

DESCRIPTION OF RESULTS

The aim of this study was to identify those factors that place adolescents at risk for suicide, as well as those factors that may protect them against such behaviour. This was achieved through an exploration into the subjective worlds of adolescents who have engaged in NFSB. The emergent themes were derived from 10 in-depth interviews with adolescents who were admitted to R.K. Khan Hospital in Chatsworth, Durban after non-fatal suicide attempts. Through the process of analysis which has been explicated in Chapter Three (Methodology) and using the conceptual framework discussed in the same chapter, the following emergent themes were conceptualised in understanding non-fatal suicidal behaviour amongst Indian adolescents.

4.1. Intrapersonal Risk Factors

All participants (N = 10) in the study attempted suicide in response to stressful situations. Most of these had been responses to immediate stressful situations, and while some of their situations had been on-going, there was generally a precipitating factor at the time of the attempt.

It is interesting to note that all participants in this study were female. Wassenaar et al. (1998) also noted an over-representation of South African Indian females admitted for parasuicide at another hospital in KwaZulu Natal, while at least two South African hospital-based studies (Deonarain & Pillay, 2000; Pillay, et al., 2000) have discovered that there are at least 2.5 female cases of NFSB for every male case. This may also be explained by the common finding that young females attempt suicide at higher rates than males, while males tend to complete suicide more often (Perez, 2005). Suter (cited in Canetto, 1997) believes that NFSB is regarded as being 'feminine' because it is interpreted as a 'call for help', which is apparently behaviour that is expected from women. Various studies on gender and suicide among adolescents and young adults conducted in the United States of America have found that surviving a suicidal act is considered to be inappropriate for a male. In keeping with this, killing oneself is

considered to be masculine. Such beliefs may somewhat explain the high suicide mortality rate and low NFSB rates among males (Canetto, 1997).

All participants in the study had overdosed on prescription medication, usually belonging to a family member. This is in keeping with a study by Pillay (1998), who found that overdosing on medication belonging to family members, was the most popular method of NFSB among Indian adolescents. In the current study, the number of tablets ingested ranged from 12 to 50 with the mean approximating 33 tablets. The most popular medications seem to have been benzodiazepines and steroidal anti-inflammatories. The dosages of benzodiazepines ingested were significant enough to have caused respiratory depression, while the quantities of steroidal anti-inflammatories ingested were large enough to have led to severe gastritis and the perforation of the stomach. Other tablets consumed were medication for high blood pressure (the quantity of which was significant enough to lower the individual's blood pressure to an extent that would decrease the flow of blood to various organs in the body) and anti-depressants. Two of the participants were unsure of what medication they had consumed. Four of the participants ingested a cocktail of tablets - the quantities of which they were unaware, while one participant consumed a combination of medication and alcohol. It is worth noting that many participants were unaware of the lethality of the type and/or quantity of the medication ingested.

At the time of the suicide attempt, seven of the ten participants felt a sense of hopelessness and despair. Such feelings seem to have been precipitated by events such as relationship break-ups, academic failure, arguments with significant others, etc. It appears that these adolescents base their feelings largely on interpersonal events which are perceived to be undesirable.

> ***Participant 1 (16)****: I felt I was not appreciated, like I was just there, like I had no reason to live.*
>
> ***Participant 2 (15):*** *I felt worthless, that I'd be better off dead.*

> ***Participant 3 (16):*** *All I thought was that I don't have a purpose. I don't want to be on this earth. Maybe I'll be better of dead.*

Despite these feelings, most participants readily admitted that they did not wish for death to be the outcome of their attempt - they just saw this as a mechanism to get others to either understand their problems or change their behaviour/attitudes towards them. For example, one participant in the study hoped that her boyfriend would reconcile with her once he realised how much pain the break-up has caused her. Another wished that her family would realise the impact of their constant arguing on her and get her mother to bond with her. Unbearable psychological pain and temporary relief from an intolerable situation are often cited as reasons for attempted suicides (O'Connor & Sheehy, 2000). This assertion is supported by Wassenaar (1987) who argued that when conventional modes of communication fail, individual needs may be expressed symptomatically, through parasuicidal behaviour, for example. Such behaviour is regarded by Schlebusch (2005a) as an inappropriate problem-solving skill.

> ***Participant 4 (15)****: It was a cry for help. It was not just for attention…I wanted someone to know my feelings, how I felt and why I did it.*

> ***Participant 5 (15)****: I knew I was not going to die. I just wanted to do something to change my mother's attitude.*

> ***Participant 2 (15)****: I'm hoping it will get my mum and I to bond. And I hope that my boyfriend hears about it and comes back to me.*

It is apparent that these adolescents do not have adequate problem-solving skills to deal with stressful situations in their lives, such as relationship break-ups, family conflict and academic pressure. They admit to using NFSB as a strategy to elicit attention from significant others - attention, as well as recognition of the emotional pain they have experienced as a result of their respective problems. It seems that adolescents in the study have a strong desire to have closer relationships with their parents, which they do not know how to achieve. It seems that verbal communication is either too difficult for them, or, more likely, perceived to be ineffective. One of the participants in the study told her

mother that she was going to kill herself, yet the mother did not take her seriously. Those participants that spoke to a confidant about their feelings felt that talking about these problems did not help. Those participants that did not speak to anyone expressed that they could not confide in their parents because they were either 'old-fashioned' or strict, while others mentioned unsupportive home environments where they couldn't confide in anyone. One participant did not want to burden her mother, a single parent, about her worries, as she felt that her mother had problems of her own to deal with. Thus, drastic behaviour, such as NFSB may be regarded as a behavioural practice used to communicate messages of personal distress.

Such neurotic coping mechanisms are also evident in many of the participants resorting to smoking to deal with stress, though they readily agreed that this did not help them feel better in the long term.

> ***Participant 6 (15):*** *When I'm stressed out I bite my nails or smoke.*

> ***Participant 5 (15):*** *I smoke when I'm stressed out.*

Most participants agreed that if they had more effective problem-solving skills, such outcomes would certainly have been prevented. They felt a great need to be taught skills such as coping and stress management skills, effective communication and social skills, decision-making and effective problem solving skills to deal with stressful and challenging life situations. Most agreed that had they been taught such skills, they would have certainly capitalised on them to solve their problems in less-painful ways.

Although all participants had at least one friend or relative that they confide in, only three of them sought help from these confidants at the time of contemplating suicide. It seems that the decision to engage in NFSB is often an impulsive one, where no help is sought, nor alternatives considered. There were cases where friends or confidants were not available to the participants for various reasons. Three of the participants in the study stated that they did not speak to anyone before the suicide attempt, due to the impulsive nature of the act. They had not planned to attempt suicide - it occurred 'on the spur of the moment'. Three of the participants expressed that their confidants were not available at

the time; but had they been available, they would have confided in them and could have come up with more effective solutions. Three of the participants did speak to someone before the attempt - and all three of them felt that this did not help them feel any better. Of these, one explicitly stated her wish to kill herself. This highlights the need to educate potential support systems on suicide risk and provide them with resources to assist those in need. Another participant expressed that she did not speak to anyone because she did not think it would help. Although it is imperative that adolescents talk to others about their problems, it also seems vital that they learn to be more self-reliant and rely upon some of their own resources in times of stress.

4.2. Interpersonal Risk/Protective Factors

Most participants in the study were living in stressful home environments, characterised by conflict and disharmony. Many came from either single-parent homes, where parents have been divorced or separated; and in some cases where one of the parents has committed suicide. Regardless of family composition, all participants described their relationships with family members as conflictual, disengaged or over-protective. Most participants experienced their family environments as unsupportive.

> ***Participant 5 (15)****: I live with my mother. It's just the two of us. We hardly ever talk. We seem to fight about everything.*

> ***Participant 7 (15):*** *Whenever my mother and I have a conversation, it always ends up being an argument. My sister and I can't see eye to eye. We can't even be in the same room together.*

Constant family conflict is often experienced as being unbearable and eventually takes its toll on an individual. With adolescence already being a time of emotional turbulence and turmoil, added stressors only serve to perpetuate the problem.

The nature of conflicts/disagreements differed across participants in the study, though the presence of such problems was unanimous. Some of the domestic conflicts that participants experienced included physical or emotional abuse (or both), substance-abusing parents, parental unemployment, the burden of household responsibilities,

absence of parents (resulting from death, divorce, etc), financial constraints, as well as living with family members other than parents. It did not make a difference whether domestic conflicts directly affected the participants or whether these conflicts primarily involved other family members (e.g. the father abusing the mother) - all such conflicts seemed to have negatively impacted on the participants, often leading to suicidal behaviour.

> ***Participant 1 (16)****: My father always accuses my mother of having (extra-marital) affairs. If she goes out or dresses smartly, he always picks on her. If I perform badly in school, they fight about that too.*
>
> ***Participant 8 (15)****: Sometimes my father goes mad and starts to fight with my mother for little things. But sometimes they argue about things like money and paying school fees.*
>
> ***Participant 7 (15)****: …it's like we can't get to an agreement - the three of us. We can be laughing about something, but suddenly one of us will get angry about something. Also, my mother doesn't like my friends and picks on them - this really irritates me. Or my mother picks on my sister's husband. When they fight they get on my nerves…*

The quantity of medication consumed by participants in the study may be correlated to their perceived helplessness. The participant who consumed the most lethal substances in terms of quantity and lethality was a victim of physical and emotional abuse, who clearly expressed her intention to die, as she saw no other way out of the problem. It is worth noting that one of the three substances she ingested was anti-depressant medication belonging to her mother. This is a clear indicator of parental psychopathology, which is regarded as a risk factor for adolescent suicide (Beautrais, 2000). This particular participant showed signs of depression and was being treated by a psychologist at the hospital.

Learned helplessness seems to be a major factor in suicidal behaviour. Seven participants in this study reported that at least one close family member had either committed or

attempted suicide. This suggests that suicidal behaviour may be a learned response to stressful situations. It may be regarded as a socially appropriate way of communicating distress. Another important point to note is that suicidal behaviour is familial and may be genetic (Bridge, et al., 2006).

> ***Participant 4 (15)****: My father killed himself when I was 8. I saw him hanging from a tree.*
>
> ***Participant 9 (15)****: My mother killed herself when I was 3. My aunt told me she took an overdose. My sister also took an overdose last year after a fight with her boyfriend.*
>
> ***Participant 2 (15)****: My cousin tried to commit suicide last year after she had an argument with her mother. Also a friend of mine committed suicide a few months ago after a fight with her cousin about her boyfriend. My father's sister also tried to commit suicide many times.*

Having either witnessed others committing/attempting suicide or just hearing about it seems to have had a negative impact on adolescents in the study. It appears that many have thereby learned to respond in such ways to unfavourable circumstances, especially when they had seen it work for others. One participant spoke of her sister who attempted suicide because of relationship problems - the result? She got the desired attention from her boyfriend, and they eventually got married. Another spoke of her sister ingesting a household detergent when her husband (from whom she was separated) threatened to take their children away from her. She eventually got what she wanted. Such instances may serve to reinforce the notion that suicidal behaviour is a means to getting what one desires - possibly an easier means to an end, or even an easy way out of an unbearable situation. Pillay and Wassenaar (1991) caution that families of parasuicides mobilising around such crises, serve as an unhealthy reinforcer for these subjects, who may realise that such behaviour is effective in achieving certain goals.

4.3. Socio-Cultural Risk/Protective Factors

Of the 10 participants in the study, 9 were Christian and one was Muslim. Most of the participants did not have overt religious beliefs about suicide. When asked about it, some believed that it was a sin to take one's life. However, none of them remembered this at the time of the suicide attempt.

> ***Participant 1 (16)****: The Bible says, 'Thou shall not kill'.*
>
> ***Participant 4 (15)****: I'm Christian. There are no religious beliefs about suicide with Christians. If you kill yourself, you're a coward.*
>
> ***Participant 9 (17):*** *You'll go to hell if you commit suicide.*

Although two of the participants dealt with previous stressors through prayer, when their problems seemed too magnanimous to deal with, they did not resort to prayer, but to suicidal behaviour. Regardless of religious assimilation or affiliation, none of the participants in the study had strong religious beliefs about suicide. The only time that participants seemed to have given any thought about their religious beliefs about suicide was when questioned in the interview - none seemed to have remembered these either before or after the attempt. Many later reported that they would seek solace in prayer when distressed in the future.

In most cases there seemed to be a conflict between value systems taught by the participants' parents and the values held by their friends. While some participants were strong-willed enough to make informed decisions on what values to follow, others felt that their parents did not necessarily practice what they preached.

> ***Participant 2 (15)****: They don't set a good example because they tell us not to drink and smoke, but my dad drinks and smokes and my mum smokes.*
>
> ***Participant 1 (16)****: My friend's parents allow them more freedom. It makes me very sad, but I still obey my parents.*

***Participant 3 (16)**: Some of my friend's parents are very cool. But even though my parents are strict, I prefer it that way.*

When values instilled by parents differ significantly from values held by friends, peer pressure often seems to be rife, with adolescents having to make difficult decisions to either obey the values taught by their parents and risk losing their friends, or give in to peer pressure at the risk of getting into serious trouble with, and losing the trust of their parents. It is clear that something needs to be done about the generation gap to help parents and children communicate more effectively, in a manner in which both adolescents and their parents can understand each other. All participants in the study expressed having difficulty speaking to their parents about certain issues, such as romantic relationships. Most have described their parents as authoritarian, who have imposed rules on their children, which cannot be negotiated. Therefore, those participants in the study who are/were involved in romantic relationships have done so secretly. A major complication arises when suicidal behaviour is precipitated by problems related to these secret relationships, leaving these adolescents with the difficult options of either disclosing this 'unacceptable' truth to their parents, or lying about their reasons for the overdose. O'Connor and Sheehy (2000) have noticed that there is a dearth of research on how people who attempt suicide communicate with others about why they have done so.

Different parents will always have different values which they teach to their children, and therefore the problem of differing value systems between peers will always exist. What is required is a method for parents and their adolescent children to negotiate their value systems, which will make them easier to be accepted.

It is apparent in the study that the participants do not have adequate problem-solving skills; the absence of which can have tragic consequences. When asked what could have protected them from engaging in suicidal behaviour, most felt that if others had reacted differently to them they may not have taken such drastic actions, suggesting an external locus of control over their behaviour, and thereby diminishing their own responsibility for their actions. Others felt that if they spoke to someone such consequences may have been averted. This highlights their need for social support, especially in times of distress.

Participant 8 (14)*: If I spoke to my friend, she would have convinced me not to do it.*

Participant 6 (15)*: I could have prayed.*

Participant 3 (16)*: I could have spoken to my mother.*

It seems that a support network is an important protective factor against suicidal behaviour, with many feeling that if they spoke to someone; such behaviour would have been prevented. Prayer had also been reported as a factor that may have protected one against such behaviour. It is, however, important to note that none of the participants in the study resorted to prayer at the time of the suicide attempt; though most later realised that it may have given them strength to cope.

4.3.1. Help-seeking behaviour/Problem-solving

It was interesting to note that none of the participants in the study sought help from organisations in their community. In fact, none of them were aware of organisations that may have been able to help them. This has highlighted the need for support structures in the community that people are aware of and perceive as helpful.

Participant 8 (14)*: There is a priest who only helps members of his church.*

Participant 7 (15)*: …no, I don't think so. The community where I live is not very stable. There isn't anybody there to help others.*

Participant 3 (16)*: People in my community are not very helpful. They are happy to see others suffer.*

It is imperative that existing organisations that are meant to help adolescents in distress are visible and publicised. It was apparent in the study that those organisations that do exist have not been utilised by adolescents in the study due to the perception that they are not helpful. Such concerns need to be addressed if adolescents are expected to seek help in times of distress.

Three of the participants in this study have made more than one suicide attempt. It seems that a lack of coping skills has often led to consistent resorting to NFSB for these participants. It is also probable that such behaviour may have had desirable outcomes for some of the adolescents, earning them attention from their family and friends - albeit in the short term. However, this was a first attempt for the remaining participants, who previously dealt with stressful events in different ways. It is important to note that even for those who had made previous attempts, this was their first hospitalisation for NFSB.

> ***Participant 7 (15)****: I ran away from home twice and I took overdoses twice. I normally…I don't know what I do. I can't think.*
>
> ***Participant 2 (15)****: I never really did anything. I used to cry myself to sleep.*
>
> ***Participant 3 (16)****: I just prayed and asked God to help me.*

After this attempt most participants were confident that they will never resort to such behaviour again in the future. The reasons varied, with the most common reasons being the pain they caused to their loved ones and the experience of being in hospital.

> ***Participant 1 (16)****: I will try to get help from a psychologist and will speak to my mother.*
>
> ***Participant 2 (15)****: … I definitely won't try to kill myself. It was too painful, being poked with needles, etc in the hospital.*
>
> ***Participant 3 (16)****: I won't even think of killing myself. I have my entire future to look forward to. And I'll think about all the people that will suffer if I do something like this again.*

It is clear that most participants have retrospectively given serious consideration to their actions. Most of them had not thought of the consequences of their actions; and the recognition of its impact on themselves and significant others seems to have brought them to the realisation that suicidal behaviour was an immature decision, which will not be resorted to in future.

4.4. Decision-making Process

According to the study, most cases of suicidal behaviour were not preceded by lengthy thought processes or planning. Most participants seem to have acted on feelings of hopelessness and helplessness, with their attempts being made on the spur of the moment. This may also explain drug overdoses as being the most common method in this group, due to its immediate availability. In the current study, all but one suicide attempt was decided on impulsively. The longest amount of time that this act was considered by a participant in the study was 2 hours. The impulsive nature of these acts suggests that restrictions to means should be an important focus of suicide prevention. If, for example, medication was not easily accessible in the home, this would not be an option for adolescents in response to unbearable stress.

> ***Participant 4 (15)****: It happened when I came home from school on Friday. On the spur of the moment, I just took the tablets.*
>
> ***Participant 3 (16)****: I don't know what I was thinking. I just did it. I was thinking that I don't need to be here and I found my granny's sleeping pills.*
>
> ***Participant 6 (15)****: I felt scared. I was not even thinking. I just took the tablets.*
>
> ***Participant 10 (17)****: On that day my mother kept pressurising me, nagging me to go and learn. It sort of pushed me over the edge. I did not plan it, I just did it. I was just sitting on the bed this morning and I was thinking about it. I always thought I was a strong person. When other people used to do it, I used to say that they're so stupid. At that time, I don't know what was going through my mind. It just happened.*

While it may happen that most suicide attempts are planned, that was not found to be the case in this study. It may be speculated that successful (fatal) attempts, where the individual has an intention to die, are carefully planned. However, it may be the absence of intention to die in these current cases that explain the lack of planning.

It seems clear that the choice of overdosing as opposed to other methods is directly related to the availability of prescription medication in the home. Many Indian homes are still inhabited by extended families; and with the presence of older adults in the home, there is usually a prevalence of chronic medication such as medication for high blood pressure and cholesterol. The reasons for choosing an overdose over other methods seems to centre around issues of less pain and the participants seeing no alternative.

> ***Participant 2 (15)****: I did not cut my wrist because I did not want to feel pain and I did not hang myself because I couldn't bear for someone to find me like that. So, the only thing I could think of was an overdose.*

> ***Participant 4 (15)****: I saw no other way out. I realised that talking wouldn't help. What was anyone going to do?*

> ***Participant 3 (16)****: I cannot bear pain so I would never want to slit my wrist or stab myself. I decided to go the most painless route. I was so fed up with everybody that I just thought I want to end my life. I thought that taking an overdose was the easiest way out.*

It must be borne in mind that while drug overdoses are often thought to be chosen due to the absence of intention to die, most adolescents are not aware of the toxicity of various prescription medications (Pillay, 1988). In fact, one participant in the study was surprised that she did not die, considering the quantity of tablets she ingested.

4.5. Consequences and Outcomes of NFSB

All but one of the participants had sincere regrets about their suicidal act. Most regrets were related to the effect on their families and the experience of being in hospital. It seemed clear that these participants would not make future attempts because of the pain they had caused to others or had to endure themselves. There was one participant whose only regret was that she did not die. She was under close observation in the hospital and was being treated by a psychologist.

***Participant 1 (16)**: …after the pain I went through at the hospital, I'll never do it again.*

***Participant 9 (17)**: Yes, I really regret it. I regret it because I broke my family's hearts. I'll never do it again.*

***Participant 6 (15)**: Yes…lots of regrets. I hurt people that love me very much. I hurt myself because I hurt those I love.*

***Participant 7 (15)**: My regret is why didn't I die? Why didn't I? I know when I go back home its going to be the same. Only now, for about 1-2 weeks, then after it will go back to the same thing.*

Despite this being a horrendous experience for all participants, most felt that something positive had come out of this experience. Most stated that this has taught them to speak about their problems and others felt that their family members have responded more positively to them, being more attentive and caring since the incident.

***Participant 1 (16)**: I think I've learned to speak to others about my problems.*

***Participant 9 (17)**: My family has been a lot more caring and attentive.*

***Participant 8 (14)**: Yes, my mother treats me better now.*

***Participant 7 (15)**: My mother and I can sit for a little longer and talk without fighting. Things have cooled down now.*

It is reassuring to note that despite receiving positive responses from their family members, participants in the study have realised that suicidal behaviour is not a solution to their problems. Most have stated that they will use non-harmful strategies to deal with problems that may arise in future - such as talking to others or praying.

The extracts cited in this chapter give a strong sense of the subjective experiences and feelings of these adolescents who have attempted suicide. It implies that prevention

programmes should not only be targeted to adolescents at risk, but also to peers, parents and other identified sources of support who will be able to identify the risk factors, thereby reducing the incidence of NFSB.

CHAPTER FIVE

DISCUSSION AND INTEGRATION OF FINDINGS

In this chapter, I offer an integration of the findings of this study (as detailed in Chapter 4), using Bronfenbrenner's (1979) Social Ecology Theory in order to facilitate an understanding of the multiple levels of risk and protective factors that mediate NFSB in adolescents. This theory takes into account the influence of four systems, i.e. the microsystem, the mesosystem, the exosystem and the macrosystem, in individual functioning.

The microsystem is any context in which the individual has direct contact and interaction, while the mesosystem refers to the relationships between the microsystems and their influence on each other, e.g. between parents and peers. The exosystem refers to those settings not directly involving the individual, but which still exert an impact on him/her. The macrosystem refers to the cultural values and societal regulations prevalent in the adolescent's community.

Because this ecological model takes into account factors inherent both within an individual and within their families, school, communities and broader socio-cultural factors, it provides a contextual map to help understand the multitude of factors contributing to the adolescents' suicidal behaviour (Abrams, Theberge & Karan, 2005).

5.1. The Microsystem

Various individual and immediate environmental factors seem to have contributed to the non-fatal suicide attempts made by the participants in this study. Such factors include feelings of hopelessness and despair, learned helplessness, inappropriate problem-solving skills, conflictual home environments, relationship problems, abuse etc. Each of these microsystemic factors will be discussed in further detail.

5.1.1. Hopelessness

Pfeffer (1986) believes hopelessness to be the most predominant feeling that precedes a suicidal act. According to Pillay and Wassenaar (1995), the more hopeless individuals

feel about their life situation, the more likely they are to use suicidal behaviour as a means of escaping the situation or as a means of communicating distress. The feelings of hopelessness and despair evident in the participants of the current study seem to have stemmed from undesirable circumstances in their lives, especially with regard to their relationships with others. The break-up of romantic relationships and arguments with family members, for example, seem to have left many of these adolescents with a sense of hopelessness and despair. Pillay and Wassenaar (1995) found that levels of hopelessness improved following psychological intervention with adolescent parasuicides. This highlights the importance of psychological intervention following NFSB, and more importantly, the dire need to identify and remedy such feelings before they lead to such behaviour.

5.1.2. Ineffective Problem-Solving Skills

The absence of effective problem-solving skills and/or the presence of neurotic coping mechanisms seem to be another factor that has contributed to NFSB in the adolescents in this particular study. The participants readily admitted that they resorted to such behaviour as they did not know what other options they had to deal with their respective problems. This could either be explained by a lack of effective problem-solving skills, which they may not have been taught either at home or at school; or because they experienced their respective problems as being too severe for them to even think clearly. We can imagine that at the time of contemplating and making the suicide attempt, an individual can be considered to be in a state of crisis - and, it therefore makes reasonable sense that someone in such a state cannot think clearly, thereby not being able to explore options to deal with their respective problems.

Schlebusch (2005a) states that suicidal behaviour is an inappropriate problem-solving technique, used especially by young people, when they feel unable to express their distress in a conventional manner. Likewise, participants in this study seemed to have been unaware of methods of communicating their distress to others, and thus, resorted to NFSB. Most participants did not even consider speaking to their parents about their distress for reasons such as believing that their parents would not take them seriously, distant relationships with parents, or if the problem they were experiencing involved the

parent/s themselves. Schlebusch, et al. (2003) found that NFSB is often employed as a first-line crisis management strategy used mainly by younger individuals. This anxiety-provoking finding highlights the need to provide youth with effective problem-solving skills as part of primary and secondary prevention programmes, in order to equip them with harmless alternatives to suicidal behaviour.

5.1.3. Parent-Child Relationships as a Risk and/or Protective Factor

It is apparent that communication between these adolescents and their parents is far from ideal, with the participants expressing that they could not confide in their parents who they felt did not understand them. It was a general feeling amongst the participants that their parents live in a different 'era', and thus, did not understand the challenges faced by youth today. This can be partly explained by the low socio-economic backgrounds of these families, indicating the strong likelihood that parents did not obtain high levels of education. As such, there appears to be a strong perception among these adolescents that their parents are unable to comprehend the demands and challenges of modern day schooling.

Relationships with parents form a core of the microsystem, and unsatisfactory relationships at this stage prove to be a major risk factor for adolescent suicidal behaviour. This assertion is supported by Fergusson, et al. (2000) who state that the risk of suicidal behaviour is increased by poor parent-child relationships. This can be understood in the current study by the realisation that stressful life situations, compounded by the absence of parental support, can predispose one to suicidal behaviour. We can therefore assume that poor parent-child relationships serve as a risk factor for adolescent suicidal behaviour - and conversely, that a strong parent-child connection may serve to protect adolescents against suicidal behaviour.

A study by Grøholt, Ekeberg, Wichstrom and Haldorsen (2001) identified a lack of social support as a significant precipitant for self-harm. This highlighted the importance of having a confiding relationship with parents, as family connectedness is believed to serve as a protective factor against adolescent suicidal behaviour. This is supported by Thompson, Mazza, Herting and Randell (2005), who believe that family support or

"connectedness" appears to function as a protective factor, counteracting family strain and suicidal behaviour. The urgent need to include parents in suicide prevention and intervention programmes cannot be ignored. Factors such as authoritarian parenting, high parental expectations and intra-familial stress that have been implicated in suicidal behaviour among Indian adolescents, suggest the pertinence of interventions at the parental level.

5.1.4. Familial Risk Factors

Wasserman and Narboni (2001) identified the following aspects of family dysfunction and instability and negative life events often found in suicidal adolescents:

- Parental psychopathology, with the presence of affective and other psychiatric disorders, alcohol and substance abuse, or antisocial behaviour
- A family history of suicide and suicide attempts
- A violent and abusive family, including physical and/or sexual abuse of the child
- Poor care provided by parents/guardians, with poor inter-family communication
- Frequent quarrels among parent/guardians, with tension and aggression
- Divorced or separation of parents/guardians
- Very high or very low expectations from parents/guardians
- Parents/guardians inadequate or excessive authority
- Parents/guardians lack of time to observe and deal with the child's emotional distress
- Negative emotional climate, with rejection or neglect
- Family rigidity

Most of these factors have been identified in participants in the current study.

(a) Parental Psychopathology

One of the participants in the study overdosed on anti-depressant medication, belonging to her mother, indicating that the mother was being treated for a mood disorder. Such parental psychopathology is believed to be a risk factor for adolescent suicidal behaviour (Wasserman & Narboni, 2001). Due to her mother having a pre-existing psychiatric condition, this may have negatively impacted on her ability to adequately parent her child. The daughter mentioned that she did not confide in her mother about her feelings,

as her mother was consumed by problems of her own. The desire to have a close bond with the mother was very apparent during the interview. This example has clearly highlighted the impact of parental psychopathology on adolescents. The need for (early), successful treatment of such psychopathology is urgent in light of not only the impact on the individual with the disorder, but also on their significant others.

(b) Family History of Attempted & Completed Suicide

Family history of suicide and suicide attempts were very apparent in the study with seven of the ten participants reporting that at least one of their family members had either attempted or committed suicide, suggesting that learned helplessness may have played a role in these participants' attempts, either because this was the way they saw significant others deal with stressful situations, or because they had seen others gain from NFSB, by getting the attention they desired, etc. As mentioned in the previous chapter, one of the participants reported that her sister took a drug overdose after her boyfriend ended their relationship. This act earned her more attention than she had previously received from him, culminating in their marriage. Another participant spoke of her sister (who was separated from her husband) who ingested household detergents when her husband threatened to take their children away from her. This act resulted in her husband allowing her to keep the children. Exposure to such outcomes of NFSB can be dangerous, in that adolescents may consider this as a (possibly easier) means to an end. Pillay and Wassenaar (1991) also caution against families mobilising around those who attempt suicide, as this could serve as an unhealthy reinforcer for adolescents who may realise that parasuicide can be effective in achieving certain goals.

(c) Abuse and Suicidal Behaviour

Although many participants reported family violence and abuse, only one participant in the current study reported being a direct victim of abuse (both physical and emotional). She clearly expressed her disappointment at having survived the suicide attempt. It is worth noting that this particular participant consumed the most lethal dosage of medication in terms of quantity and lethality. This clearly illustrates the impact of living in an abusive family environment. In a review of international literature by Evans, Hawton and Rodham (2005), it was found that adolescents who had been abused (either

physically or sexually) were significantly more likely to experience suicidal thoughts and behaviour than adolescents who were not abused.

In this particular case, the participant was abused by family members (her mother and sister), who would traditionally be expected to protect, rather than harm one. It is not surprising that abuse - from family members, none-the-less - would serve as a risk factor for suicidal behaviour, as family members, especially parents are expected to serve as a support in times of stress, and not contribute to the stress of their children.

(d) Intra-familial Communication, Conflict, & Support

Poor inter-family communication was evident in all of the cases in the current study. None of the participant's shared open, trusting relationships with their parents, and most also did not have close relationships with siblings. A study by Coggan, et al. (1997) identified family support as a critical element for youth in crisis, with participants in their study feeling an overwhelming need for families to be there for the young people who were suicidal. They felt that youth in times of crisis needed to be listened to, loved unconditionally and not judged for their feelings or intentions. Families were identified as one group who were usually in frequent contact with the suicidal young people and that families could have a lot of influence. It was therefore seen as important for families to know what to do when faced with a crisis. As families usually represent the core of an individual's microsystem, it is essential that they are equipped to provide the support that may be required of them.

Coggan, et al. (1997) also state that adolescence and young adulthood are more often than not difficult times for family dynamics. Participants felt that many parents were overprotective and often judgemental. This resulted in young people not confiding in their families at a crucial time in their lives, which has also been a critical factor in the current study. Grøholt, et al., (2001) have highlighted the importance of a confiding parent-child relationship, as this is believed to protect against all types of self-harm.

Frequent quarrels amongst parents were also reported by participants in the current study; and even in cases where these quarrels did not involve the participants; they were

undoubtedly affected by them, as evident in their suicidal behaviour. Some of these parents are divorced, and though not living together, the conflict still seemed to have prevailed.

(e) High Parental Expectations as a Risk Factor

High expectations of parents were also a factor in the current study. For example, one participant's parents expected her to perform extremely well academically, which eventually pushed her over the edge, due to her anxiety of not living up to their expectations. She was the youngest of her parents three children (the elder two also being female) and as neither of the others had completed matric (Grade 12), her parents had pinned all hopes on her to be the first in the family to achieve this milestone. For her parents, her completing matric was not an end in itself, but rather a means to an even more important end - the realisation of financial security for the family.

As mentioned earlier, Chatsworth is dominated by Indian families of low educational and socio-economic backgrounds. The resultant effects of such poverty can range from high stress levels to depression, and for many parents living under such constrained circumstances, their children represent the light at the end of the tunnel, as it seems to be their last hope that their children would perform well academically, gain meaningful employment, and thus remove the family from the shackles of poverty. Such parents often seem to be ignorant of the pressure experienced by their children who may feel overwhelmed by the responsibility that seems to have been unfairly placed upon their shoulders.

It is rather apparent that high expectations of parents are an important risk factor in adolescent suicidal behaviour. As mentioned earlier, parents represent the core of the microsystem in which adolescents live, and should therefore be serving a protective, nurturing role, rather than placing additional stresses on their children.

Authoritarian parenting is another factor that has surfaced as an important variable in the current study and will be dealt with in greater detail under the section, 5.4. 'The Macrosystem'.

5.1.5. Support Structures within the Microsystem

In the current study, individuals other than parents were reported to be confidants of the participants. These were mostly friends or neighbours. Those participants who did confide in someone before the act, however, reported that this did not help them feel any better. This highlights the need to target prevention efforts at such potential support structures, so they will be able to help in times of need. Research findings have suggested that high school students would tell a friend about suicidal feelings rather than tell a parent or counsellor (Dunham, 2004). There is therefore a clear tendency for suicidal adolescents to disclose to peers, which indicates the importance of targeting prevention efforts at this level, so adolescents are equipped to deal with a peer that may be suicidal.

On the other hand, some participants stated that they had not spoken to anyone prior to the non-fatal suicidal act, as it was an impulsive decision. This once again emphasises the importance of teaching adolescents effective problem-solving skills, to prevent them from resorting to such behaviour in desperate situations. The teaching of such skills should also incorporate issues such as conflict resolution, overcoming depression, dangers of substance abuse, stress management, methods of dealing with the emotional trauma of relationship break-ups, etc (Coggan, et al., 1997).

These are just some of the microsystemic factors that are believed to have either predisposed the participants to NFSB or precipitated the behaviour.

5.2. The Mesosystem

The mesosystem refers to the relationships between microsystems. According to Bronfenbrenner (1979), one's development will be enhanced if the different microsystems are strongly linked. However, if these are not consistent, the adolescent may become confused. The major conflicts between microsystems that are apparent in this study are the conflicts between values taught by parents and peers and conflicting values held by parents, compared to values acquired through education and acculturation.

5.2.1. Negotiation of Value Systems as a Protective Factor

A conflict between values taught by parents and values held by peers was strongly indicated by the participants in this study. The most commonly cited examples were parents discouraging behaviours such as smoking and consuming alcohol, while peers engaged in such behaviour. This often led to peer pressure, with the participants being forced to make difficult choices such as either obeying their parents at the expense of losing their 'friends' or giving in to peer influences at the risk of losing their parents' trust. It was clear in the study that parents seemed to hold rigidly to the values they teach their children, often disapproving of their children's peers whose values differed from their own.

It was also apparent that adolescents were given no freedom to negotiate these values - rather, they were imposed on them by their parents and were expected to always comply. It must be reported that some participants in the study were able to make informed decisions about which values to incorporate and abide by these values, even in the presence of peer pressure. Others who found this difficult may have also been influenced by their parents, who they reported, did not practice what they preached - for example, expecting their children not to drink and smoke, while indulging in such behaviours themselves. It seems vital that parents allow for negotiation of value systems with their adolescents in order to make them unanimously acceptable, as incongruent family and peer values may serve as a risk factor for adolescent suicidal behaviour.

5.2.2. Adolescent Exposure to Alternate Values

Another conflict between microsystems arises with differing norms, practices and values of parents compared to those acquired through socialisation of adolescents in educational and other social settings. According to Wassenaar, et al. (1998) young Indian women are exposed to various western norms, values and practices, including the emancipation of women from patriarchy and submission to male dominance. However, for those women who have been raised in traditionally orthodox families, these influences are not easily assimilated into their personal and family lives due to the opposition and resistance of parents. Although this represents a conflict between differing viewpoints and ideals of the different settings in which adolescents interact, another huge contributing factor is

culture, specifically cultural norms in Indian families, and will, accordingly be discussed in further detail in 5.4. 'The Macrosystem'.

These examples clearly support Bronfenbrenner's (1979) assertion that inconsistencies between an individual's various microsystems leads to conflict and confusion.

5.3. The Exosystem

The exosystem refers to those systems which do not directly involve the adolescent, but which nonetheless impact on their lives (Abrams, et al., 2005). In this study, such influences included parental conflict and parental unemployment, with the resultant financial difficulties.

5.3.1. Indirect Family Conflict as a Risk Factor

As mentioned earlier, many participants reported family conflict between parents or between other members of the family, which greatly influenced their decision to resort to NFSB. One participant resorted to NFSB as she could no longer tolerate the conflict between her parents and the father's constant accusations of the mother having an extra-marital affair. Another could no longer endure the constant fights and arguments between the mother and sister over the mother's disapproval of the sister's husband. It is clear that even though the family conflict may not have involved the respective adolescents and did not revolve around issues about them, they were still greatly impacted by such tensions between other family members. It is important that families realise that, as individuals do not exist in isolation, they are often affected by conflict in their immediate environment, even if not directed at them. However, family conflict is inevitable, and as such, individuals (both adults and adolescents) need to learn how to deal with such conflicts constructively to prevent drastic outcomes such as NFSB.

5.3.2. Parental Unemployment as a Risk Factor

Another such example is parental unemployment, which ultimately has a resultant impact on adolescents in various ways. Firstly, the financial implications of parental unemployment spiral down to the other family members having to cut down on their expenses. This is often a huge adjustment for adolescents to make. Another consequence

of parental unemployment is often the increased pressure on young adults in the family to perform exceptionally well academically, in the hope that they would be able to prosper and save the family from poverty. The Family Stress Model described by Yoder and Hoyt (1995) has linked family economic pressure to adolescent suicidal behaviour by indicating that family economic pressure influences parental emotional distress that, in turn, impacts their parenting behaviours, which themselves affects adolescent psychological well-being.

Emotional distress experienced by parents due to economic difficulty can often lead parents to myopically focus on their poverty, while ignoring their parental responsibilities. Such parental unavailability may mean that adolescents will not turn to their families in times of stress - either because they do not want to add to their parents' stresses or they do not expect to get any support from their parents.

5.3.3. Exosystemic Barriers to Help-Seeking

It can be reasonably assumed that when parents are consumed by their own stressors, the chances that their children will not seek help from them in times of need are great. So, it follows to reason that parental unavailability, regardless of the reason for it, serves as a definite barrier to help-seeking from them.

All participants in this study were still at school and financially dependent on their parents. Such financial difficulties of these families may serve as a barrier to help-seeking in these individuals. If adolescents cannot or choose not to confide in family or friends and/or feel that they require professional help for their problems, this is often not a possibility due to financial constraints.

It is clear in the above-mentioned examples that exosystem influences, though not directly involving individuals, may still have a huge impact on them

5.4. The Macrosystem

The macrosystem refers to cultural values and larger societal factors that influence individuals. The macrosystem influences that were pertinent in this study were religion, social support structures and cultural values.

5.4.1. Religion

Colucci and Martin (2008) cite numerous studies that have found religious factors to be associated with lower rates of suicidal behaviour as well as more negative attitudes towards such behaviour. A study by Colucci in 2008 (cited in Colucci & Martin, 2008) found that students in India, who described themselves as religious or spiritual reported lower suicidal ideation than those who claimed to be non-religious. This was, however, not the case in the current study. Although most participants described themselves as religious individuals, who regularly attended religious services, none of them resorted to prayer in times of distress or when contemplating NFSB. Two of the participants did, however, resort to prayer when faced with stressors in prior instances, but NFSB seemed to be a preferred option at the time of the most recent attempt, due to their problems appearing to be so magnanimous to them, that they saw no other way out. For example, the participant who reported being abused admitted that she resorted to prayer previously, but seeing that the abuse did not stop felt that suicide was the only way out. Another participant who reported that she had in previous instances resorted to prayer in times of stress, said that the constant pressure and 'nagging' from her parents to study hard, stressed her out so much that she couldn't think clearly and made an impulsive decision to overdose on medication.

Most participants admitted that they had not given any consideration to their religious beliefs about suicide until questioned about it in the interview. This could have, perhaps, resulted from the non-fatal suicidal act being so impulsive that there was no time to think about anything at all, including prayer.

O'Connor and Sheehy (2000) attribute the rise in suicide rates in many western countries to changes in religious worship practices. These authors report that there are some who argue that church attendance and other social integrative aspects of religion that were believed to buffer against suicide are not as strongly associated with suicide as levels of religious belief and suicide tolerance (O'Connor & Sheehy, 2000).

5.4.2. Social Support Structures

Despite the myriad of community organisations in Chatsworth that target youth and the problems faced by youth in the community, none of the participants sought help from any of these organisations. Most were unaware of the presence of such organisations in their community. The participants' ignorance of existing support structures in their community highlights the importance of increasing awareness of such organisations which are easily accessible to adolescents. If it is, indeed, their lack of knowledge about such organisations that acted as a barrier to seeking help from such sources, it is vital that awareness campaigns be capitalised upon to provide young people with what resources are available to them, how they may be accessed and what types of help is provided.

5.4.3. Cultural Values

One of the most prevalent factors that arose in this study was the impact of authoritarian parenting on the participants. In South Africa, the rate of parasuicide among Indian adolescents is extremely high, considering the small number of Indians in the country (Pillay & Wassenaar, 1991).

South African Indians have been described as an acculturating community, a phenomenon that researchers have linked to the soaring rate of parasuicide in adolescents (Pillay & Wassenaar, 1991). There is now a tendency towards individual rather than collective expression, with this need for individualism being linked to parasuicide in young Indians. According to Pillay and Wassenaar (1991), in seeking a less restrictive and rigidly controlled lifestyle, like their western counterparts, Indian adolescents are deviating from cultural norms, and, as a result come into conflict with parents holding traditional values. Developmental needs such as dating and contemporary entertainment are often seen as a deliberate violation of cultural norms and lead to parent-child conflict which is often cited as a contributor to adolescent parasuicide (Pillay & Wassenaar, 1998). These authors also cite studies which report that such conflict is associated with over 50% of parasuicide behaviours in adolescents. Pillay and Wassenaar (1991) believe that parasuicide among Indian adolescents belonging to traditionally orthodox families, may serve as a means of communicating their unhappiness at their restrictive environments.

According to Pillay and Wassenaar (1995) Indian adolescents appear to be struggling to individuate from their families, and, in so doing, are engaged in battle with their parents who seem to be blocking or frustrating these developmental endeavours. As a result of restrictions on their social life these adolescents often conduct their romantic relationships secretly, which often leads them to feel alone and unsupported in times of relationship conflict (Pillay & Wassenaar, 1995), making suicidal behaviour more likely in such situations.

The demise of apartheid has increased cross-cultural contact, especially amongst younger generations. Thus, families who hoped to retain a core cultural identity in their children have found themselves increasingly faced with children who aspire to lifestyles and goals associated with other cultural groups (Wassenaar, et al., 1998). These authors describe Indian families as being traditionally patriarchal, with women occupying submissive positions, leading orthodox older generations to shun the western lifestyles adopted by many Indian youth (Wassenaar, et al., 1998).

Acculturation, coupled with exposure to alternate values and ideals through education, socialisation and the media seem to be leading the younger generations to develop their own personalities, values and lifestyles - some of which may conflict with the values held by their traditional families.

As Indian parasuicides tend to perceive their families as rigid, over-controlling and lacking in emotionally positive closeness, prevention efforts need to target these issues at a community level (Pillay & Wassenaar, 1991). Parent-effectiveness programmes can be extremely valuable in educating parents on the impact of different parenting styles. Ideally, parent-child interaction should allow children to experience and express their individuality while remaining intimately connected to the parent. In this way the parent is able to build a relationship with a child, in which processes such as the extent of dependence, decision-making regarding family matters and area of interest will indicate a balance in the family relationship between cohesiveness and uniqueness (Avnir & Shor, 1998).

As is apparent in the above discussion, there are multiple levels of risk and protective factors that appear to mediate NFSB in Indian adolescents.

In summary, the factors that seem to place adolescents at risk for suicidal behaviour are as follows:

	Risk Factors	**Protective Factors**
Microsystem	*Feelings of hopelessness and helplessness *Ineffective problem solving skills *Neurotic coping mechanisms *Stressful home environment *Family conflict *Poor parent-child relationships *High parental expectations *Learned helplessness/modelling *Family history of suicide *Lack of family/social support *Abuse	*Effective problem-solving skills *Parent-child connectedness *Positive intrafamilial relationships *Open parent-child communication *Stable home environments *Adequate social support * Religious assimilation
Mesosystem	*Exposure to inconsistent value systems	*Negotiation of value systems
Exosystem	*Conflict between parents *Parental unemployment	*Positive parental relationships *Parental financial stability
Macrosystem	*Ignorance of religious beliefs about suicide *Lack of awareness of community organisations *Perceived ineffectiveness of community organisations *Acculturation	*Religious affiliation/assimilation *Awareness of community organisations & other sources of help

It is critical that these risk and protective factors are taken into account when designing effective suicide prevention programmes. These factors highlight the importance of

targeting prevention programmes, not only at an individual level, but also at a familial and social level, e.g. parenting programmes, school-based prevention and community-level interventions. This will ensure that adolescents receive support at various levels, which would hopefully reduce the incidence of NFSB.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusions

The recent shift in suicide rates from the elderly towards younger people is alarming, considering that suicide is now one of the leading causes of death in young people (Schlebusch, 2005c). The rate of attempted suicide amongst adolescents seems to be much higher than fatal suicides (Grøholt, et al., 2006). As previous research has found that adolescents from the minority Indian community appear to be particularly vulnerable to suicidal behaviour, judging from the high suicide rates among this group (Pillay & Wassenaar, 1995), this project aimed to identify the dynamics of NFSB in this group.

Gutierrez (2006) believes that identifying adolescents who are at the greatest risk of engaging in suicidal behaviour before such behaviour becomes fatal would reduce the incidence of such behaviour. Accordingly, this study set out to identify, not only the risk factors, but also factors which appear to protect against suicidal behaviour.

This study provides valuable insight for researchers, psychologists and other stakeholders involved in suicide prevention programmes, in that it highlights individual, familial, community and societal factors that either place these adolescents at risk for suicidal behaviour or protect them against it. Such information is vital in designing effective prevention and intervention programmes.

This study attempted to understand, from the perspective of the participants, the collective influences of individual, familial, cultural and societal factors on their decision to engage in NFSB. The most salient findings are outlined below under these categories. Key recommendations are then extrapolated, particularly to aid in the designing of effective prevention programmes. Finally, the limitations of this study are critically appraised.

6.1.1. Microsystemic Factors

This study has found that several individual and immediate environmental factors play a role in the occurrence of NFSB in Indian adolescents. These factors are outlined below:

- Most participants reported feelings of hopelessness and despair resulting from undesirable life circumstances, prior to their suicide attempt.
- Learned helplessness resulting from exposure to neurotic coping mechanisms of family members or friends also seems to have played a role in the non-fatal suicidal acts of these adolescents.
- The absence of effective problem-solving skills among these adolescents was evident in their failure to think of alternate methods to deal with their respective problems
- Many of the participants described their home environments as stressful for a variety of reasons, such as family conflict, parental unemployment, etc.
- Poor parent-child relationships seems to have been a major factor in this study, as adolescents felt that they could not confide in their parents about their problems.
- High/unrealistic parental expectations were reported to be a major stressor for adolescents, who felt that there was too much of pressure on them to perform well academically.
- A family history of suicide/attempted suicide was evident in most of these cases, implying that such behaviour may be learned.
- Lack of family support seemed to play a major role in NFSB, particularly in cases where adolescents felt that they would not be understood or supported by their families, and therefore did not turn to them for help instead of resorting to NFSB.
- Although there was only one reported case of abuse in this study, the impact of abuse in relation to suicidal behaviour cannot go unacknowledged, with the participant feeling that it was more desirable to end her life than live with the abuse.

While these individual and immediate environmental factors play a role in the occurrence of NFSB, the presence of factors such as effective problem-solving skills, parent-child connectedness, positive intra-familial relationships, open parent-child communication,

stable home environments, adequate social support and religious assimilation are believed to protect against such behaviour.

6.1.2. Mesosystemic Factors

According to Bronfenbrenner (1979), a person's development will be enhanced if the different microsystems are strongly linked. It was, however, found in this study, that inconsistency between the various microsystems in the adolescents' lives led to conflict. The main inconsistencies were between:

- Value systems taught by parents and value systems assumed by peers; and
- Values, norms and practices taught by parents and those acquired through socialisation, education and exposure to western ideals.

Such inconsistencies between value systems lead adolescents to either become confused about their own values or to question their existing values. Implications of this may take the form of peer pressure to conform to peer norms, which may be unacceptable to parents or conflict between parents and children in cases where adolescents from traditional Indian families are exposed to and incorporate western values and ideals. Because exposure to alternate value systems appear to serve as a risk factor for NFSB, it seems vital that parents allow their adolescent children to negotiate such values so they are more likely to abide by them.

6.1.3. Exosystemic Factors

It was found in this study that adolescents were not only affected by circumstances that directly affected them, but also by certain factors by which they were indirectly affected. Such circumstances included:

- Indirect family conflict, mainly between parents, which seem to have impacted on the participants decisions to resort to NFSB, as it appears that conflictual home environments contribute to existing stressors experienced by adolescents.
- Parental unemployment is believed to be a major contributor to adolescent stress, and subsequently to NFSB for various reasons, such as adolescents having to cut down on their expenses and parents focusing most of their time and attention on their financial difficulties and thereby neglecting their parental responsibilities. It

stands to reason that when parents are consumed by their own stressors, their children are less likely to turn to them in times of need.

Because adolescents are sometimes negatively affected by factors that do not directly involve them, there is a definite need for prevention programmes to target parents and significant others as well.

6.1.4. Macrosystemic Influences

The exploration of socio-cultural factors seems to have played a significant role in explaining NFSB among Indian adolescents. The following socio-cultural factors were prominent in the study:

- Although religious factors have been associated with lower rates of suicide (Colucci & Martin, 2008), religion did not seem to serve as a protective factor against suicidal behaviour in the current study. It is argued that the impulsive nature of the suicidal acts in this study impacted on the adolescents' ability to consider their religious beliefs in times of dire stress.
- The participants' lack of awareness of community organisations from which they could have sought help is anxiety-provoking considering the numerous such organisations that exist in Chatsworth. It is essential that the presence of such organisations and their services be well-publicised to ensure that those who need help are able to turn to such sources.
- Acculturation was found to play a major role in precipitating NFSB, with adolescents who may have deviated from cultural norms coming into conflict with their parents. Traditionally orthodox parents are also prone to frustrating normal developmental needs of their adolescent children, such as needs for individuation and romantic relationships.

It is clear that socio-cultural factors play a major role in adolescent NFSB, implying that these issues be targeted at broader levels.

In conclusion, the above-mentioned factors have important implications for the designing of effective suicide prevention programmes, as they give a clear indication of the areas to be targeted.

6.2. Recommendations

A number of clear priorities for prevention programmes have emerged from the results of the current study. It is recommended that the following areas are further researched and prioritised for the development of new prevention programmes as well as for the improvement of existing programmes.

6.2.1. Recommendations for the Promotion of Help-Seeking Behaviour

Because life is never constant, with stressors being inevitable, suicidal behaviour will continue to occur. Primary prevention programmes should therefore focus on increasing help-seeking behaviour among those at risk. This can be achieved by awareness campaigns in various mediums, such as print, audio, visual and electronic media in order to target diverse groups of people. Furthermore, it is essential that such campaigns endeavour to decrease the stigma associated with suicidal behaviour to ensure that more people seek help. Campaigns need to promote awareness of the risk factors for suicidal behaviour, so people are able to identify those at risk.

6.2.2. Recommendations for School-based Programmes

One of the significant findings of the present study was that those adolescents, who did confide in someone, confided in friends or peers rather than family members. This highlights the need to target prevention programmes at this level, so adolescents can firstly establish when a peer may be suicidal, and secondly, know what to do in such situations. Peer-counselling or peer-supporter programmes, which are already manifest in some schools, need to be capitalised upon and spread to all schools to increase the likelihood that students in distress will confide in a peer-counsellor/supporter, which will thereby reduce the incidence of non-fatal and suicidal behaviour if alternatives are presented to the individual.

Life-skills should ideally form part of school-based education, so students can be equipped with tools and options for dealing with various stressors. This would be an ideal platform to impart skills such as problem-solving skills, conflict resolution, stress management and decision-making skills.

6.2.3. Recommendations for Parent-Effectiveness Training Programmes

Various findings in this study suggest an unquestionable need to incorporate parents into suicide prevention programmes. In fact, parent-effectiveness training in general, focusing on issues such as substance-abuse, adolescent development, parent-child connectedness, negotiation of value systems and other related issues may serve to strengthen the bond between parents and their children, as well as give them effective strategies for dealing with specific problems. It was suggested that, as parents (particularly in this community) did not obtain high levels of education, they failed to understand the pressures of modern education. Programmes such as these can serve to educate parents on such challenges faced by adolescents and help them support their children. Parents need to be educated on the possible implications of authoritarian parenting, familial stress and unreasonable expectations on their children. It can be assumed that if parents are aware of the possible impact that such behaviours can have on their children, then they would be more likely and willing to change those behaviours.

6.2.4. Recommendations for Community Organisations

It was apparent in the present study that regardless of the numerous community organisations in Chatsworth that aim to provide help to adolescents in need, none of them were utilised by the participants in the study. What is even more surprising is that many of the participants were unaware of the existence of such organisations. This highlights a definite need to increase awareness of such services, which will hopefully result in increased usage. Strategies to create awareness of such organisations may include billboards and posters in areas frequented by adolescents, pamphlets distributed to schools and talks and/or awareness campaigns in schools. Such organisations need to clearly outline their service objectives and make these known. Adolescents, for example, may want to know specifics such as that their confidentiality and/or anonymity will be maintained. Such organisations also need to be easily accessible to adolescents if they are

to be used, as transport may present a huge barrier to adolescents, especially those who choose not to confide in family members.

6.2.5. Recommendations for R.K. Khan Hospital

Many adolescents who engage in NFSB are admitted to hospital, as was the case with all participants in this study. The hospital is therefore able to play a larger role in secondary and tertiary prevention. It is recommended that patients admitted for NFSB be offered post-discharge help, such as out-patient psychotherapy or the option to join a support group. As most of these patients present with family-related stressors, parent-effectiveness training should be an option to parents of these adolescents to help increase positive parenting behaviour and facilitate connectedness with their children. The Social Work Department at R.K. Khan Hospital have indicated an interest in being trained to run such programmes, and it is envisaged that this will take place in the near future.

6.3. Limitations of the Study

The present study provides a deeper understanding of the risk and protective factors that mediate non-fatal suicidal behaviour in Indian adolescents, and has highlighted important factors to aid in the designing and implementation of prevention programmes. However, despite the contributions of the present study, the following limitations should be noted:

- Given the small sample size and the fact that the sample was drawn from a single site, generalisability of the findings is likely to be limited. It is important that future studies draw their samples from a variety of sites, specialising in NFSB.

- Although it was not intended, all participants in this study were female. It would have been interesting to note whether the dynamics that contribute to NFSB would have been different with male participants.

- Limited demographic information (such as age, education level, etc) was obtained about parents of the participants, which suggests that vital risk factors may not have been discovered.

However, despite these limitations, the present study provides many important insights into the multiple levels of factors that place Indian adolescents at risk for, or serve to buffer against NFSB.

6.4. Researcher Reflexivity

The present study proved to be an extremely rewarding process for the researcher due to her personal interest in the phenomenon of NFSB among Indian adolescents. The main obstacle faced in the process was getting access to the sample, due to the rapid rate at which such patients are discharged from the hospital. This is in part due to the realisation that NFSB seems to be perceived as a medical problem, rather than a psychological one. Hence, patients admitted for NFSB are discharged as soon as they are medically stable.

The researcher was pleasantly surprised at being perceived as being supportive by the participants, who seemed to freely disclose personal information related to their non-fatal suicidal acts. Many participants disclosed that their non-fatal suicidal act was merely a cry for help – even though they were not asked.

As the results have indicated numerous priorities for the development of prevention programmes it is hoped that this research will, through its findings, ultimately lead to a decrease in both non-fatal and fatal suicidal behaviour.

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