ADOLESCENT SUICIDAL BEHAVIOUR - A DESPERATE CRY FOR HELP

By

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DECLARATION

I, Amutha Govender, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor part thereof has been submitted for a degree at another university.

Amutha Govender

DEDICATION

To my dearest Husband

"The wind beneath my wings"

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- The Principal, governing body, parents and staff of the school that participated in the study – thank you for allowing me time at your school and access to the learners

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ABSTRACT

There appears to be a need to demystify suicidal behaviour not just for the benefit of researchers and health workers but equally for parents, teachers and most importantly for adolescents themselves. The focus in this study was on attempting to provide a fresh perspective of adolescent suicidal behaviour by viewing some delinquent and deviant behaviour as possible manifestation of suicidal behaviour and by decoding and making an attempt to understand the non-verbal voices/cries of suicidal adolescents.

In general, suicide and suicidal behaviour among adolescents, has received relatively little attention from Education Departments throughout South Africa. Suicide-prevention is also sadly neglected by government and public health authorities. Unfortunately, despite the fact that the phenomenon has become the first cause of death among the younger age groups, with a higher mortality rate than for road accidents, it has not so far managed to provide backing for preventive schemes within the school and community systems of the same magnitude as the ones developed to tackle other public health problems, such as Aids.

The purpose of this study was to gain greater insight into the phenomenon of adolescent suicidal behaviour so that a clearer and broader definition (that included both overt and covert behaviour) was formulated. This will then assist, amongst others, educators, parents and adolescents to identify more easily adolescent suicidal behaviour in its various forms. The study also hoped to investigate and identify the factors that could contribute to suicidal behaviour in adolescents. It also hoped to explore what support systems were available and accessible to the adolescents, more especially those manifesting deviant and delinquent forms of suicidal behaviour and to investigate the effectiveness of the support systems.

The concept of networking and creating supportive connections is strongly supported when facing problems of suicide and suicidal behaviour. In creating a connection with the

parents, teachers are able to better connect with learners because they will be more aware of the stressors that adolescents are experiencing.

Since evidence indicates (Snyder, 1971) that potential suicide victims typically turn first to family and everyday friends and to the more traditional and perhaps formal sources such as clergy, psychiatrists, social workers only later, the need for the school to be more ready to play the role of referrer to other established sources of help is apparent. Teachers should not mistake adolescent suicidal behaviour for just delinquent 'brat' behaviour. In many situations adolescent suicidal behaviour becomes a way of communicating with others after all other forms of communication have broken down – when connections with the outer world is tenuous or non-existent.

Stigma keeps adolescent suicidal behaviour from being identified as a public health problem that is preventable. This could be the reason (besides financial ones) why the Department of Education has not seen the urgency to strengthen counselling services in schools. In the absence of such support parents, educators and adolescents need to join forces – create a network of connections – both physical and emotional – so that desperate cries of adolescents are heard, interpreted and eliminated.

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CHAPTER 1

1.1. INTRODUCTION

The efforts, to clearly and operationally define a particular form of behaviour as suicidal has so far been problematic for both researchers and clinicians (O'Carroll, Berman, Maris, Moscicki, Tanney & Silverman, 1996). This is because of the difficulty to prove posthumously any intention to die. Researchers are still grappling with the fine and subtle distinction between non-suicidal self-injurious behaviour and suicidal behaviour. While this academic debate takes centre stage in international journals and at world conferences the statistics on suicide, and more especially adolescent suicides, keep mounting.

Several studies presented at South African conferences have noted that during the last few decades, up to about a third of all non-fatal suicidal behaviours involved children and adolescents (Schlebusch & Bosch, 2000). More recent research, that was hospital based, noted that 24.5% of the total sample of suicidal behaviour patients were black youth aged 18 years and younger (Schlebusch, Vawda & Bosch, 2003). In 2004 many Grade 12 learners in South Africa called a toll-free suicide help line. Most callers were black and Coloured pupils who felt under pressure from parents who had told them they had to do well because of the sacrifices they had made for them. Teachers also called to get tips on how to handle depressed or suicidal learners (Khan, 2004).

There appears from the studies cited above that there is a need to demystify suicidal behaviour not just for the benefit of researchers and health workers but equally for parents, teachers and most importantly for adolescents themselves. The research focus for this study, therefore, in an attempt to distinguish the act of suicide itself from suicidal behaviour in general and adolescent suicidal behaviour in particular, was school based. The study did not attempt to present a clinical perspective of suicidal behaviour as this is best left to those trained in the field of suicidology. The focus in this study was more on attempting to provide a fresh perspective of adolescent suicidal behaviour by viewing some delinquent and deviant behaviour as possible manifestation of suicidal behaviour and by decoding and making an attempt to understand the non-verbal voices/cries of suicidal adolescents. This is explained further later in this chapter.

To enhance the merit of this study, it was prudent to examine research in suicide not just in the South African context but internationally as well. The background to what was happening in the field of suicide provided the starting point for this study.

1.2. BACKGROUND

The National Health Minister in South Africa, Dr Manto Tshabalala-Msimang declared 21-25 February, 2005, Teen Suicide Awareness Week. This was as a result of the South African Youth Behavioural Survey (Sunday Times, 2005) which indicated that suicide appears to be more common among young people than among old people and that it is a global phenomenon rated thirteen on the list of leading causes of death and ranked third, as the cause of death, among youngsters aged between 15 and 24 – topped only by car accidents and murder (Green, 2005).

Sadly, South Africa has become one of the major suicide capitals of the world. A survey by the South African National Injury Mortality and Surveillance System (Clarke, 2004) shows that about 10% of all non-natural deaths in South Africa are due to suicide, a figure that far exceeds the yearly world average of 16 for every 100 000.

However, this is only "the tip of the iceberg" according to Lourens Schlebusch, Professor and Head of the Department of Behavioural Medicine at the University of Kwa-Zulu Natal's Nelson R Mandela School of Medicine. He states that "at least two fatal suicides occur in South Africa every hour and 20 attempted suicides occur every 60 minutes" (Clarke, 2004:4). This figure has doubled since 2003, when Schlebusch reported (Clarke, 2003) that one person takes his own life every hour in South Africa and that those living with HIV/Aids are 36 times more likely to do so. He states however that these figures are rather conservative and under represented because suicidal behaviour among the black population is under researched (Green, 2005). Schlebusch, Vawda & Bosch (2003) reviewed some of the more recent research on suicidal behaviour in black South Africans. The results indicate an apparent increase in suicidal behaviour in this group. Some of the explanations offered for the change in suicidal behaviour in the reported clinical populations includes past difficulties for all South Africans to access health care facilities in the Apartheid era, and present difficulties of post-apartheid transformation the South African society is undergoing as the people struggle to come to terms with the deleterious effects of the former South African racial policies, related socio-cultural, socio-economic, and other pressures.

It appears, from reports in the media and the limited research studies undertaken with adolescents in particular, that an increasing number of South African adolescents are committing suicide to escape life's problems. To date, despite various conferences on suicide (including an international one held at the International Conference Centre in Durban, South Africa in April 2006), enormous media coverage and an alarming increase in adolescent suicides, no simplified formula has been found to decrease the rate of suicidal behaviour. South Africa, however, is not alone in facing the challenge of suicide prevention. Other countries are experiencing similar challenges.

Watkins (2000) reports that suicide claims more adolescent lives than any disease or natural cause and that adolescents now commit suicide at a higher rate than the national average of all ages. According to Juon and Ensminger (1997), suicide ranks among the top ten causes of death in most countries that record suicide rates, and constitutes one of the top two or three causes of death among African American youth. Kimmel and Weiner (1995) also note that suicide and suicidal behaviours among youth are increasing at an alarming rate in the USA. Portner (2001) reports that each year hundreds of thousands of U.S. teenagers attempt suicide. While boys succeed at higher rates, girls try more often. Portner states that no single group of children is exempt. Suicide does not discriminate by race, class, religion or gender. All are crying out to be heard in this silent crisis. This pattern is substantiated by Diekstra (1989) who found that the rate of suicidal behaviours within the 15 to 24 year old cohort worldwide has increased dramatically in the last thirty years.

In 1998 the World Bank and the World health Organization deemed that suicide causes at least 800,000 deaths per year throughout the globe and that the number of attempted suicides is probably ten times higher (De Leo, Schmidtke & Diekstra). This view is substantiated by Watkins (2000) who reports that there are far more suicidal attempts and gestures than actual completed suicides. One epidemiological study (Watkins, 2000) estimates that there were 23 suicidal gestures and attempts for every completed suicide. It follows that the people involved each year in suicidal behaviour are several million in number, often leaving a long-term legacy of emotional, social and economic distress. Despite the early warning signs however, the suicidal adolescent often goes undetected and untreated.

In addition to the number of suicidal deaths, De Leo, Schmidtke & Diekstra (1998) estimate that at least ten times as many persons make a non-fatal attempt to harm themselves, often serious enough to require medical attention and not infrequently resulting in irreversible disability. Such estimates

are however based upon data of suicide attempts that led to hospital admissions or contact with health agencies. It has been shown however that the majority of suicide attempts or attempts at deliberate self-harm remain unknown to or unregistered by such agencies. According to Clemenstone, (1991), suicide is often viewed as a cowardly and disgraceful act in some cultures and is therefore frequently concealed by families and medical personal. Other reasons for under-reporting according to Goldney (1991) are:

- reluctance to conclude that death has been caused by suicide for fear of causing distress to the surviving family
- the general religious stance on suicide
- many life insurance policies are void when death has been self-intentioned
- the medical profession itself has been tardy in acknowledging that adolescents can have severe depressive illness with intense suicidal ideation.

Mellish (1993) states that, in South Africa, the percentage of suicide in the white community is the highest. This is followed by the Asiatic. Black and Coloured rates are low. Thirteen years later the statistics, after a study by the National Injury Mortality Surveillance System in all the metropolitan areas of South Africa, shows that suicide figures in the white community is still the highest (Smit, 2006). These statistics need to be read with caution as studies have not been done in rural areas and semi-rural areas where the black population is higher. The accuracy of statistics and stigma therefore may be a limiting factor.

As early as 1910, suicide was the subject of the Vienna Psychoanalytic Society (Wekstein, 1979). Suicide then was a phenomenon that aroused suspicion, silence, condemnation and moral indignation and could only be discussed by a small group. We know more today about the nature and magnitude of the suicidal phenomena than we did a century ago. It is clearly recognised as an international mental health problem.

However, despite the increased public concern about suicidal behaviours, it is still viewed with negativity and condemnation in virtually all cultures. Cases of suicide are increasing in different parts of the world. Rapidly changing societal values, population mobility and economic pressures have presented our adolescents with decision-making conflicts that result in uncertainty and stress. Zane Wilson, founder of the South African Depression and Anxiety Group, predicts that (Green,

2005) as this country's youth experiences grinding poverty, a growth in drug use, the increasing spread of HIV and Aids and poor job prospects, more would become depressed and contemplate suicide.

Goldney (1991:199) reflects the current view towards suicidal behaviour with the following words:

> "suicidal behaviour tends to be denied by society in general as it is difficult to come to terms with the fact that so many people feel that life is not worth living."

Suicide has become a social disease. Her words are therefore profoundly sad when you consider the fact that in many cases adolescent suicidal behaviour is a desperate cry for help when other attempts at 'problem solving' have failed. Society needs to acknowledge this and recognise the pain and cries for help behind adolescent suicidal behaviour which is often disguised in the form of delinquent and deviant behaviour.

1.3. RESEARCH FOCUS

'Suicide' and 'suicidal behaviour' are frequently used interchangeably in research studies and statistics on the phenomenon of suicide. To date a clear, precise and unambiguous definition of suicidal behaviour that is seen as separate from the act of suicide itself or the actual overt attempt of suicide could not be accessed therefore it became the main focus of the study. It is acknowledged that suicidal behaviour is multi-tiered and multi-faceted and therefore a definition of suicidal behaviour should be broad enough to include behaviour that is often passed off as deviant or delinquent. The exclusion of such behaviour from the definition could explain the reason why so many adolescent suicides happen without parents, teachers and adolescents themselves being aware of the build up to the eventual act of suicide.

The aim of this study was not on defining suicidal behaviour for clinicians and other health workers but rather to unpack the enigma of adolescent suicidal behaviour for parents, teachers and most importantly for adolescents themselves. An in-depth examination of the behaviour of adolescents by using questionnaires and unstructured interviews illuminated the complexity of adolescent lives through the interacting factors like culture, environment (school and home), family dynamics and problem solving skills.

Para-suicides among adolescents in South Africa have already received some attention from clinicians and researchers over the years. However many of these studies focus primarily on the reasons for the actual eventual act of suicide itself rather than the phenomenon of the impulse that leads to suicidal behaviour. Furthermore, most studies in the 1980's have attempted to account for the increase in para-suicide only among Indian adolescents. Issues such as family functioning (Wood & Wassenaar, 1989), personality factors (Bhana, 1982) and management (Wassenaar, 1987) have been examined. Pillay & Pillay (1987) identified single persons between 16 and 25 years who have a background of authoritarian parenting, to be at greatest risk. Wassenaar (1987) focused on the family dynamics of Indian adolescent para-suicides. It was suggested that para-suicides in adolescents appears to be a gesture communicating distress related to a developmental difficulty. Families of these individuals were unable to accommodate the adolescent's drive toward individuation. Wood & Wassenaar (1989) noted in particular disturbed role functioning, rigid problem-solving behaviour and lack of open communication. Such findings were later confirmed by Pillay's (1989) study of the family dynamics of Indian adolescent para-suicides.

Despite the above studies, there is still sadly a paucity of research investigating the covert and less obvious forms of adolescent suicidal behaviour. It was hoped that this study would firstly define more clearly and broadly adolescent suicidal behaviour and then expose some of the reasons for the increase in cross-cultural adolescent suicidal behaviour (more especially the less obvious forms) and then hopefully make recommendations that would lead to the decrease of suicidal behaviour amongst the youth of South Africa.

In general, suicide and suicidal behaviour among adolescents, has received relatively little attention from Education Departments throughout South Africa. Suicide-prevention is also sadly neglected by government and public health authorities. This is surprising in view of the fact that both fatal and non-fatal suicidal behaviours are becoming more and more common in young people of all races; and that suicide, following suicidal thoughts, threats, plans and attempts among the youth is so common in South Africa. Unfortunately, despite the fact that the phenomenon has become the first cause of death among the younger age groups, with a higher mortality rate than for road accidents, it has not so far managed to provide backing for preventive schemes within the school and community systems of the same magnitude as the ones developed to tackle other public health problems, such as HIV and Aids.

Raging hormones, confused cognition and emotional turmoil makes the average adolescent of today a highly complex individual. The gap between the generations has obviously widened. Adults (more especially parents and educators) and adolescents appear to speak different languages and live in different time zones. The factors that contribute to adolescent suicide and suicidal behaviour are often ignored or not identified. This could play a contributory role in the increase in adolescent suicidal behaviour.

Recently after the suicide of a Stanger adolescent, I overheard an educator say: 'she killed herself just because her mother did not allow her to make a call to her friend'. The adolescent's act of suicide was perceived to be that of a selfish, spoilt individual. The history behind her behaviour and feelings were ignored. The impulse that eventually triggered the actual act of suicide ... the impulse caused by the feeling of total disconnection that the adolescent may have felt at being cut off from her friend ... her mother and the world in general ... appear to be unconceivable by those who inhabit the world of the adolescent.

Adolescents are no longer encouraged to express their deepest feelings and resolve their inner conflicts. In the past diaries helped adolescents to externalise their conflicts. Diaries became their best friends – the vent for their emotions. It was non-judgmental and cathartic. Today adolescents in schools have moved away from the culture of writing about anything let alone about personal issues. 'Creative writing' or 'Free-writing' where adolescents were encouraged to write their deepest and most private thoughts is no longer a compulsory part of the syllabus in South African Schools. Counselling services within the school structure has also become a privilege.

As an educator at a number of secondary schools over the last twenty seven years, as a counsellor at Life-line Durban and more recently as an Educational Psychologist this study is of personal and professional interest to me - a mission to unravel threads in a complex pattern. To achieve this mission a purpose had to be articulated and critical questions formulated to frame the quest/study.

1.4. PURPOSE OF THE STUDY

The purpose of this study was to gain greater insight into the phenomenon of adolescent suicidal behaviour so that a clearer and broader definition (that included both overt and covert behaviour) was formulated. This will then assist, amongst others, educators, parents and adolescents to

identify more easily adolescent suicidal behaviour in its various forms. The study also hoped to investigate and identify the factors that could contribute to suicidal behaviour in adolescents. It also hoped to explore what support systems were available and accessible to the adolescents, more especially those manifesting deviant and delinquent forms of suicidal behaviour and to investigate the effectiveness of the support systems.

1.5. CRITICAL QUESTIONS

The following critical questions were asked:

1. What constitutes suicidal behaviour?
2. What factors contribute to adolescent suicidal behaviour?
3. What support systems are available for adolescents with suicidal behaviour?

1.6. METHODOLOGY

I chose to position the methodology in the interpretative paradigm by using the case study approach. The post-positivistic paradigm was utilised to provide baseline information for the interpretation. Both the quantitative and qualitative methods for data collection were therefore employed. This allowed for the collection of data that was comprehensive in nature. This will be elaborated on later in the chapter on methodology (chapter four). Questionnaires and case studies of selected adolescents were used in this study for the data collection were:

- the use of questionnaires for adolescents from grade 10 – 12
- case studies of selected individuals

1.7. STRUCTURE OF THE RESEARCH STUDY

Chapter One is introduction to the study. It states the purpose of the study, the rationale, the critical questions asked, the focus of the study and a brief statement on the methodology used.

Chapter Two provides an exploration of the literature on adolescent suicidal behaviour that is available both in South Africa and abroad.

Chapter Three provides the theoretical framework on which this study is based.

Chapter Four presents the research methodology adopted in this study.

Chapter Five presents results, data analysis and interpretation in light of the critical research questions.

Chapter Six analyses data for the structured interview.

Chapter Seven presents the discussions, conclusions and recommendations based on the findings of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1. INTRODUCTION

According to Schlebusch (2005) much of the relevant literature on suicidal behaviour in South Africa is epidemiological or simply descriptive in character. It is for this reason that literature from South Africa and further a field that dates back to more than a decade was included.

Before an attempt is made to present a global review on the literature available on the topic of suicidal behaviour, it may be prudent to ensure that there is a clear understanding of which constitutes the action of suicide and more importantly suicidal behaviour. This chapter therefore commences with a definition of suicide and suicidal behaviour. It proceeds to unpack the various layers of indirect self-destructive behaviour (the main focus of this study). Perceptions of suicide held by schools, religions and the adolescents themselves are then highlighted. The chapter concludes with the literature that focuses on the factors that influence adolescent suicidal behaviour.

2.2. DEFINITION OF SUICIDAL BEHAVIOUR

According to the World Health Organisation (Goldney, 1991:200) suicidal behaviour is "self injury with varying degrees of lethal intent". Schlebusch (2005:6) defines suicidal behaviour broadly as 'a term to denote a wide range of self-destructive or self-damaging acts in which people engage, owing to varying degrees of levels of distress, psychopathology, motive, lethal intent, awareness and expectations of the deleterious consequences or outcome of the behaviour'.

This study uses Schlebusch's definition of suicidal behaviour as a basis to unpack the more specific definition of adolescent suicidal behaviour. An attempt has been made to interrogate the wide range of self-destructive and damaging acts that adolescents engage in so as to make the society in and around schools more aware of the broader forms of adolescent suicidal behaviour. Thus far the society in which adolescents live in appears to be unsympathetic to the unconventional manifestations of suicidal behaviour (explained further in this chapter). I state this

because despite the alarming rate of suicide, there is still a considerable degree of disagreement as to what precisely constitutes the act and the behaviour leading up to the eventual act of suicide.

It has been argued (Schoombee, 1978) that the concept of suicide should be confined to an act in which a person intentionally takes his life or fails to save his own life where this is possible. The World Health Organisation (Goldney, 1991:200) defines suicide as "a suicidal act with fatal outcome". Based on these beliefs suicide may be defined as 'intentional self-slaughter' implying premeditation.

However, according to Schoombee (1978), soldiers who die in battle or sportsmen who knowingly participate in a dangerous sport and who lose their lives while participating in the sport, are also essentially committing acts of suicide. Schoombee (1978) even suggests that people who drink alcohol excessively or who smoke cigarettes are guilty of unconscious suicide. It is at this point that the blurring of definitions begins for me. 'Suicide' and 'suicidal behaviour' are seen by many researchers as synonymous.

The act of suicide is constructed in this study as separate from the suicidal behaviour. An individual's suicidal behaviour may not necessarily end in the act of suicide if her/his emotional needs are detected and attended to. It is for this reason that the secret to decreasing adolescent suicidal behaviour lies in society accepting that sometimes delinquent behaviour (not doing schoolwork, aggression, smoking or drinking excessively or participation in risky sport) may be the desperate cries of help from the socially disconnected adolescent wanting release from emotional pain.

The starting point of this study therefore has to be a clear understanding that the actual act of suicide and the suicidal behaviour may not have the same initial intention. I read the difference to be that in the act of suicide the individual is saying, 'I want to die' whereas in the suicidal behaviour the individual is saying 'I see no reason to live'. To literary critics both individuals may be saying the same thing but the subtlety in difference lies in the unspoken emotional plea in the second statement that begs society to provide a reason for the individual to live. Only if society sees and recognises this difference will the desperate cries for help of suicidal individuals be heard and understood.

Researchers over the years have added to the ambiguity by speaking of suicide and suicidal behaviour in the same context. Even Levinson's (1978) definition of suicide borders on a definition of suicidal behaviour. He defines suicide as a passive letting go. He (Levinson, 1978) believed that accidents, that is fatal accidents, of people driving vehicles in a sense of 'it does not matter now', 'I don't care now' – could be classified as suicides. This however is not a general view held by society and therefore the reporting of motor vehicle accidents do not indicate suicide as the cause of the accident. However, if it can be proven that suicide was the motive then it certainly makes a mockery of the statistics that we have on suicide and suicidal behaviour. This would then mean that deaths as a result of suicide are underreported. Because of the stigma attached to suicide, physicians and coroners may be persuaded by the family to list a death as accidental when the circumstances are questionable. Many single-car accidents are probably suicides. Some people who engage in dangerous sports and occupations, who adopt lethal habits (heavy use of drugs and alcohol), or who are physically ill and terminate their medication may also be seeking death (Atkinson, Atkinson, Smith & Hilgard, 1985). This opens up the field for further research in the field of suicidal behaviour.

Society's mindset needs to change. Suicidal behaviour should not be regarded merely as deviant behaviour or as a 'disease' (Hare, 1995). Neither should those attempting suicide necessarily be regarded as being 'ill' despite the fact that a small proportion of attempters do have a psychiatric disorder (Hare, 1995). Adolescents who harm themselves should not generally be considered to be psychiatrically ill just because of their behaviour. They should be seen as individuals made vulnerable by personal and social difficulties but who remain responsible for their actions.

There is a need at this point to distinguish between the two broad types of suicidal behaviour that I have thus far mentioned in passing. One type of this behaviour is overtly suicidal in nature. It might take the form of a drug overdose, the slitting of the wrist or an attempt at hanging oneself. The other type of suicidal behaviour is rather covert, not easily detected as suicidal and may even be heavily denied and debated as being suicidal by parents, teachers, society in general and even adolescents themselves. This type of behaviour may be merely classified as reckless or risk-taking behaviour and resorted to under the pretence of the need for a 'thrill' or a 'bit of excitement' in life. There is an urge for an adrenaline rush. Behaviour of this type may include activities like drug experimentation, bungy-jumping or drag racing. In South Africa, it could also be train surfing (youth who jump onto train roofs and dodge overhead cables or dodgem cars (youth running across roads to avoid speeding vehicles). Suicidal behaviour, whether overt or covert in nature, comes

about as a result of life losing its meaning. The individual is aware either consciously or subconsciously that the behaviour is dangerous and may lead to death but is unconcerned and unafraid. This becomes highly significant when the individual exhibiting suicidal behaviour is an adolescent who is supposed to be in a phase in life that is full of new experiences and hope (Sdorow, 1993).

The term 'suicidal' therefore, in this study, is used to convey the information that an individual was self-destructive, is currently self-destructive, or may be so in the future. Most diagnoses in the field of suicide are post hoc definitions, labelling an individual as suicidal only after she/he has attempted or committed suicide. An adolescent's indirect self-destructive, suicidal behaviour is often denied, ignored or even defended as behaviour other than suicidal. I believe that it is largely for this reason that the rate of completed suicides continue on an up-climb. The findings in this study point to a need for the same attention and focus to be given to an individual's indirect self-destructive (covert) behaviour as is given to her/his direct self-destructive (overt) behaviour.

2.3. INDIRECT SELF-DESTRUCTIVE BEHAVIOUR

This study defines indirect self-destructive behaviour as covert rather than overt or direct behaviour, with latent and subtle signs. Frederick (1980) views self-destructive behaviour as on a continuum between self-assaultive on one end, and overt, unmistakeable suicide on the other.

Because of society's lack of focus on or acceptance of certain types of indirect self destructive behaviour (certain delinquent and deviant behaviour) as suicidal behaviour, the degree of the adolescent's personal awareness varies directly with the clarity of the behavioural act in the direction of suicide. Frederick (1980) characterises self-assaultive behaviour as personal abuse of oneself, without total awareness of its life-threatening components. Anorexia nervosa and picking at a melanoma would constitute illustrations of self-assaultive behaviours assuming that one has no knowledge of its dangers. Self-destructive acts fall between the two ends of the continuum and suggest relatively more conscious understanding of one's behaviour (Frederick, 1980). It may be seen in adolescents who possess a known physical problem but neglect proper health care. Specific instances are smoking after developing emphysema and neglect of medication in the presence of severe diabetes mellitus.

Filstead (1980) adds that the despair in indirect (or even direct for that matter) self-destructive behaviour is not always at a conscious level. Diabetics who go off their diet, or patients who episodically violate a medical regimen required by other forms of chronic illness, often do not regard their behaviour as problematic. Other forms of behaviour such as risk-taking in the form of 'train-jumping' may actually produce a sense of euphoria or elation at being able to beat the odds. Despair does not appear to fit into this scheme of things for the adolescent. Filstead (1980) speculates that such behaviour may represent unconscious self-destructive motivations.

Filstead (1980) also suggests that such behaviour might have an ability to repress certain feelings - for example - by being able to engage in risk-taking behaviour, an adolescent can 'deny' the need to examine some other facet of her/his identity or situation. However, removing the façade produced by risk-taking may bring into awareness a problem that needs to be addressed. Indirect or direct self-destructive behaviour may be the mechanisms for suppressing personal problems and may be the very action that would eventually produce a climate in which the conditions would be set for a self-destructive action to occur.

Frederick (1980) states that indirect suicide is rarely obvious to the unskilled observer (like parents, teachers and fellow adolescents). A variety of terms have been used to describe behaviour that can be characterised as indirect suicide, such as: psychological equivalents of suicide; hidden suicide; latent suicide; covert suicide; and indirect self-destruction. Although patterns may vary, as a rule, the following comprise the prominent characteristics of indirect suicide: -

- there is a lack of full awareness of the consequences
- the behaviour is rationalised, intellectualised or denied
- the onset is gradual, even though the death may appear to be precipitous
- open discussion, seldom occurs, in contrast to obvious 'cries for help' in direct suicide
- long suffering martyr-like behaviour often appears
- secondary gain is obtained by evoking sympathy and expressing hostility via the process and
- the death is often seen as accidental

Many adolescents exhibiting indirect self-destructive behaviour therefore seem to move towards death without those around them and even themselves being fully aware that they are doing so (Frederick, 1980).

Hendon (1974) states that some adolescents present a bland front that conceals self-destructive impulses probably stemming from early painful relationships and anxiety related to their primary care givers. According to Hendon (1974) many adolescents who have been deprived of emotions early in life feel alive only when they experience some unusual thrill, become anxious or feel pain. The life-and death struggle seems to heighten the sensations and the feelings which some adolescents need.

It is decades after Hendon's study and self-harm behaviour is still on the increase. This is evident in the study carried out by the Samaritans (2002) in 41 schools with 6020 adolescents in Birmingham, Northamptonshire and Oxfordshire during 2000-2001. At least 90% of the adolescents were aged between 15 and 16 years old. 69.6% of them were living with both their parents. 82.3% were white, 11.1% were Asian, 2.8% were black and 2.6% were of mixed race. The results of the study showed that 10% of the adolescents have deliberately self-harmed - 7% in the previous year. The majority of those, more than 64%, of those who self-harm cut themselves. Girls were four times more likely to self harm. The most common reason given was 'to find relief from a terrible situation'. 41% of those who self-harm seek help from friends before hurting themselves. The results of the research showed that few turned to other sources of help such as family, teachers, doctors or social workers.

The study (Samaritans, 2002) found that what differentiated those who self-harm from those who do not are:

- those who self-harm have more problems and life events than other adolescents
- adolescents who self-harm are also more likely to suffer from anxiety, depression and have low self-esteem than others
- those who self-harm often have friends who self-harm
- those who self-harm find it difficult to cope and are more likely to blame themselves, get angry, drink alcohol or shut themselves in their room than talk things through

- those who self-harm believe that they have fewer people in whom they can confide compared to other adolescents

Since the vast majority of learners who self-harm do not go to hospital, prevention needs to take place in the community, ideally within schools. It is important to firstly identify the adolescents in need of help and secondly to develop educational programmes to promote psychological well-being – to help adolescents to recognise and deal with emotional problems. As adolescents generally turn to their friends for help and advice, they need help not only in coping with their own emotional problems but also in recognising and helping friends in need. Teachers should also be helped to recognise learners who are getting into difficulties so that some screening can take place in schools to detect those adolescents at risk (Samaritans, 2002).

Suicidal behaviour has now become a significant public health problem and should receive greater attention from social scientists, health practitioners and educationalists all over the world, including South Africa. Greater preventative measures need to be put in place, especially in homes and schools. This however, cannot, be implemented without a thorough understanding of adolescent suicidal behaviour (or self-destructive behaviour) and its antecedents (Pillay, 1989).

What follows is a further deconstruction of the concept indirect self-destructive or suicidal behaviour. It needs to be stressed that the focus of this study is not on the overt, obvious, easily identifiable forms of suicidal behaviour but rather on the indirect self-destructive forms of suicidal behaviour that relate more specifically to adolescents. The discussion that follows therefore explores drug abuse, alcoholism, cigarette smoking, self-mutilation and delinquency as examples of suicidal behaviour.

2.3.1. Drug Abuse as indirect self-destructive (suicidal) behaviour

Drug abuse is a symptom of deep psychological pain (Klagsbrun, 1976). It is an individual's cry for help. Rather than choosing outright suicide, many adolescent drug users chip away at their lives, dying slowly, little by little. The suicidal behaviour here is an expression of an adolescent's inability to cope with daily stress in a healthy way (Stols, 1990).

Many adolescents, at one point or another in their lives, may have thought of killing themselves, but most don't act impulsively on it. Suicide is not the result of a sudden impulse, but is generally caused by longstanding mental or physical distress. The inclusion in this study of drug abuse as a form of indirect suicidal behaviour will hopefully make more detectable this distress. Many adolescents who commit suicide are ambivalent about their wish to die, and the attempt may result from a strong wish to live and a need to communicate a plea for help (De Korte, 1992). Fear of dying and other thoughts usually prevent adolescents from fatally harming themselves. Some don't want to hurt their families. Some have been taught that suicide is a sin. Others hang on and hope that their anger and sadness will go away. The influence of drugs makes it easier to express anger and unhappiness – and it is when a person has been drinking, sniffing, or using drugs that she or he is more likely to act impulsively through suicidal behaviour (Gould, Shaffer, Fisher & Garfinkel, 1998).

Adolescents may turn to drugs to relieve tension when pressures are intense (Stuart & Sundeen, 1991). Our 'pill relief' society provides the perfect backdrop for the abuse of drugs in this case. This may develop into a drug-induced exploration of life. The meaning of drug use in adolescents is therefore a difficult and complex one. It may appear to be rebelliousness with the support of a peer group as adolescents often report a wish for closeness that is satisfied by sharing experiences with friends. It may also be a way of obtaining gratification of instinctual needs at a regressed level. On the other hand, it may indicate an effort to come to grips with feelings of vulnerability and emptiness (Stuart & Sundeen, 1991). Some adolescents fill the void of isolated loneliness and social disconnection with drugs.

There is little doubt therefore, that drug abuse and self-destructive behaviour are related problems in society today. The leading question, however, is still whether drug abuse may be a causal factor in precipitating self-destructive acts or whether self-destructive behaviour leads to drug abuse (Smart, 1980). The personal conflicts and tensions which give rise to such aberrant behaviour may be expressed through different avenues. There are growing indications that drug abuse itself can be a precipitator of self-destructive behaviour (Frederick, 1980). Deliberate drug overdose demonstrate this convincingly, but less obvious indicators, such as feelings of haplessness and helplessness which signify a loss of hope should not go undetected.

Drugs can bring temporary psychological as well as physical relief to adolescents who are in mental anguish or bodily pain (Frederick, 1980). Such relief leads to tension reduction and

becomes automatically reinforcing. Any anxiety-reducing process is a strong reinforcement for the accompanying response. The probability of repeating such an act on subsequent occasions increases markedly thereafter. Thus it is easy to see how drug addiction can be quickly learned. The relief which it offers initially becomes a way of 'ending it all' on a temporary basis. In the psychoanalytic sense the act of drug taking becomes an offering of a portion of one's life, or body, as a symbolic payment in death for the value received from the drug (Frederick, 1980). One of the insidious aspects of the addictive process is that, initially, relief comes readily, but later a tolerance for drugs often develops and increased dosages are required to bring relief. It is important therefore that this form of suicidal behaviour is detected in the early stages.

Fear of failure, pressure to achieve, excessive concern for material gain, recklessness and lack of acceptance amongst peers are all factors that give into the directorship of drugs in a drama that has the main theme of suicidal behaviour (Rawlings, Williams & Beck, 1993). For the adolescent, as drug abuse develops, it becomes easier and easier to ingest an overdose, either accidentally or 'accidentally on purpose'. Escape from 'life's problems' into sleep provides an escape into a 'temporary' death or a more permanent escape in death itself.

Alcohol, like drugs, produces a similar escape and the abuse of it could also be a manifestation of suicidal behaviour.

2.3.2. Alcoholism as indirect self-destructive (suicidal) behaviour

Alcoholism with its characteristic pattern of denial, low frustration tolerance, need for immediate gratification, and self-centredness, qualifies as an indirect self-destructive condition; nevertheless, alcoholism can also greatly overlap with direct self-destructive behaviour (Connelly, 1980).

According to Connelly (1980), alcoholism has clear self-destructive consequences for the person afflicted with it. It could facilitate latent suicidal impulses, catalyse angry abreaction resulting in suicide attempts, and promote the development of severe depression either from psychological mechanisms or physiological ones.

Frankel, Ferrence, Johnson & Whitehead, (1976) discuss three major theoretical frameworks that might be used to explain the relationship between drinking and self–injury. Their first postulate is

that alcoholism facilitates suicidal behaviour; the second, that alcoholism is a form of chronic suicidal behaviour and the third, that alcoholism and suicide are effects of the same underlying cause. To Frankel et al (1976) the association of alcoholism and suicide is based on the presence of common underlying factors such as social integration, similar personality types and depression. This is plausible since suicidal behaviour and alcoholism can be conceptualised as attempts to cope with intense intra-psychic pain, and depression is frequently the underlying affect in both.

The indirect self-destructiveness of alcoholism can have its origin in one of two very different sources: in frustrated infantile needs or in the actual alcoholic process. Menninger (1938) develops Freud's idea of a life instinct or primary creative instinct and a death instinct or primary destructive instinct. Menninger (1938) believes that as the person matures these instincts or drives become modified, fused to varying degrees, and invested in external objects. In certain circumstances, the life and death drives tend to revert back to the person of origin: the self. According to Menninger (1938), if one's destructive impulses are not neutralised properly, suicide may occur. Menninger (1938) reasons that alcohol addiction being one form of chronic self-destruction, has an adaptive function in that it spares the individual from immediate suicide. Alcoholism allows for some expression of aggressiveness and at the same time permits gratification of infantile oral needs, but at the price of indirect self destructiveness. When hope disappears through lack of opportunity to reach life goals, destructive drives previously subordinated by other drives become unbound, and may be released against the self in the form of total self-destruction.

For many adolescents, the rites of passage into adulthood, is incomplete without a taste of alcohol or the experience of being intoxicated. The alcoholic process itself however can generate and perpetuate the pressure for indirect self-destructive behaviour and eventually suicide (Connelly, 1980). Initially, alcohol gratifies needs, relaxes tension, and sedates. However, as the alcoholic process develops a destructive element is introduced. Amongst other negativity, there is characteristically an erosion of health, a deterioration of performance and interpersonal relationships, broken promises, lying, cheating and hurting. All these failures may inflame an already punitive superego and result in intensification of feelings of worthlessness, badness, guilt, and remorse. Such feelings demand recompense, and one readily available way is through the self-inflicted punishment of alcoholism - and so the cycle continues (Connelly, 1980). The alcoholic adolescent tries to break the cycle, but as she/he more often than not finds herself/himself unable to

do so her/his feelings of guilt and worthlessness increase, further contributing to self-destructive patterns, including resistance to help (Connelly, 1980).

I have found in my years of experience as an educator in various secondary schools that adolescents linked to drug addiction and alcoholism provoke rather strong negative social reactions. Adolescents who smoke cigarettes however are more socially accepted. Adolescents caught smoking, in or out of school, are not branded in the same way as adolescents who are accused of drug or alcohol abuse.

2.3.3. Cigarette Smoking as indirect self-destructive behaviour

Medical evidence concerning the deleterious health consequences of habitual cigarette smoking has been accumulating since the early 1960's (Lichtenstein & Bernstein, 1980). Today cigarette smoking is firmly established as the primary cause of lung cancer. Coronary heart disease is the most important single cause of excess mortality among cigarette smokers. Compared to individuals who do not smoke, cigarette smokers have an increased incidence of respiratory diseases (such as emphysema). Smoking is linked to several other diseases, and it also appears to influence some of the problems associated with pregnancy.

The dangers of cigarette smoking are discussed and highlighted in the media. The packaging carries a warning. Education Departments in South Africa have included the health hazards of cigarette smoking in school syllabi. Yet the percentage of adolescents (both girls and boys) that smoke still appear to be substantial. In a study by Flisher, Ziervogel, Chalton, Leger & Robertson (1993) 18.1% of the sample high school students from the three education departments in the Cape Peninsula indicated that they smoked at least one cigarette a day. This could be because adolescents and society in general experience effects of drinking and drug taking more strongly than smoking despite the knowledge that it has serious health implications. Suicidal adolescents who smoke cigarettes could graduate to smoking marijuana (the health effects are more severe and the activity is illegal). If they have emotional issues that are not dealt with, the temporary relief provided by a 'smoke' becomes a regular sought after activity and this compounds the problems that the adolescent has to deal with.

Self-mutilation, like cigarette smoking, is also not regarded socially as a serious problem. The activity can be easily concealed from others, including close friends and family members.

2.3.4. Self-mutilation as indirect self-destructive (suicidal) behaviour

In a study by Gould, Marrocco & Kleinman (2005) of 6000 UK adolescents 15 to 16 years of age, 6.9% had experienced self-injurious behaviour within the past 12 months - the rate was much higher in girls. 12% of adolescents with self-mutilation behaviour had to seek medical care for the injury sustained. Within this cohort it was demonstrated that self-mutilation behaviour could occur as a result of an irresistible urge to appease some emotional tension. Completing the urge allowed the adolescent to release emotional tension and provide temporary respite. However, if the adolescent is not assisted in dealing with the issues that cause the build-up in emotional tension then the tensions inevitably build up again. If the initial self-mutilation behaviour provided relief for the adolescent, then she/he is at risk for repeating the behaviour.

De Leo & Heller's review (2005) of research developments in 2004 and early 2005 published in English language journals on deliberate self-harm among children and adolescents shows that it is becoming apparent that much more deliberate self harm occurs in the community that does not come to medical attention. For example, 6.2% of school students in Queensland, Australia reported deliberate self-harm in the previous 12 months. The main methods were cutting and overdose. Only 10.3% of them went to hospital.

Motives for deliberate self-harm vary. In a school-based study of adolescents (Rodham, Hawton & Evans, 2004) those who took overdoses more often said they wanted to die, whereas those who cut themselves more often reported self-punishment and escape from a terrible state of mind as motives for their deliberate self-harm.

Self-mutilation can therefore be defined as behaviour producing physical injury to the person's own body, regardless of apparent or presumed intent. It may involve removing, destroying, maiming, disfiguring, or impairing the appearance or function of some body part or parts (Simpson, 1980). Such acts are usually classified as suicide attempts but rarely distinguished appropriately from other varieties of suicidal behaviour. Although the act may seem overtly self-destructive, the process and motivation are far more complex than is usually recognised. Wrist-

cutting is a supremely economic technique whereby a delicate dermal injury can serve multiple psychological functions in the cutter, while stirring up an inordinate amount of attention from others whose outrage and alarm is usually out of all proportion to the scale of the event. Such self-mutilators are almost inevitably very badly handled by the doctors and nurses they encounter. They arouse a strong sense of hopelessness and hostility among such professionals, whose ambivalence may be dramatic as they vacillate between regarding the adolescent as high risk and high lethality (and to be curbed and restricted at all times) and as indulging in highly manipulative and frivolous acting out (Simpson, 1980). They may also become the objects of ridicule in school and home. Such reaction from others only encourages further attempts by the adolescent.

Menninger (1938) regarded self-mutilation as a type of indirect and incomplete self-destructive behaviour which allowed one to live while gratifying irresistible urges. This was done by concentrating the suicidal impulse on part of the self as a substitute for the whole. He referred to it as *focal suicide.* Simpson (1975), on the other hand thought that self-mutilation represents an attempt to counteract an overwhelming situation, by performing a physical act against the self. This is related to the concept of identification with the aggressor. Adolescents in helpless and overwhelmingly passive situations may identify with their aggressor and act out against themselves, the victim. In aggressive situations adolescents are not acting out against themselves - they act out against the world in the form of delinquency.

2.3.5. Delinquency as indirect self-destructive (suicidal) behaviour

Adolescents who are injured or killed in accidents in stolen cars or motorcycles or who drug themselves to the point of stupefaction or hospitalisation are likely to call attention to the self-destructive aspects of their behaviour (Hendon, 1980). Adolescents who break into houses to steal whatever they can sell, who set fire to stores or houses, who vandalise their school, who bunk classes, who engage in promiscuous behaviour, whose lives are a series of encounters with school authorities, police, and the courts are likely to arouse enough irritation at the antisocial nature of their behaviour to obscure its self-destructive aspects. These adolescents appear to sabotage their schoolwork, alienate their families, and destroy their future prospects in ways that are perhaps the most self-destructive of all. To parents and teachers it may seem as if they (parents and teachers) are more concerned about the delinquent adolescent's reputation, her/his education, her/his future, than she/he is. However in many cases the behaviour of this socially disconnected adolescent could

be grossly misunderstood. She/he could be crying out for help in a language that parents and teachers do not understand.

According to Schlebusch (2005) school- related and academic problems in young people can be a significant risk factor for suicidal behaviour. What is perhaps less known in South Africa is that reading impairment has been associated with many psychopathological disorders and can serve as a co-morbid factor in suicidal behaviour, especially in young people in school. Identifying and treating learning disabilities (especially problems in reading) can be a powerful preventor of subsequent psychological disorders and potential suicidal behaviours (Wood & Goldston, 2000).

A survey by Rutter & Behrendt (2004) also shows that adolescents with a combination of mood disorders and disruptive behaviours have a significantly increased risk of suicide. The survey indicated that those with 1 problem behaviour had a 2.3 times greater risk of suicide compared with youth with no problem behaviours. Individuals with 3 problem behaviours had a risk that was 18.3 times greater, with risk continuing to escalate as the number of problems increased.

For large numbers of adolescents, social structures including schools continue to be no solution. Schools, especially with limited human resources, are unable to encourage socially cohesive values in delinquent adolescents. The years of pain and failure, frustration and humiliation that schools represent only foster further social alienation. Hendon (1980) believes that although it is not difficult for delinquent adolescents to see the self-destructive aspects of their behaviour, unless one can help them get in touch with the sources of their unhappiness and find some less destructive adaptation, it is difficult for them to stop. They are more likely to be aware of their anger at the police or school authorities with whom they come into conflict than the anger and pain of their relationship with their families; and the delinquent behaviour itself often permits them to express their frustration while enabling them to deny its origins. A rising tide of unfocused anger, tension, and depression are usually antecedents to the delinquent behaviour, and the delinquent activity seems to provide an element of emotional release that makes a recurrence unlikely for several months.

The views on adolescent suicidal behaviour, expressed by the main role players in the life of the adolescent, provide the backdrop for this section of the study. It was interesting to examine the actions or reactions of the school, the religious bodies and the adolescents themselves to the phenomenal problem of adolescent suicidal behaviour.

2.4. SUICIDAL BEHAVIOUR: PERCEPTION OF SCHOOLS

Despite the growing numbers in adolescent suicides and adolescent suicidal behaviour, schools around the world still display a rather secondary concern in regard to adolescent suicidal behaviour.

According to Forrestier (1998), Hong Kong schools have traditionally not paid much attention to the emotional needs of learners. Welfare organisations, however, are responding to the rising number of adolescent suicide by launching life-skills projects in schools. Hong Kong social service director, Leung (as cited in Forrestier, 1998) criticises this effort as she believes that teachers are ill-prepared for meeting their own emotional needs, let alone those of their students. She therefore recommends that meeting students' psychological needs should be included in teacher training. In contrast to this however, educationists in Japan (as cited in Fitzpatrick, 1998) believe that the high incident of suicides among Japanese students is a myth and that suicides resulting from exam pressure and bullying are over-hyped.

Reports from Australia (Maslen, 1998) however, agree with the general feeling towards suicide as few Australian families and schools remain unaffected by the apparent epidemic of self destruction. The government in Australia was so concerned that it has funded a special taskforce to look at the issue. Pierre Baume, director of the Australian Institute for Suicide Research and Prevention at Griffith University in Brisbane (as cited in Maslen, 1998) says that suicide is the product of three fundamentals: vulnerability, self-destructive responses to a stressful situation and the 'lethality' of the behavioural responses. Sydney psychiatrist Jean-Lennane (as cited in Maslen, 1998) believes that the decline in formal religion, in the ideals of public service and helping others and the 'greed is good' philosophy, have contributed to a sense of hopelessness among the young. Maslen (1998) therefore states that teachers need to be better informed about adolescent suicide. A survey (as cited in Maslen,1998) in the state of Victoria showed more than half the state's teachers and 40 percent of GPs failed to recognise the role they could play in preventing suicide. The report on the survey however argues that schools are well placed to assist learners in developing self-esteem and self-confidence.

An Irish teachers' union (as cited in Walshe, 1998) has issued guidelines to schools on how to respond to suicidal behaviours. This is particularly because suicide in Ireland is now more common than death in car accidents. A survey by the union, The Association of Secondary

Teachers in Ireland (as cited in Walshe, 1998), found that 13 percent of secondary schools had reported a suicide. There have been some instances of learners committing suicide following years of bullying at school.

In South Africa adolescent suicide is mounting. Almost one in ten teen deaths is a suicide (Green, 2005). Adolescents are crying out for attention. Grounding by parents or failing a test is enough to trigger a suicidal attempt (Bisetty, 2002). Adolescents do not have adequate coping skills. Parents are now calling for the return of guidance counsellors that were removed under a restructuring programme when the various education departments in South Africa amalgamated in 1996 (Bisetty, 2002). In 2004 the Love to Live counselling initiative was established in the community of Chatsworth in Kwa-Zulu Natal to try to stem the tide of adolescent suicide. Premdev (2005) reports that this initiative was intensified when in one area more than 10 adolescents had attempted suicide and nobody had even known that they had lost their will to live. The frequency of suicidal behaviour in the area, however, has since not decreased. There is still something that is not being addressed.

The answer to the riddle could lie in the fact that often certain forms of adolescent suicidal behaviour is described by teachers and other adults as merely 'rebellion' or 'delinquency' and adolescents manifesting this form of suicidal behaviour are punished and further ostracised from society. The desperate cries for help fall on deaf ears because suicidal behaviour is so often mislabelled, misunderstood and misinterpreted.

When the connection with the physical world (home and school) is severed the connection with God and other forms of spirituality may provide some hope and solace for suicidal adolescents and it may point to a reason for their existence and suffering. It therefore proved interesting to find out what the religious perspective was on suicidal behaviour.

2.5. SUICIDAL BEHAVIOUR: A RELIGIOUS PERSPECTIVE

Stein, Witztum, Brom, DeNour & Elizur (1992) states that the suicide rate is higher in nonreligious youths than in those who are religious as some religions encourage individuals to view life as sacred. Baroody (1999) adds that this could be based on the belief that humans are created in the

image of God, and as a result, suicide is forbidden. Other religions, on the other hand, facilitate suicide as it is seen as a sacrifice to God (Schneidman, 1981).

To Christians life is a gift from God. In the cross of Christ the Christian sees the compassionate love of God who becomes a victim of the powers of death and at the same time, in Christ's resurrection, the victory over death. Suicide as such is giving in to God's archenemy: death. It is a betrayal of life and the God of life (Baroody, 1999). In the Western World, it has been traditionally said that suicide among Catholics and Jews is absolutely prohibited. Christians who commit suicide are therefore deprived a Christian burial (Patterson, 1978). However neither the Old nor the New Testament directly forbids suicide. It was just believed that suicide was a mortal sin as it usurped God's power over man's life and death. As a result, western religious groups in the past showed significantly low suicidal figures. Suicide, however, over the recent years has lost the sense of sin with which it has been associated in Judeo-Christian cultures. The choice of ending one's own life has become increasing available as a resolution of intolerable pain and conflict (Mack & Hickler, 1981).

The Koran (Oosthuizen, 1978) prescribes severe punishment for those who violate the sanctity of human life as it is a gift from Allah and needs careful handling. The Koran states 'do not kill yourself' or 'do not take your life' (cited in Oosthuizen, 1978:29). This command means that suicide is absolutely forbidden in Islam. Thus anyone who commits suicide is accountable to Allah in the hereafter. Islamic jurists have gone so far as to say that anyone who commits suicide has died without Islam and that this act forbids anyone to say funeral prayers for her/him. A Moslem who thus commits suicide becomes an outcast, even more so than an unbeliever (Oosthuizen, 1978).

Hinduism (Oosthuizen, 1978) maintains that the soul inhabits many bodies on its journey through the cosmos until it reaches its final destiny. Souls are to be found in all living beings which, being essentially equal, are all only differentiated through 'karma'. The shell of subtle and gross matter imprisons the soul that leads to successive rebirths in different types of bodies. Although the emphasis is on freeing the soul from matter, suicide is not prescribed to rid the imprisoned soul from this state of affairs (Oosthuizen, 1978).

Buddhism (Oosthuizen, 1978) finds the taking of life most abhorrent. The reverence for life is an integral part of Buddhist ethics. Religion helps shape attitude towards death, and in turn concepts of death should be related to how and how readily we renounce life (Kua & Ko, 1992).

Kaplan & Sadock (1985) state that suicide in African countries is very rare, probably less than 1 in 100,000, and if it occurs, it is almost always an impulsive act, seldom premeditated. However in the developed African countries an ominous rise of suicide attempt has been observed in the younger age groups. The general belief amongst Africans that mental illness is caused by supernatural forces, mainly bewitchment, frees depressed persons from all personal responsibility for their suffering (Kaplan & Sadock, 1985). For some, a person who is mentally ill is considered to have been bewitched through black magic, and when such a person 'has no strength' she/he hangs herself/himself and becomes an evil spirit or a roaming ghost, not going to the kingdom of the ancesters (Oosthuizen as cited in Schlebusch, 2005).

A South African study by Heuer (cited in Schlebusch, 2005) attributes the increase in suicidal behaviour across the cultures to a decline in religious fervour, along with the technological explosion and increased emphasis on material prosperity. Suicide may be condemned by the various religions but suicidal behaviour, especially in its covert self-destructive form, receives very little attention or focus. This is because the suicidal behaviour itself (example drinking, drugging and delinquency) is not seen as a sin. The adolescent in the depths of emotional suffering is still very much alone and confused – for she/he is also not aware that delinquent or deviant behaviour could be manifestations of feelings of hopelessness and disconnection from the world of living.

2.6. SUICIDAL BEHAVIOUR: THE ADOLESCENTS' VIEW

Schlebusch (cited in Green, 2005) outlined the following factors that drive adolescents to suicide or suicidal behaviour: interpersonal problems, family and financial problems, stress, examinations, problems at school, mental illness and physical and sexual abuse.

Although suicide rates around the world are about three times higher for boys than for girls, evidence is mounting (Sunday Times, 2004) that in Asian countries more girls kill themselves. Globally, the suicide rate for men is about 24 per 100 000 and for women 6.8 per 100 000 (Sunday Times, 2004). According to experts (Portner, 2001, Marshall, 1998, Maslen, 1998) girls attempt

suicide more than boys, because their act is an effort at communicating their desperation. Boys tend to keep their emotions hidden. They are taught that boys 'do not cry'. They become so ashamed of their feelings that they figure they would be better off dead than expressing their pain. What these experts may be missing is that girls and boys traditionally may have shown their emotions in different ways. Girls may have chosen more overt forms of behaviour and boys more covert forms of behaviour.

Furthermore for the adolescent, suicide is still very much a subject that is cloaked in superstition, mystery and sometimes romanticism (Schlebusch, 2005). When adolescents talk about suicide, the word 'romance' is often invoked. Supposedly, suicide is not real to them. They are anaesthetized to life and desensitised to death. They do not understand that it is final, irreversible. Young boys and girls often see suicide as the end of their problems, not their existence (Gaines, 1991). Suicide and suicidal behaviour have also become more socially acceptable amongst adolescents (Ryan, 2006) and this adds to the appeal. What makes it more undetectable is that adolescents have a spectrum of suicidal behaviour to choose from.

2.7. SPECTRUM OF SUICIDAL BEHAVIOUR

According to Wekstein (1979) there is a spectrum of suicidal behaviour. The following classification includes a selection of the few commonly referred ones:

- chronic suicide: the victim masks her/his death orientation by excessive use of and addiction to drugs or alcohol
- neglect suicide : the victim ignores reality factors. It is exemplified by the diabetic who indulges herself/himself with a harmful diet of her/his own choosing
- sub-intentional suicide: the victim engages in dangerous activities such as reckless driving, hazardous sport
- surcease suicide: the victim recognises that her/his plight is irremediable, is suffering intractable pain and decides on intellectual grounds to bring her/his life to an end
- psychotic suicide: victim does not intent to die. There is an underlying schizophrenic ideation where she/he merely attempts to excise/exorcize her/his psychic malignancy
- focal suicide: here there is a concept of partial death, where a limited part of the body is killed. Self-mutilation, maiming, contrived accidents fall into this classification

- automatization suicide: this depicts a relatively unmotivated suicide when an individual under severe stress proceeds to alleviate tension by the utilization of a barbiturate, achieves little or no relief and continues to ingest more. The victims ability to perceive is progressively diminished –constricted- and a hypnogogic state ensues in which she/he ingests even more of the same drug or adds others in a robot-like fashion with resultant death
- existential suicide: the burden of enduring hypocrisy, the meaninglessness of life, the ennui, and the lack of motivation to continue to exist

Suicidal behaviour, according to the spectrum that Wekstein (1979) has classified it by, points to a phenomenon that is multi-dimensional. However, no suicide or suicidal behaviour fits neatly into any specific category. There is a degree of overlap. Wekstein's classification therefore should be viewed merely as another tool to assist in the demystification of the phenomena. Using the above spectrum as a guide an attempt is made to highlight some of the factors that play a contributory role in enhancing adolescent suicidal behaviour.

2.8. FACTORS INFLUENCING ADOLESCENT SUICIDAL BEHAVIOUR

Schlebusch & Bosch (2000) have persistently cautioned that as children grow up, the prevalence of self-destructive suicidal behaviour can increase dramatically if risk factors are not timeously identified and addressed. Adolescents' perception of suicidal behaviour is also a significant factor in regards to the increase in suicidal behaviour. It is primarily for this reason that I felt the need to list and elaborate on some of the factors that influence adolescent suicidal behaviour.

In general, suicidal behaviour is influenced by several factors. In a South African study by Madu & Matla (2004) conflict in a family was a significant correlate for adolescent suicidal behaviour. Wild, Flisher & Lombard (2004) point to depression and low self-esteem in the family context as being independently associated with suicide ideation and attempts. Low parental monitoring of adolescents (King, 2001), acute alcohol use (Cherpitel, Borges & Wilcox, 2004) and a lack of resources (Flisher (2000) are also highlighted as factors influencing adolescent suicidal behaviour.

From the research cited thus far it appears that generally factors influencing adolescent suicidal behaviour include having parents who are psychiatrically disturbed; parents who are drug and

alcohol abusers; parents who are neglectful or abusive; losing parents through death or divorce; being physically and sexually abused as a child; and having family members who committed suicide. Recognized stressors that contribute to suicidal behaviour include recent experiences with high levels of anxiety and breakdowns in interpersonal relationships. Other indicators include low self-esteem, irrational thinking, and poor problem solving skills. Another important factor is the availability of a lethal method of suicide. Overall, suicidal adolescents have more psychological disorders, addictions to alcohol and drugs, and a depressed mood.

The examination of the extensive research done in the field of suicide and the continuous escalation in suicide rates, led me to draw certain conclusions especially about the large numbers of suicidal adolescents that go undetected. This in turn allowed for my own theory of Connectiveness to emerge – to explain the enigma of adolescent suicidal behaviour. At this point it was just an hypothesis but what was becoming more and more evident to me was that the common thread linking all the above factors was the adolescent's emotional distance from her/his soul, her/his spirit and her/his physical world. She/He is too old to be classified a child and too young to be called an adult. Confusion reigns supreme. She/He is confused about her/his role in the world and the world is confused by her/his confusion. Her/His behaviour, especially her/his suicidal behaviour is seen as one-dimensional. It is for this reason that the desperate cries for help from adolescents go unheard or unattended to.

Adolescent suicidal behaviour needs to be viewed as a multi-tiered phenomenon. Solutions to this global problem can only be found if society has the courage to unpack the feelings that come from the souls of these desperate adolescents rather than judge harshly their actions to destroy or terminate their lives. There is a need therefore, at this point in the chapter, to elaborate further on some of the factors mentioned above so as to demystify the adolescent. The first factor, and by no means the most important factor, influencing adolescent suicidal behaviour, is the feeling that life has no value – its meaning has disappeared – it no longer has purpose.

2.8.1. Life has no value

For every human being, the question of whether to live or die presents a profound philosophical choice to be confronted many times in the course of one's life. Camus (cited in Mack, 1986:55) wrote that 'there is but one truly philosophical problem, and that is suicide'. The decision to

commit suicide is a statement not only that one's own life is not worth living, but may also express a view that life itself has no value.

Several participants in a study by Wassenaar, Van der Veen & Pillay (1998) said that they attempted suicide as a result of extreme isolation and that their lives were meaningless. They had disturbed interpersonal relationships that brought about extreme social destabilisation.

To Gaines (1991) suicide is a disease of helplessness and hopelessness - helpless because you feel that nothing you can do will ever make a difference – and hopeless because you see no choices. There are adolescents who under varying circumstances perceive life as so ungratifying, so unfruitful and so futile that they feel powerless and trapped. They cannot defend themselves. They become angry with the world and then themselves. When the anger is turned inwardly and hopelessness, desperation, guilt, shame and humiliation take root, life for the adolescent slowly ceases to have meaning. The decision to end one's life is an ultimate statement that life is worthless and not worth the pain and suffering (Gaines, 1991). For many adolescents, therefore, suicide promises comfort.

Alvarez (1971) shares the sentiments of Gaines. He believes that there is a whole class of suicides who take their own lives not in order to die but to escape confusion, to clear their heads. They deliberately use suicide to create an unencumbered reality for themselves or to break through the patterns of obsession and necessity which they have unwittingly imposed on their lives.

Some experts (Pillay, 1991) use the term *para-suicide* for nonfatal acts in which a person deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognised therapeutic dosage. The term para-suicide is preferred to 'suicide attempt' because it does not necessarily imply a wish to die. Adolescents who 'para-suicide' may not always get the kind of attention that they crave. Their unspoken cries for help are misunderstood because the language that they use is unconventional (destructive/ deviant acts). They have to be taught to speak a 'language' that is socially accepted by their society and their coded language needs to be decoded and understood by the society in which the adolescent lives. It is not important which term is preferred (para-suicide or suicide). Both terms are indicative of suicidal behaviour because the risk of death is present. Most adolescents who commit suicidal acts are experiencing such turmoil and stress that their thinking is far from clear - they are not sure whether they want to live or die; they want to do both at the same time, usually one more than the other.

Pessimism about the future is a major factor in adolescent suicidal behaviour. Beck, Kovacs & Weissman (1975) suggested that hopelessness might be the main symptom preceding suicide, and of greater importance in causing suicide than depression itself. This hopelessness in adolescents, however, is not always visible to parents, teachers and adolescents themselves as it manifests itself in a variety of ways. A scale designed by Beck (Beck, Weissman, Lester & Trexler, 1974) could be used to evaluate hopelessness in adolescents. Beck, Steer, Kovacs & Garrison (1985) after a number of empirical studies that supported the hypothesis that hopelessness might be the main symptom preceding suicide put forward the interesting idea that a sense of hopelessness arises out of activation of particular underlying cognitive schemata when an individual becomes depressed for whatever reason. These schemata are probably determined by early experiences. Individuals therefore differ in the degree to which they are prone to developing pessimistic attitudes about the future, even when suffering from similar degrees of depression. Thus an individual who experiences a high degree of hopelessness during an episode of depression is likely in a subsequent episode to experience a similar high degree of hopelessness, and therefore be at greater risk of suicidal behaviour than a depressed individual who does not become so pessimistic, when depressed (Beck et al, 1985).

According to Engelbrecht (1978), although it is dangerous to generalise, there appears to be certain traits which adolescent suicides have in common. Adolescents who take their lives regardless of the specific psychodynamic trigger identified, tend to have one thing in common, namely a nagging lack of optimism and hope for the future and an overwhelming sense of unhappiness.

Adolescents who took their lives were essentially less likely to have sent out unambiguous, overt, decoded communication signals for help than those who did not. This is consistent with the character of a large number of suicidal adolescents whose ability to relate, not only with their parents, but also with significant others, is minimal, and who are unable or less likely to ask for direct help than their less suicidal counterparts, even by means of threatened or attempted suicide. Case studies (cited in Engelbrecht, 1978) confirm that the adolescent's suicidal act in the majority of cases is not an elaborately pre-planned act. In many cases it is of an impulsive nature. What was not examined however was the suicidal behaviour in other forms (delinquent and deviant behaviour) that also create and set the stage for suicides.

Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann (1988) report that the rate of suicide and suicidal behaviour is higher in individuals with chronic and life-threatening illnesses, like cancer

and Aids. The feeling of hopelessness and chronic pain that come with both physical and mental illnesses are sure ingredients and precipitators for suicidal behaviour. The adolescent, especially in a situation like this, needs strong family support and acceptance.

2.8.2. Quality of family life

Many South African studies have noted the role of family dynamics in suicidal behaviour. One study by Pillay (1995) found a significantly higher prevalence of family conflict as a recent stressor among suicidal adolescents as compared to control subjects.

The quality of family life appears to have an enormous impact on the emotional and psychological development of a child. More than anything else, family background and experiences during the early years of life play a major role in creating suicidal wishes among young people. The results of one study (Wild, Flisher, & Lombard, 2004) show that depression and low-self esteem in the family context were independently associated with suicide ideation and attempts. Moreover, low family self-esteem significantly differentiated suicide attempters from ideators. According to Klagsbrun (1976) a number of young suicide attempters and completers came from disturbed or disrupted homes, lacking in stability and support. In some disrupted homes parents were divorced or constantly quarrelling; in others a parent had died or had deserted the family or one or another parent was an alcoholic or had spent considerable time in jail (Henry, Stephenson, Hanson & Hargett, 1993, Wright, 1985). Adolescents who grew up in these broken homes felt abandoned and lonely, filled with anger at the parent who had hurt them and at themselves. Marshall (1998) reports that high-risk children overwhelmingly had a negative view of their family and often felt alone. Studies by Mack & Hickler (1981) also stress the frequency of divorce, abandonment, broken homes and parental rejection or loss in the family of suicidal adolescents.

Adolescents are affected when the breadwinner is unemployed. As a result of loss of income, standards (including health) decline. Adolescents may have to leave school sooner, in an effort to supplement family income (Rip & Bezuidenhout, 1992). Exposure to work environment at an earlier age may have serious effects on the adolescent. Adolescents may or may not attend school, resulting in unwanted pregnancies, juvenile delinquency, crime, alcohol and drug abuse, all of which predispose suicide. A study by Pfeffer (1989) also points to adolescents who attempt suicide frequently as having a long history of escalating family instability and discord. According to

Pfeffer (1989) they have reached a point at which they feel unable to communicate with their parents or turn to them for support. Madu & Matla (2004) report that conflict in a family was a significant correlate for the three forms of suicidal behaviour that they studied. They found that family independence, family cohesion and family organisation were also significant correlates for suicide threats. Early parental loss is also common among suicidal adolescents (Bolger et al, 1989). Although socio-demographic data play an important role in identifying suicide risk, it does not however eliminate it. These factors are only useful when coupled with examination of clinical issues.

Levinson (1978) believes that the experiment of the small family has failed. The move towards westernisation has created nuclear families in South Africa. The withdrawing from or pushing out the support of grandparents, aunts and uncles, has left behind a small vulnerable family of husband, wife and one or two children. Strangers are paid to act as mother surrogates while parents are at work. Society is even moving into an age of the one-person-parent because of the splitting of so many marriages. Parents do not touch or hold their children as much as their parents did. There is no space for an emotional bond or connection to develop.

Adolescence is typically a time of challenge, change and adjustment, when the developing youngster begins to move away from familiar nurturing models so as to experiment with a variety of roles and identities (Hare, 1995). The result is often a behavioural configuration which is exciting yet frustrating. On the one hand the period of adolescence is often marked by a continual striving for independence and an apparent rejection of previous dependency patterns, on the other hand, the 'experimenting' youngster relies heavily upon the support of home and family when developmental tasks being faced become intense and overwhelming. Clearly the response of parents, teachers and other primary caregivers is crucial to the subsequent adjustment that the adolescent makes. Adolescence is clearly a developmental period which carries with it much anxiety and Hare (1995) postulates that in order for the adolescent to make a satisfactory adjustment, her/his often irrational and contradictory behaviour needs to be met with sympathy and sensitivity by parents. The parents' own level of adjustment is crucial here, and their own personal recollections and experiences of adolescence take on a special meaning.

The influence of the family, especially the parental system is one of the most studied of variables in studies of adolescent suicides (Atkinson, Atkinson, Smith & Hilgard, 1985). The family certainly exerts a potent influence on the development of the individual, particularly the

development of emotional responses, ideas, attitudes and values. It is therefore obvious that the family has a role to play in the development of suicidal behaviour in the adolescent. Compared to normal adolescents, suicidal adolescents suffer greater family stress particularly due to changes and threatened changes in the parental system such as loss, death, separation and divorce and a subsequent lack of support. In addition these families are characterised by greater parental dysfunction, suicidality and psychopathology, the latter ranging from generalised psychiatric problems to depression and substance abuse including aggression, abuse, violence and neglect of children (Bongar, 1992). Atkinson et al (1985) states that the outstanding characteristic of adolescents who attempt suicide is social isolation: they describe themselves as loners, most have parents who were divorced or separated, a large number have alcoholic parents, and one-fourth were not at home at the time of their suicide. Maltsberger (1986) also found that suicide in children and adolescents very commonly takes place in the context of family disruption, alcoholism, quarrelling and open threats of abandonment.

Research findings over the years have not changed much for similar views as those above were expressed almost thirty years ago by Engelbrecht (1978) who states that although many factors seem to contribute to the overall suicidal intent of the adolescent victims, family problems seem to predominate. Nearly two-thirds of the adolescents were not on good terms with their families. Not being appreciated or understood by their families was the most common feeling selected from the continuing chaos and unhappiness which mark the life of these youngsters. It is my belief that many adolescent suicides could have been averted had the parents forged a strong, solid connection with their children and taken early notice of their children's unhappiness. It is this neglected possibility of intervention that stamps the adolescent suicidal act with a sense of tragedy. An analysis of family histories of adolescent suicides convinces me that if there is a common thread running through the family histories of victims it is to be found in the disturbed home settings in which many of the victims had been reared and the apparent ignorance of the suicidal adolescent's family to the emotional pain being experienced by the adolescent. Based on an analysis of case histories alone Engelbrecht (1978) hypothesises that adolescent suicide results from the adolescent feeling that she/he has been subject to oppressive isolation from meaningful social relationships. The hypothesis is based on the fact that the victims in his case studies experienced the following:

- a long-standing history of problems from early childhood to the onset of adolescence

- the escalation of problems since the onset of adolescence above and beyond those usually associated with the years of adolescence
- the progressive failure of available adaptive techniques for coping with old and new increasing problems which lead to the victim's progressive isolation from meaningful social relationships
- a chain reaction dissolution of any remaining meaningful social relationships in the days and weeks preceding the act which caused the young person to believe that she/he had reached the end of hope
- the internal process by which the victim justified suicide to herself/himself and thus managed to bridge the gap between thought and action

The hypothesis has not changed since Engelbrecht (1978). Family tensions still appear to be an important reason why adolescents take their lives. The total family situation cannot be ignored by any care-giving service. It must be impressed on parents that they dare not ignore any 'cry for help' signs by adolescents. Adolescent suicidal behaviour is undeniably unpredictable. Any threats of suicide by the adolescent must always be taken seriously. Sadly, practically all attempts to date to prevent adolescent suicide focus on individuals who have shown overt symptoms of self-destructive tendencies (e.g. overdosing). Society should also be concerned with identifying the suicide impulse in those who are unhappy, dissatisfied or disconnected from their world - who have not actually made an attempt on their lives, but who are nevertheless a suicide risk (Engelbrecht, 1978). These adolescents need help to improve their poor self images and low self-esteem.

2.8.3. Poor self-esteem

Gould, Shaffer, Fisher & Garfinkel (1998) identified a negative self-concept or poor self-esteem as an additional risk factor in suicidal behaviour. Self-esteem is the evaluation of the self in relation to the goals and standards that the individual carries within. High self-esteem is experienced when the self, as it is perceived by the judging capacities of the ego, comes close to fulfilling these standards. Conversely, low self-esteem results when a wide gulf is experienced between the perceived self and the ideal self (Sdorow, 1993).

A factor distinguishing adolescents prone to self-destructive behaviour is that of problems in the development of self-esteem. Self-esteem as a person enters adolescence is often based on their ability to fit in with their peers. Low self-esteem leads to school difficulties and/or lack of confidence in success at school or in the future (Bronheim, 1986). There is then a greater likelihood that risks will be taken without appropriate regard for long term consequences (Bronheim, 1986).

All of us experience times of lowered self-regard when failure, disappointment or loss informs us that we have fallen short of our ego-ideal expectations. Ordinarily, however, such experiences are transient and do not achieve the intensity or depths of melancholia. A realistic assessment of the self's value is soon restored. If this is not done however, then suicidal behaviour may follow.

Contributions are made to the development and sustenance of positive self-esteem at each stage of childhood. Cotton (as cited in Mack & Hickler, 1981) divides the sources of positive self-esteem into three strands. First is the esteem of others, the message conveyed to the infant and the small child initially by the parents, and later by siblings, peers and other adults, that she or he is empathetically loved and valued. Parental praise and approval, if genuine, as well as appropriate limit-setting, will contribute to the development of high self-regard. Gradually these attributes are incorporated into the child's personality. A core of good feeling about oneself develops, which is more or less independent of the approval of others, although some appreciation and external validation of one's value is important throughout life for sustaining high self-regard. The second strand is the experience by the child and later the adolescent of real accomplishment, the pleasure or satisfaction in successful mastery of tasks or activities she/he has initiated. The experience of being effective or competent in areas the adolescent designates as important to her/his self-concept, whether physical attractiveness, athletics, intellectual achievement, or popularity with peers, will contribute strongly to positive self-regard. Since successful mastery or skilfully performed activity is likely to bring praise from others, the first and second strands tend to become intertwined. The third strand is contained within the adolescent's personality or self. It is the outcome of the evaluation the individual makes of how well the self is measuring up to the ego ideal.

Susceptibility to the experience of low self-esteem can thus occur as a result of injury or developmental failure in relation to any one of these three strands. The parents may have shown

too little approval, or set expectations of achievements too high for the adolescent to reach. The role of parents in the development of healthy egos in their children cannot be overemphasised.

2.8.4. Types of parental models

An interesting South African study involving black suicidal adolescents, showed a relationship between self-punitive wishes and dissatisfaction with father-adolescent relationships, mother-adolescent relationships, family interaction and the degree of family acceptance (Mayekiso, 1995). The study shows that the role that these parents play in their adolescents' lives will shape the kind of role models they will be for their children especially when it comes to dealing with life's trials and stresses.

Undoubtedly parent-child experiences have an important determining role in the development of adolescent attitudes, personality, and ways of coping with stress. Types of parental models, and the world views they espouse, obviously directly influence how an adolescent views situations. Parents pass on messages to their children, consciously and unconsciously, about how threatening everyday situations are, and how capable they feel their children are of coping with these situations.

Rigid parents with strict, uncompromising standards, who view their adolescents as helpless and not measuring up, put her/him at risk. In most suicides, the common penultimate act is some interpersonal communicative exchange related to the intended final act that included a sense of helplessness (Roy, 1986). A variety of factors, however, within the individual, between individuals and significant others and environment – may lead to disruptions in the development of self-esteem.

Inconsistent limits or lack thereof placed by the parents on their adolescent children can also interfere with the adolescent's ability to perceive needs and rights of themselves and of others (Stuart & Sundeen, 1991). Lack of satisfactory relationships in infancy, or conversely excessive protection, can stimulate envy: the infant believes in fantasy that the mother is keeping the good things for herself and is all powerful. Such envy can be generalised to others in society. The person feels eventually that good things are not worth having, and find fault in everything. Such envy impairs the adolescent's relationships (Nash, Stock & Harper, 1990) – this could lead to the

adolescent emotionally disconnecting herself/himself from others. It is at this point that the emotional gap between adolescents and their parents start widening. Many parents are unaware of their children's daily stresses and the effectiveness of their coping skills.

Low parental monitoring of their children's risk behaviour (such as smoking, physical fighting, alcohol intoxication and promiscuous sexual behaviour) have been found by King et al (2001) to be independently associated with increased risk of suicidal ideation and attempts – adolescents are crying out for help but parents do not hear the cries. In many cases suicidal behaviour may be a manifestation of depression but this is often not recognised and identified by parents.

2.8.5. Depression

Depression is stated as one of the strongest predictors of suicide (Klagsbrun, 1976, Smith, 1995). About 15 percent of clinically depressed individuals will eventually kill themselves. This rate is 22 to 36 times higher than the rate for the general population. Surprisingly, suicide often occurs as a depressed person seems to be emerging from depression. The lifting of depression may provide the energy needed to complete the act without affecting the individual's underlying cognitions of hopelessness and despair (Smith, 1995).

For many years, however, the prevailing psychiatric belief was that children and adolescents could not experience clinical depression. This was influenced by Sigmund Freud's theory that depression was anger turned inward by the superego and since a child's unconscious was not fully developed, depression was not possible. The idea was that children were not self-reflective enough (Sdorow, 1993).

However, according to the National Institute for Mental Health (Portner, 2001) one in five children under age 18 suffers a mood disorder, from obsessive-compulsive disorder to depression to bipolar disorder. While children as young as 4 have been diagnosed with depression, it generally appears in those between the ages of 12 and 14, according to psychiatry professor Kay Redfield Jamison (cited in Portner, 2001). A 1999 report on mental health released by the U.S surgeon-general (cited in Portner, 2001) estimates that at least 90 percent of children and adolescents who commit suicide were diagnosed with a mental disorder before their deaths.

Williams (1992) states that everyone becomes a little depressed from time to time. But sometimes, the depth of depression outweighs a person's ability to cope. Mood spirals downwards, the person experiences hopelessness and despair, and almost total emptiness, feels unmotivated to do many of the things they used to find enjoyable, or feels that they would rather not meet other people – and they turn to suicidal behaviour.

Watkins (2000) also associated suicidal behaviour with depression. However this does not mean that every depressed adolescent commits, attempts, or even thinks about suicide - or that every suicide comes about as a result of depression. Other co-existing disorders, such as attention deficit hyperactivity disorder, substance abuse and anxiety can increase the risk of suicide. Chaos churning inside adolescents' heads is often unlocked by environmental stress. Suicidal thoughts and behaviour, especially in impulsive adolescents can be triggered by stressful events (Watkins, 2000).

Umhlanga-based specialist psychiatrist, Dr Agambaram (cited in Kitchen, 2004), who works predominantly with children, says that depression is becoming more and more prevalent in younger children. Weepiness, sadness, unhappiness, boredom, withdrawal, physical complaints, failure in school, difficulty sleeping, changes in eating habits, sexual promiscuity, a tendency to have accidents, feelings of being unloved, abuse of alcohol and drugs, and suicide threats may all, for example, be expressions of depression that may lead to suicide. Parents, teachers and adolescents need to become more attuned to the various manifestations of depression as typical suicidal adolescents will feel depressed and sexually abnormal for some time.

Suicidal adolescents have maladaptive coping styles (Kornstein, 1997). Many of them rely on others to solve their problems for them. According to Maltsberger (1986) it is because they have not achieved satisfactory separation from their mothers.

2.8.6. Separation anxiety

Maltsberger (1986) states that it is quite common for both boys and girls to be locked into an intense sadomasochistic attachment to the mother from which escape is impossible. The sequence leading to attempted suicide is set into motion when external events demand a step that threatens to

break the tie to the mother. Quite often this will be the high school graduation, taking a first job or going away to college.

The adolescent fails to make the necessary step of independence away from the mother. The demand the external world seems to make and the failure to meet it lead to a worsening of emotional distress, and the adolescent becomes acutely aware of dependency on the mother. The failure to make the normal adolescent move away from the mother leads to an intensification of the longstanding sadomasochistic entanglement. A girl, terrified of being abandoned by her mother, unconsciously hating her, and longing to be free, may submit to her while at the same time repeatedly creating situations which drive the mother away (Maltsberger,1986).

The suicide thoughts that have been present for some time will now take on a new importance – suicide seems the only possible resolution. Suicide may even seem heroic. Totally preoccupied with suicidal impulses the adolescent will now turn again to the outside world, but this time not for help. Unconsciously the adolescent provokes a rejection from someone not the mother. Suicide can then occur with attention centred on someone else; the mother is not the person to blame. By provoking rejection from someone else, she/he can avoid conscious awareness that the suicide is an aggressive attack on the mother (Maltsberger, 1986).

In a study by Wade (1987), which examines separation anxiety in suicidal adolescent girls, it is postulated that adolescent girls who attempt suicide suffer from separation anxiety more than their non-suicidal counterparts. Hansburg (1972) suggests that failure to adapt to a normal separation experience in adolescence without serious pathology is often evidence of an earlier failure to solve the problem of disentanglement from parental figures.

Bowlby (cited in Powell & Enright, 1990) argues that the formation of early attachments, particularly with parent figures is crucial to the development of later relationships and psychological health. Unhappy early relationships can very often lead to similar relationships later in life; affecting the individual's self-esteem and the quantity and quality of social support. Studies by McCulloch & Phillip (1972) demonstrate that there exists a relationship between suicidal behaviour and deviations in the normal child-parent relationship. Lack of maternal stimulation or attention deprives the infant of a sense of security (Klerman, 1986, Fisher, 1987).

An adolescent who is deprived of her/his mother's affection through maternal rejection/disconnection may tend to become unhappy in her/his real surrounding or environment. She/He may then form patterns of frequent escape into a compensatory, unreal dream world, until fantasy overcomes reality. When this fantasy world predominates she/he is heading for mental illness (Fisher, 1987).

Unhappiness that persists leads to depression and eventual suicide. Lack of normal sources of interest, warmth and comfort may lead the adolescent to turn to her/his body. Intellectual growth retardation may also ensue. Roy (1986) sees suicide as a more or less transient psychological constrict of affect and intellect.

For boys, according to Owen (1995), the age at which separation from the father occurs is a critical factor affecting children's adjustment. Early separation could prevent masculine identification from occurring and could create a disruptive effect on learning masculine gender-role behaviours. Owen (1995) went on to state that, boys whose fathers were frequently absent from home are less socially adjusted, have more difficulties in peer interactions and tend to be significantly more dependent on peers. The longer the adolescent boy is separated from his father, the greater the regression for the boy. This could in turn retard his problem solving skills amongst other deficits.

2.8.7. Deficits in problem solving

Suicidal people are often poor at solving interpersonal problems (Williams & Pollock, 1993). Current research is showing more and more that adolescents who would not always be considered to have particularly overt psychological morbidity are using suicidal behaviour as a first line, crisis management strategy (Schlebusch, Vawda & Bosch, 2003).

The central and most frightening aspect of adolescent suicide is its increasing attractiveness as a solution to personal situations which are viewed as being without hope or without the possibility of change. If Camus (cited in Mack, 1986:55) is correct that 'killing yourself amounts to ... confessing that life is too much for you,' then more and more adolescents are making the confession. The adolescent sees no future for herself/himself. Suicide is viewed as the only alternative after a period of longstanding personal problems when there seems to be no one out there who understands and is willing and capable to assist her/him cope.

Deficits in the problem-solving skills of suicidal adolescents have been well-documented (Berman & Jobes, 1991). These deficits distort perceptions, narrow the range of alternatives and greatly increase the sense of hopelessness and the risk of impulsive behaviour. Under such conditions the risk of suicidal behaviour greatly increases. Moreover, once the suicidal behaviour occurs the risk for more lethal consequences increases as well (Bongar, 1992). Cognitive strategies, such as problem solving skills, are essential to arrive at rationally derived alternatives to engage cognitive rehearsal, to think hierarchically versus dichotomously, to assess self and to tolerate ambivalence. Problem-solving skills and coping strategies are significant variables in understanding why adolescents commit or attempt suicide. However, not all adolescents with deficits in problem solving resort to suicidal behaviour.

Certain personality characteristics help to increase resilience in adaptive capacity in adolescents. Garmezy (1985) identifies other such protective factors that make some youths more adaptive than others even though in similar situations of stress and pain. They include self-esteem, feelings of autonomy and self-control, the presence of external supports and resources, family cohesion and warmth and the absence of family discord and neglect.

In Garmezy's study (1985) adolescents who seemed most susceptible to suicide and suicidal behaviour tended to be hypersensitive. They over-reacted and tolerated frustration poorly. They had poor coping skills. They were also rather suggestible and easily influenced towards suicidal behaviour. They also had problems adapting to new or changing situations.

2.8.8. Failure to adapt

Wandrei (1986) reports that para-suicides are more likely to have undergone a crisis that precipitated the attempt - they fail to adapt to the new situation. Research indicates that compared to other psychiatric patients and general population controls, individuals who attempt suicide have more troubled interpersonal relationships (Linehan, Chiles, Egan, Devine & Laftan,1986) and thus limited or no support structure. They cannot, for example, adapt after a break-up in a relationship. The suicidal behaviour among adolescents is often typically the final, often impulsive step in a progressive failure of adaptation (Wade, 1987). At the core of the suicidal behaviour of adolescents are feelings of low self-worth, free floating rage, helplessness and an inability to solve problems in more rational and effective ways. These feelings may manifest itself in a wide variety

of ways, from over-compliance to promiscuity, from anti-social behaviour to isolation and withdrawal, and from rigid perfectionism to anorexia. Often the motive for the suicide attempt that follows is to alter the situation in which the adolescent feels trapped or expendable. Such an adolescent becomes an easy victim to bullying.

2.8.9. Bullying

In a study by Ryan (2006), social isolation and being a victim of bullying are strong factors linked with suicide. Bullying is the intentional, unprovoked abuse of power by one or more individuals to inflict pain on or cause distress to another individual on repeated occasions. It includes several different activities: pushing, hitting, spreading slanders, provoking, making threats, extortion and robbery. It is a common international phenomenon that occurs to some extent in all schools. Bullying may be a contributory factor in why some adolescents harm themselves or commit suicide (Walshe, 1998). Espelage (cited in Portner, 2001), an expert on bullying at the University of Illinois, believes that adolescents who are bullied are more likely to commit suicide. To ignore bullying or not to recognise that the adolescent has a problem with bullying can condemn adolescents to misery now and perhaps also in adult life (Dawkins, 1995) and may even give them a reason to turn to suicidal behaviour.

2.8.10. Sexual relationships

Mack & Hickler (1981) found a correlation between suicide and personal relationships that were no longer meaningful. According to Hawton and Catalan (1987) the most common general type of problem for adolescents is a recent row in the setting of a difficult relationship (with their parents or with a boyfriend/girlfriend). Curran (1987) states that suicidal adolescents have fewer close friends, but their relationships with them are much more intense. According to Curran (1987:30):

- their relationships become supercharged with a degree of desperation and need that is often not shared by friends and lovers

The adolescent's failure to connect meaningfully with others leads to a break down in relationships. Homosexuality may also be a suicidal risk factor for adolescents (Stoelb &

Chiriboga, 1998). The pressure of identifying as homosexual in a homophobic culture is particularly confusing for the adolescent struggling with issues of acceptance. Studies by Rotheram-Borus, Rosario, Reid & Van Rossem (1995) found that 30% of gay adolescent males had attempted suicide at least once and more than 50% had multiple attempts. Those with conflicts about their sexual identity are more at risk for suicidal behaviour. Although sensitivity to these issues is required in establishing any suicide prevention programme, it is important not to miss the presence of any associated mental disorder, as well as addressing the more obvious issues of the varying degrees of societal acceptance, depending on the cultural views of individual communities. Gay Rights Groups have come a long way in gaining greater acceptance from the legal system with the recognition of gay marriages. However media reporting on gay rights continue to be contradictory. The media undoubtedly plays a significant role in reporting suicidal behaviour and in some cases influencing susceptible and vulnerable individuals (Schmidtke, Schaller & Wassenaar, 2001).

2.8.11. Influence of the media

When adolescent suicides are publicised by news media or when there are television dramas about suicide, the rate of adolescent suicide increases several weeks following the event (Fontaine & Fletcher, 1991, Schmidtke, Schaller & Wassenaar, 2001). Clusters of suicide amongst adolescents who know one another and attend the same school have also been reported (Schlebusch, 2005). This could be because suicidal behaviour may precipitate other such attempts within a peer group via identification. Kaplan & Sadock (1988) state that there was an increase in adolescent suicide after the screening of television programmes, whose main theme was the suicide of an adolescent. 'Copy suicide' seems to be an adolescent phenomenon with girls being more susceptible than boys. The potential copycat seems to be a troubled adolescent who empathises with the pain of the suicidal person and is easily influenced by the media. The copycat phenomenon therefore raises issues around the responsibility of the media in reporting suicidal behaviour (Schlebusch, 2005).

Exposure to the suicidal behaviour of another person in the social network of family is itself a significant factor of risk for ideators, attempters and completers. Adolescents, in general are highly susceptible to suggestion and imitative behaviour. To a disturbed adolescent, particularly one with pre-existing suicidal impulses and diffuse ego boundaries, the perceived attention and notoriety given to a suicidal event by the media might easily stimulate irrational cognition that there is much

to be gained through suicidal behaviour (Bongar, 1992). Suicidal behaviour appears to be a solution to a problem that has thus far had no solution. Suicidal behaviour, then, may seem to some adolescents as an opportunity to gain some recognition, personal attention, power and control.

2.8.12. Gaining attention, power and control

Many adolescents struggle to incorporate their new awareness of themselves and toy with death as a possible means of controlling their own destinies. Some adolescents may even kill themselves to get attention or revenge (Gaines, 1991). Suicide is seen by them as hip, dangerous, the final resistance to adult authority - a last stand against conformity. They view suicide as death before dishonour, heroism over defeat. Because attempts so greatly outnumber actual suicides, suicide is as much a statement of the desire to control life as it is to end it.

Most adolescents who are obsessed with thoughts of death don't view suicide simply as a way to end life. For them the act of killing themselves takes on symbolic meaning. By choosing when and how they will die they gain power and control. They master life by mastering death, and in that way they achieve a sense of immortality. They often think of death as a long, peaceful sleep or interlude that will somehow make things better. Or they picture death as a way to punish others or to make others show love for them. It would appear that the act of suicide is often a revengeful deed. The disconnected adolescent wants to punish the parent or loved one for a real or imaginary wrong committed against her/him. The adolescent hates the love object who she/he feels has betrayed or deserted her/him (Engelbrecht, 1978) - and somewhere in her/his mind, is the belief that she/he will be present to benefit from the punishment that her/his death has inflicted or the love it has aroused (Klagsbrun, 1976).

2.8.13. Dealing with death

Silverman & Worden (1992) studied the reaction of children in the early months after the death of a parent. They found amongst others, that the children's inner feelings about death were somatizised by early health problems. Silverman and Worden (1992) also found that there were emotional distress, preoccupation with thoughts of their dead parents, serious behavioural problems, inability to function in school, dreaming of their dead parents and a change in daily

living. They concluded by expressing that children were dealing not only with the death of a person, but also with the death of a way of life. This is particularly significant in the South African context when we consider the number of adolescents who have been forced to take over the responsibility of heading households because both parents have died of Aids or other illnesses.

Those who have experienced the death of others, particularly if that death has been by suicide, appear to be more vulnerable to experiencing suicidal impulses. This is particularly so at the anniversary of the death - and an expression of a wish to join somebody who has died should be interpreted as of grave significance in terms of suicidal intent.

2.8.14. Those with a past history of attempted suicide

In a study of 174 cases of under 25 year olds completed by the Centre for Suicide Research at the University of Oxford (2007) nearly half (44.8%) of the young people had a history of previous self-harm, nearly half of these having carried out multiple episodes and 80% having self-harmed within the previous year. In another study by Olfson, Shaffer, Marcus & Greenberg (2003) when children and adolescents completing suicide were compared with community controls, there was a noticeable relationship between antidepressant medication treatment and past suicide attempts. In a post-suicide reconstruction of causes, Gould, Shaffer, Fisher & Garfinkel (1998) found that the leading risk factor for completed suicide among adolescent boys was a previous suicide attempt, followed by a major depressive disorder and substance abuse.

There have been many studies (cited by W.H.O., 1993) indicating that those who attempt suicide are far more likely to commit suicide in the future than other groups. Indeed, probably about 1 % per year of those who attempt suicide go on to commit suicide, and the risk is particularly high in the first year after an attempt. Quite clearly this is a high risk group and considerable attention should be paid to these persons. Full assessment with attention to socio-cultural factors as well as the optimum management of mental disorders is required, as is the promotion of more appropriate problem solving methods. It is quite clear from its prevalence in those who engage in suicidal behaviour that there is a "window of opportunity" for preventing suicide. This is particularly so as many who attempt and commit suicide have had recent contact with the helping professions. However, even when there has been contact, that has not always resulted in adequate management. In fact, there are studies (Marzuk, Tardiff, Leon, Hirsh, Stajic, Hartwell & Portera, 1995) which

demonstrate that only a relatively small percentage of those who have committed suicide have had the potential benefit of standard treatments. For example, in an American report (cited in Marzuk et al, 1995) only 16 per cent of 1635 persons who had committed suicide had evidence of psychotropic drug use at autopsy.

There are also challenging new findings with the more recently available anti-depressants - there has been a demonstrated reduction in suicidal behaviour in patients with repeated suicide attempts but without major depression or another axis one diagnosis when treated with an anti-depressant with central serotonergic functioning (Verkes, Van der Mast, Hengeveld, Tuyl, Swinderman, & Van Kempen, 1998). There has also been a reported decrease in negative affect and an increase in affiliative behaviour in volunteers given similar serotonergic drugs (Knutson, Wolkowitz, Cole, Chan, Moore, Johnson, Terpstra, Turner & Reus, 1998). With the correct support and intervention suicidal behaviour can be reduced and controlled.

2.8.15. Lack of support systems

Social disconnection/isolation and alienation, lack of support systems or unavailability of somebody to turn to certainly increases risk of suicidal behaviour for the young person in extreme distress (Garfinkel & Northrup, 1989). When social integration is high, suicidal behaviour rates for all age groups are lower (Lester, 1991). Suicide attempters often state that they do not feel close to any adult (Samaritans, 2002). They often have trouble communicating with significant others around them (Strivers, 1988). There is no one to turn to when they need to talk to someone. Lack of closeness to parents lead to a lack of emotional support when needed (Dukes & Lorch, 1989).

Adolescence is normally a period of turmoil, frequently characterised by rebellious and impulsive behaviour. During times of stress, thoughts of suicide are not abnormal. Often adolescents are crying out for help because they are dealing with overwhelming burdens such as academic demands, parental divorce, family illness ... as well as changes in their social relationships. Adolescents with poor social adjustment or adolescents with psychiatric or family problems are at increased risk of suicide (Stanhope & Lancaster, 1992). To Badger (1995) suicidal adolescents usually lack interpersonal communication and coping skills and good social support.

To adults, adolescents appear to have everything - they are in the prime of life, filled with strength, health, and the beauty of youth. To a large extent, the non-recognition by adults of the problems and concerns of the young has been largely responsible for the alienation/disconnection of adolescents from their world. It has also helped lead them into a culture in which drugs, alcohol and violence have come to be substitutes for love, feelings, and shared understandings (Klagsbrun, 1976).

Adolescents who engage in suicidal behaviour often find that their efforts to express their feelings of unhappiness, frustration, or failure, are totally unacceptable to their parents (Engelbrecht, 1978) and maybe even other adults. Such feelings are often ignored or denied by parents, or are met by defensive hostility. Such response drives the adolescent into further isolation, reinforced by the feeling that something is terribly wrong with her/him. The parents do not understand the emotional turmoil the adolescent is experiencing and this results in the adolescent withdrawing/disconnecting from the family circle and even other social circles. In most cases the adolescent has failed to relate/connect meaningfully to her/his parents.

The process leading to suicide in young people is often long term, with untreated depression in the context of personality and/or relationship difficulties being a common picture at the time of death. The prevention of suicide in adolescents clearly needs multiple strategies from a strong, understanding support base.

2.9. CONCLUSION

The societies of parents, teachers and adolescents have clearly not yet begun to understand the etiology or disease process of suicide. The definition of suicidal behaviour has been restricted to the eventual act of suicide itself or the overt forms of suicidal behaviour. We have failed to realise that adolescents who finally take their own lives may have, by and large, been harbouring thoughts of death for a long time (Madu & Matla, 2003).

We have failed to reduce the rate of suicide and adolescent suicidal behaviour - possibly because we have been working at the wrong end. We are working with adolescents who are attempting suicide when we should go back to understand the whole process of how they were raised. The factors leading to adolescent suicidal behaviour is overwhelming. It is apparent that a number of

factors can be found within the adolescent and in family interactions that distinguish those adolescents who get involved in self-destructive behaviours from those who do not. The most significant one relates to the adolescent's ongoing relationship/connection with herself/himself and with others – parents, peers and significant others. Adolescents become 'unhooked' or disconnected from living when they have no anchor. They do not value life and therefore start to challenge it.

This study has broadened the definition of adolescent suicidal behaviour to be any behaviour that is harmful or self destructive. The suicidal individual is aware, either consciously or subconsciously, of the consequences of her/his action but she/he chooses to indulge or continue with the self destructive behaviour.

In chapter three the theoretical framework, around which this study on suicidal behaviour is based, will be explored.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1. INTRODUCTION

Suicidal behaviour has been present since recorded history and yet there is still no clear and unambiguous definition of the phenomenon. This could be because in documented definitions suicidal behaviour is not seen as separate from the act of suicide itself. In answering the first critical question (What is adolescent suicidal behaviour?), I have attempted to critique the various theories on the subject and based on the data collection and literature review formulated a theory of suicidal behaviour that foregrounds the adolescent. Current thinking on suicidal behaviour falls into three major categories: biological, psychological and social. Biological theories address the possibility that there are physiological factors, such as an imbalance of neurotransmitters - serotonin especially - that create a predisposition in adolescents toward suicidal behaviour. The psychological perspective focuses on the role played by attachments in early development and the ability of individuals to form and maintain stable relationships. The thinking here is that disruptions in relationships increase the risk of depression and also the risk for suicide in some adolescents. Social theories hypothesized that relationships or lack of relationships that adolescents had with their society, and the meaning that they find in their larger social contexts, are important factors in suicide.

With respect to the great theorists of suicide, no theory is predominant. Despite such intense study into suicide, there is no universally accepted "theory of suicide". Indeed, there may never be, as suicidal behaviour, by its very nature, challenges our ability to provide a cohesive conceptual hypothesis within which to work. The diverse rationalizations that supposedly resulted in self-inflicted death have included a poor scholastic grade, an insult from a peer or a superior, concern about health despite repeated negative physical examinations, revenge and the wish to escape into a better existence. Because of the complexity of suicide it is futile then to attempt to reduce the problem to simple causes.

All three major theories mentioned above (biological, psychological and social) are important ways of thinking about suicide, and they all have implications for prevention and intervention. No one theory completely explains the theory of suicidal behaviour or demystifies it. The sociological and psychological theories will be explored further in this chapter. The biological theories are

more medically based and outside the scope of this study. Not being trained in the medical field I felt it prudent to reflect on it but not to delve deeper.

After much research and reflection on the sociological and psychological theories of suicide I have found that what no theory focuses on and yet ironically what appears to link all the theories to suicidal behaviour or be the common thread in each hypothesis of suicidal behaviour is the concept of connectedness or connectivity or the ability to connect. This discovery has given creation to my own theory to explain the phenomenon of suicidal behaviour. I have chosen to call it the Theory of Connectiveness. Other theories have alluded to a suicidal individual's lack of connection to her/his world but no theory has focused predominantly on connectiveness. This is the gap that my study hopes to close in some way so that there is a fuller and richer understanding of this complex phenomenon of suicidal behaviour. Society (which includes parents and school personnel) needs to understand that the lack of connection for adolescents is an emotional experience that cannot be medicated away or managed at an administrative level. It is a personal experience, unique to each individual but with common threads. To give impetus to my theory I prefixed the discussion on the sociological and psychological theories of suicide and suicidal behaviour with what I call 'The Theory of connectiveness'. I have chosen to do this so that I can make apparent the gaps or lapses that I have found in the sociological and psychological theories of suicidal behaviour. The notion of connectiveness will be used as the theoretical lens in chapters five and six to analyse the interviews with the subjects chosen for the study.

3.2. THE THEORY OF CONNECTIVENESS

Durkheim (cited in Alvarez, 1971) hypothesized that connectedness of people to their society, and the meaning that they find in their larger social contexts, are important factors in suicide. While this may have been true in a number of cases of suicide, I would like to suggest that it goes beyond, deeper and wider than an individual's mere connectedness with society. Based on my experience as an Educational Psychologist and my research findings for this study I believe that adolescents self-destruct because of a total lack of connectiveness.

Many times throughout our lives, we experience painful feelings of loneliness and isolation. It would seem that the natural thing to do at such times is simply to reach out and connect with those around us. But from my experience as a Psychologist, it appears as if individuals experiencing

feelings of self-doubt too often find the act of reaching out very difficult, if not impossible. As a result they remain isolated from the very thing that can ease their pain ... the warmth of the human heart.

Why do suicidal individuals often feel so separate from everyone around them? Why do they often feel so alone? Why do they often feel like outsiders looking in? If we are alike in so many ways, why do they often feel so inferior? My limited practice as a psychologist makes me believe that the answer to these questions lies in the way we have been trained to see ourselves relative to other human beings. When we are born we are taught by our parents and our society that what we are supposed to be in this life is a 'somebody'- we have to achieve some measure of external success. Our self-worth is dependent on such factors as money, status, power, personality, looks and intellectual excellence. If we cannot measure up to this we feel like failures. We strive to fill ourselves up with approval from people 'out there', we twist the essence of who we really are and create a false picture which we hope will bring the acceptance we crave. When we lose sight of who we truly are we feel empty inside. When we focus only on externals, such as looks, money, success or sex appeal, we lose sight of our common humanity. We lose sight of the feelings that lie within, of those unseeable qualities that create a feeling of bonding ... and we feel alienated.

Parents play a fundamental role in helping children connect with their inner selves. However, no matter how involved and supportive parents are, no matter how much they build up their children and try to make them feel great about themselves, it is virtually impossible for them to escape the framework of success set down by society. Because of our social conditioning we all live to some degree with a feeling of toxic shame (whether we are successful or not), experienced as the pervasive sense of being flawed and defective as human beings. Equally devastating to our ability to connect is the way society fosters an atmosphere of judgement. We are not rich enough, outgoing enough, clever enough, kind enough or beautiful enough. We are put down by others in order for them to puff themselves up.

It is amazing how psychologically numb our entire social structure (including parents and teachers) is to the feelings of children and adolescents. The number of negative messages adults give to children and adolescents is staggering. Even as adults, everywhere we turn we are reminded of our imperfections. For example, advertisers in magazines and the media sell us illusions which we will never be able to achieve in life. Yet, we put up with it because we are conditioned to focus only on

the external packaging, whether it is someone else's or our own – and in this way separation, loneliness and disconnection will inevitably prevail.

People do not survive in a vacuum. We are social beings. We need to be socially connected. Connection is made easier when we approach other people with the primary purpose of making them feel better about themselves. The reason most of us are so fearful of approaching others is that, whether we are consciously aware of it or not, we usually approach people with the primary purpose of making us feel better about ourselves. Our hesitation about approaching others comes from the awful possibility that, instead of feeling better after we make the big move towards a connection, we will end up feeling like a jerk. The basic reasons we are timid about making contact are:

- we fear rejection
- we fear that we are not good enough
- we fear that we have nothing to say
- we fear we will make fools of ourselves
- we fear being put down in some way

This fear keeps suicidal adolescents disconnected and they feel a sense of loneliness, low self esteem, emptiness, dependency, anger and fear as a form of 'spiritual separation'. They experience a lack of connection with the essence of who they truly are.

Given our society's priorities, it is not surprising that one can live for years without ever having faced the question: 'who am I?' In an environment that conditions adolescents to suppress their true selves and conform to the dictates of parents, peers, religion and society, there is little room for self discovery and spiritual growth. Denied the knowledge of how to access this place of safety within, suicidal adolescents constantly feel a yearning to return 'home'. They try desperately to create a new place of safety by attaching themselves to somebody else – but it never works for long because the relationship becomes obsessive. When they are lost to themselves, how can they connect meaningfully with someone else. The only way to authentically connect with themselves is to 'find themselves'.

Individuals who are not connected with the self may have a negative view of themselves. They may also have a negative view of the world, their relation to it and their future. They may see no

meaning in their lives. According to Williams (2007) it is because suicidal adolescents feel trapped in a meaningless existence. What appears then to be lacking in a suicidal individual is her/his sense of being connected – she/he feels trapped in a body that she/he is not connected to. The main connection, obviously, is with the self. When one is connected with ones self, one is able to make the connection with others. An individual with a strong self-concept is well integrated in society. She/He can be alone in a social setting but not feel alone, isolated or alienated. An individual with some sort of connection with self will realise the need to foster or maintain strong family ties and rely on the assistance of supportive friends and the use of community support systems.

Powell & Enright (1990) argues that individuals who are part of an extensive social network are less negatively affected by stressful life events. I present the argument that only when individuals are well connected with the self, will they turn to existing support systems within the family, school and communities.

The suicidal adolescent's cry for help is a cry for connection to a real world that meets her/his needs spiritually, emotionally and physically. If these needs are not met further distancing occurs causing the adolescent to live in an imaginary world – a world that does not value her/him so why should she/he value self – this then leads to risk behaviour. The case studies cited in chapter six are examples of this behaviour.

Individuals who lack the connectedness with self, society and spirit often develop a dependence on drugs or alcohol to relieve tensions and facilitate social relationships. They have the inability to maintain social relationships and often resort to fantasy relationships or crushes. It is when reality dawns and the individual realises that there is no connection or link or attachment that the need to live dies.

Our sense of connection with ourselves and the people around us does not come from externals – rather it comes from learning how to find that place within us where there is no fear or hatred – where we always feel loved and safe – at the heart of connection – the soul – the spirit.

My Theory of Connectiveness does not exist in a vacuum. It uses as its foundation the research and thinking of the various sociological and psychological theories but goes further in conceptualising the connection to self and others. To trace the path of this transition the chapter

moves in the direction of an exploration of the sociological and psychological theories in an attempt to present more clearly the root and foundation in the thinking and creation of the Theory of Connectiveness.

3.3. SOCIOLOGICAL THEORIES OF SUICIDE

3.3.1. Durkheim's Theory

Today, most social scientists believe that a society's unity can influence suicide deaths. Durkheim (cited in Wikipedia, 2007) claims that greater social integration translates to fewer suicides. Durkheim (cited in Lester & Danto, 1993, Goldney, 1991, Alvarez, 1971, Schoombee, 1978) insisted that every suicide could be classified scientifically as one of three general types – egoistic, altruistic and anomic – and that each type was the product of a specific social situation.

Egoistic suicide occurs when the individual is not properly or too weakly integrated into society (family, religion, state) but is, instead, thrown onto her/his own resources. The old pattern of family life – grandparents, parents and children all living intensely together under one roof – protected each member from her/his impulses to self destruction. The modern disintegration of family life, however, – children scattered, parents divorced – encourages them to self-destruct (Lester & Danto, 1993). Rural communities, because of the traditional family structures, have more social integration than communities in urban areas and thus less suicide (Kaplan & Sadock, 1998). This could be because the family and society provide the support that the adolescent needs to give her/him a reason to live. The social integration is the glue that creates the social connection – it gives her/him a sense of belonging.

The exact opposite of all this is 'altruistic suicide'. It occurs when an individual is so completely absorbed in the group that its goals and its identity become hers/his (excessive identification and integration). She/He loses herself/himself in the group. The group has such 'massive cohesion' that each member is willing to sacrifice her/his life for the sake of her/his beliefs. Durkheim (cited in Goldney, 1991) saw altruistic suicide as resulting from an excessive sense of duty to society such that an individual would take her/his own life rather than risk disintegration of their society. The individual who resorts to this form of suicide has no connection at all with the 'self'.

In apartheid South Africa, during the period of the fight for liberation, young black people were prepared to die for 'the cause'. They were driven by emotion and faith. The liberation movement wanted nothing more from the youth than unquestioning devotion to something far larger than their own needs. The faith was so great that it was able to overpower an ingrained instinct and logic that tell them that in the act of protecting this cause, they could very well die. However, when freedom was finally achieved, the freedom fighters were no longer needed. They had been driven by a cause, and now they were left with no cause. They no longer had a connection with their 'society' as it had ceased to exist. New societies were created. Many battled to fit in. They felt alienated even from themselves because during the struggle they had ceased to be individuals – they had ceased to BE. They felt displaced and alienated. Life ceased to have meaning.

Both egoistic and altruistic suicides are related to the degree to which the individual is integrated into her/his society – too little or too much. Anomic suicide, on the other hand, is the result of a change in a person's social position so sudden that she/he is unable to cope with her/his new situation (Saunders & Valente, 1987). The social regulation is so weak that it does not control the person. The individual experiences alienation, social isolation and loneliness. This may be the problem in current South Africa. Affirmative Action and massive retrenchments have caused social status to change overnight. The new government opened schools to all and neighbourhoods became multiracial. A move to a new neighbourhood, a change in schools, a death in the family or even parents divorcing can thrust an adolescent into a world where her/his old coping strategies are no longer adequate, her/his old needs are no longer satisfied. Instead of her/his society being too slackly or harshly structured, it seems no longer structured at all. She/He kills herself/himself because, for better or worse, her/his accustomed world has been destroyed and she/he is lost (Alvarez, 1971, Schoombee, 1978). She/He is disconnected. The alienated adolescent feels despair that her/his desires can never be gratified by society. This may explain the increase in risk taking behaviour in our country such as train surfing.

Durkheim also mentioned the possibility of a 'fatalistic' type of suicide (cited in Schoombee, 1978), in which an excessive normative regulation of the individual's life frustrate attempts at individual expression. This creates despondency and again the possibility of suicide. The social regulation is too strong – the connection here is unhealthy as it does not allow the individual a 'self'. Individuals commit suicide as a method of escaping from "bonds of society".

Durkheim's theory on suicide (cited in Alvarez, 1971) is based on the premise that suicide is not an irredeemable moral crime but a fact of society. He views it as a social disease, like unemployment, which can be cured by social means – by social engineering, social conscience, social concern and genuinely enlightened social services. McCulloch & Phillip (1972) echo this view.

Durkheim (cited in Schoombee, 1978) clearly saw society as an entity which is more than the sum of its constituent members. He also saw it as the interactions of these individuals upon one another, as well as the material things which are important for group life. Society, he believed, is qualitatively different from its individual components, and a reality existing on a higher level than the psychological (individual) level. Society thus manifests itself as an external force which exerts a coercive pressure upon its individual members. The individual cannot escape this coercive pressure and consequently her/his actions are largely determined by collective social patterns and practices over which she/he has little or no control. Human group behaviour can therefore only be explained with reference to social facts, that is, a social act is always caused by some preceding social act or set of acts, and never by individual volition. The individual is thus dominated by a moral reality that transcends her/him, namely collective reality. Consequently, Durkheim's theoretical approach is an anti-individualistic and a causally deterministic one.

Durkheim (cited in Schoombee, 1978) believed that to understand the problem of suicide one must consider dynamic social factors rather than isolated individual motives. He saw suicide as a normal condition where certain social circumstances exist - since all societies tend to have disrupted conditions to some extent, suicide and suicidal behaviour will always be present and it must thus be expected. But when the rate becomes as excessive as it is at present, a pathological condition exists. Durkheim saw the answer to the enigma of suicidal behaviour in just increasing the integration (connectiveness) and thus the solidarity of the group. This is a mammoth task and so far has proven to be an impossible task (suicidal behaviour has become a major health issue). What society should be focusing on is the integration and connectiveness of individual body and self. This then will lead to the connectiveness of society as a group. The general aim then must be to make members of society realise their mutual interdependence and independence and to create a society which fulfils not just the physical needs of each of its members but also the psychological, emotional and spiritual needs. Durkheim is not without critics even from fellow sociologists and the theory put forward by Giddens highlights some of the gaps left by Durkheim.

3.3.2. Giddens Theory

Giddens (1977) rightfully objected to Durkheim's theory where suicide can only be explained with reference to social facts. Giddens acknowledged that the incidence and nature of suicidal behaviour in a society is influenced by the general traits of that society. He contended however that it must be shown how these are expressed in the more concrete forms of interaction in which the actors are implicated. Such interaction must also be seen as actively sustained by those concerned, rather than as mechanically determined. Giddens makes use of Durkheim's idea of 'egoistic' and 'anomic' suicide to explain his theory.

Giddens points to the importance of social isolation in the origins of suicide. Social isolation seems to be related to suicidal behaviours in a direct and fundamental way (Trout, 1980). By social isolation Giddens (1977) means the detachment of individuals from close and stable social relations with others. What Giddens fails to point out however is that suicidal individuals do not merely experience a detachment from others – they feel a disconnection from society as a whole.

Giddens (1977) states that moral isolation, that is, the separation of individuals from morally binding commitments relate directly to the day-to-day enactment of life activities. Each of these activities reflects aspects of the overall society and the changes which transform it. Each is fostered by the development of large scale urban communities and the increase of geographical mobility, as well as the spreading of middle class values which stress individualism and personal initiative in major institutional spheres. However, these factors do not only operate directly to influence suicide rates, but are also mediated through the socialisation processes that govern personality development. This, according to Giddens (1977), is crucial to the reproduction of both social and moral isolation because 'suicide-prone' persons are likely to be involved in a 'deteriorating spiral' of interaction. The term 'socialisation' here refers to a continuous interchange between the personality of the actors and their social relations with others, that is, the actor helps to create her/his social milieu at the same time that she/he is created by it.

In South Africa some adolescents have become hardened criminals – some of them live in a society shaped by men and women who had been driven by a cause (fight for liberation) and who are now left with no cause other than to serve their own interests. For some their passion, energy and aggression are left abandoned, so they look to channel it into something else – crime. They may not be focused on creating a moral, safe and loving society for the youth. Unbridled violence

and aggression may have taken over their society. This may isolate the youth more and more from a sense of positive connectivity and moral growth.

Giddens (1977) proposed that the differentiation between social and moral isolation (societal conditions) can be linked to the characteristics of suicide-prone personality types (psychological states) to yield two forms of 'deteriorating spiral' of interaction involved in suicidal conduct. This explains why every youth growing up in a violent, aggressive society in South Africa has not become suicidal. The first type proposed by Giddens (1977), which relates to social isolation, is drawn from Freud's theory of depression. This personality tends to introvert feelings stimulated by the conduct of others. A person with such a personality will have difficulty in developing stable emotional attachments or connections, will thus have few of these, and will have difficulty in maintaining them. Whatever ties the person may manage to develop, will be particularly unstable in social contexts where personal initiative and responsibility for action are strongly sanctioned normatively. The pattern of dependency which is characteristic of this personality type means that suicidal behaviour related to social isolation represents both an aggressive impulse towards others, but turned back against the self in the form of a feeling of guilt, and an attempt to gain the affection of others. The feeling of guilt is the dominant motivational source of the tendency towards suicide. A variety of contingent events may under such circumstances set into motion a deteriorating spiral of events in which the demands of the individual alienates others, causing further withdrawal, thus accentuating her/his social isolation, and so on, until a point is reached at which suicide follows. Whether this will follow, depends greatly on the responses/support of others in the adolescent's social ambit during succeeding phases of the spiral.

Giddens' (1977) second personality type, which relates to moral isolation, is one in which shame rather than guilt is the dominant mobilising motivational force. Such a person has difficulty in sustaining morally satisfying transactions with the normative framework of the surrounding social world. Any generalised social condition promoting the instability of such transactions will tend to influence the person's propensity to suicidal behaviour. Giddens (1977) contended that in contemporary western society there is such a generalised social condition, in that there is little moral legitimation for behaviour, apart from that derived from competitive economic success. Furthermore, the chronic tendency to crisis in the social system finds expression on a concrete level in the tensions and anxieties of a morally tenuous 'adjustment' to the exigencies of good or ill-fortune. The second type of suicidal personality is therefore prone to a chronic anxiety which is focused upon perceived inadequacies of performances or attainment and which results in strong

feelings of shame. Shame demands a change in the self, that is, a moral 'rebirth' and the suicidal act may be the 'rebirth' for the suicidal type of personality. However, a person of this type may continue to sustain established social relations with others and may hide her/his anxieties as far as possible for to show others her/his anxieties would reinforce her/his feelings of worthlessness. Such a person would therefore be less likely to give a warning beforehand of her/his suicidal inclinations. In the current South African context there is great pressure on the youth to perform academically. Shame could result from the inability to achieve results that are expected from external (parents, school) and internal forces (herself/himself). Failed relationships could also fill a youth with shame. She/He may feel inadequate yet create an illusion of social connectiveness. This serves to deceive and keep people unaware of her/his decision to end her/his life. The psychological theories of suicide helps in deconstructing such an individual.

3.4. PSYCHOLOGICAL THEORIES OF SUICIDE

3.4.1. Depression

Now, in the 21st century, it is generally accepted in psychiatric circles that depression does not spare the young. Children as young as eight can now be given Prozac (a drug to treat depression) (Frith, 2006). It is important to recognise that the study of childhood and adolescent depression and adolescent suicide and suicidal behaviour is still relatively new. Because their personality organisation has not reached a level of complexity sufficient to fulfil the conditions of adult depressive states, it was often believed in the past that children and adolescents could not be depressed. Suicide and suicidal behaviour were therefore not considered to be phenomena associated with adolescents.

Rice (1996) still argues against the belief in adolescent depression by stating that they are still dependent on love objects for gratification. He believes that they have not yet completed the process of identification within themselves and therefore the thought of turning hostility towards themselves is too painful and frightening. He further explains that only as children find more self-identity can they be independent enough to commit suicide. However, clinicians have now increasingly realised that children and early adolescents have their own ways of showing depression consistent with their level of development, but different from that of adults (Mack & Hickler, 1981, Stevens, 2006).

Beck (cited in Klagsbrun, 1976) described three major characteristics of deeply depressed adolescents. Firstly, adolescents have a negative view of themselves. They constantly put themselves down and believe themselves helpless to change their lives. This could be because they are disconnected from themselves and see no worth in themselves. Secondly, depressed adolescents have a negative view of the world and their relation to it. They distort reality so that even the slightest challenge becomes overwhelming. This could be because the adolescent does not see herself/himself as part of the world – she/he is not connected to it. She/He plays no valuable part of it and the world does not appear to acknowledge her/his worth. Finally, depressed adolescents have a negative view of the future. They expect little to come their way. As their depression deepens, they give up hope that they will ever feel better. For many adolescents in South Africa the future is indeed daunting. Unemployment, affirmative action and poor job opportunities create a bleak future for many adolescents. The suicidal adolescent sees no future for herself/himself because she/he is totally disconnected.

The helpless and hopeless feelings clinically depressed adolescents have, show themselves in their actions. Depressed adolescents may have trouble sleeping, and keep awakening in the middle of the night or the early morning hours. Or, just the opposite, they may sleep all the time, dozing constantly in the middle of the day or the early evening. They usually lose their appetites, eat little, and become drawn and gaunt. Adolescents who feel deeply depressed want to be alone much of the time. They withdraw from family and friends, keeping silently to themselves. They lose their sense of humour, and may cry for the most trivial reasons. Or, when the depression becomes especially severe, they find themselves incapable of crying even when they want to. To adolescents suffering from clinical depression any kind of decision becomes difficult, and even the slightest task becomes insurmountable (Mhlongo & Peltzer, 1999, Klagsbrun, 1976). Because of the break in connection with the outer world, adolescents do not reach out for help even if help is available. Shneidman (cited in Wikipedia, 2007) argues that depressed adolescents who are victims of suicide show a sense of unbearable psychological pain, a sense of isolation and the perception that death is the only solution to their problems.

Profound feelings of worthlessness and lack of self-esteem lie at the base of many severe depressions, and these feelings separate clinical depression from ordinary sadness and grief (Bostik, Everall & Paulsen, 2005). Klagsbrun (1976) states that depressed adolescents tend to blame themselves for whatever bad things have happened to them, and they punish themselves

again and again for the failings they believe they have. This punishment may take the form of suicidal behaviour.

According to Klagsbrun (1976), however, the classical symptoms of clinical depression – withdrawal, crying and inability to sleep, do not make up the complete picture of depression among adolescents. Symptoms of depression may be more concealed, more misleading, and more often misinterpreted. Young people tend to act out their feelings rather than talk about them, to be impatient, impulsive and destructive rather than cautious and thoughtful about what they say and do. As a result, adolescents faced with an agonising problem or suffering from an intolerable situation may not show the slow-moving, oppressive symptoms of despair. An adolescent may suddenly switch from being a pleasant, well-behaved student to a wild and unruly one. Another may drop out of school altogether, or even run away from home. Acting bored and listless and unable to concentrate on even the simplest task may also be a manifestation of depression. Someone who had received top grades may begin failing courses. Someone who had been a healthy athlete may suddenly develop physical aches and pains that have no physiological basis. The range of ways in which depression manifests itself is so wide that it is often masked and therefore the adolescent receives no sympathy or help. An adolescent who is disconnected is seen as a disinterested youth – a delinquent – a trouble causer. She/He is often punished instead of helped and this cements the disconnection. It is this disconnected adolescent that the study hopes to highlight and reconnect with life.

Klagsbrun (1976) states that at the root of many emotionally caused depressions lies a profound sense of loss, of someone or something that has been deeply loved. A depressed adolescent may have lost something real like in the loss of a parent or the adolescent may have experienced the loss of a special feeling or a state of being, such as the loss of power in a relationship or the loss of feeling needed and wanted. In either case the loss is so significant to the adolescent that it leads to overwhelming sorrow along with feelings of weakness and unworthiness. This may be exacerbated when the feelings of loss that the adolescent experiences are not acknowledged by her/his society.

In the case of children and early adolescents the boundary therefore between an affective state or mood and a clinical syndrome is blurred (masked depression); - they rarely show a picture of depression that could properly be called an 'illness'. The reason for this is the variability or fluidity of children's responses to painful or stressful situations. It is when the manifestation of a mood of

the adolescent is merely labelled 'rebellious' that an adolescent may turn to suicidal behaviour or suicide itself.

Depression has been singled out as a major etiological factor in suicide (Rawlings, Williams & Beck, 1993, Stevens, 2006). A state of sadness becomes a psychiatric symptom when it occurs as a mood of such persistence and severity that it interferes for a substantial period with the person's daily routine and adjustment to life. In these circumstances, it is usually accompanied by feelings of anger and guilt or in other instances by an overwhelming sense of complete hopelessness. Depressed teenagers may experience psychomotor retardation (lethargy) or agitation, persistent feeling of worthlessness or inappropriate guilt, and recurrent thoughts of death (Landry, Smith & Guin, 1991).

Freud (cited in Kaplan & Sadock, 1998) stated that suicide represents aggression turned inwards against an introjected, ambivalently cathected love object. Freud doubted that there would be a suicide without an earlier repressed desire to kill someone. Building on Freud's ideas, Menninger (cited in Wikipedia, 2007) suggested that all suicides have three interrelated emotions: revenge, depression and guilt. In attempting to clarify the various components of the psychological theory of depression, the Threshold and Trigger Model, the Cognitive Theory and the Hopelessness Theory will be examined.

The threshold and trigger model is synonymous with the stress-diathesis model. The diathesis of longitudinal issues which may lower or raise the threshold to engage in suicidal behaviour is impinged upon by stressors or a trigger, which precipitates the behaviour. Factors related to the threshold include genetic predisposition, biochemical factors in a person's metabolism, personality traits, the emotional state of hopelessness, and the presence of ongoing support systems. Triggers can include mental disorders or physical illnesses, alcohol and/or other substance abuse, and interpersonal loss or rejection. Clearly these issues are not independent and mutually exclusive. For example, even the biological marker serotonin is influenced by other factors such as diet (in particular it is affected by cholesterol levels); drugs, including alcohol; gender; and age (Powell & Enright, 1990).

Although people have experienced stress throughout history, there is evidence (Powell & Enright, 1990) to suggest that the problems associated with stress have escalated during the last century, particularly in highly developed westernised countries. An explanation for the increase could be

that the pace of life has increased, there's been a decline of traditional structures such as community networks and extended families, there has been a decline of commonly held values, beliefs, and rituals incorporated in traditional religions, changing working practices, greater social and geographical mobility, poor diet, lack of exercise, and even the restrictive medicalization of symptoms (Powell & Enright, 1990).

Lazarus (cited in Powell & Enright, 1990) defined stress as:

> a broad class of problems differentiated from other problem areas because it deals with any demands which tax the system, whatever it is, a physiological system, a social system or a psychological system and the response of that system (p.3).

This definition contains three important components for a model of stress:

- the idea of demands taxing a system
- the idea that there is some form of appraisal or perception of threat
- the importance of the response of that system

The notion of demands taxing an individual or a system implies a temporary state of imbalance or dis-equilibrium. These demands are not just a result of external forces acting on a point, they are rather the result of the interaction between external forces and the internal factors which make up an individual or system (Powell & Enright, 1990).

Powell & Enright (1990) argue that people who are part of an extensive social network (who have the social connections) are less negatively affected by stressful life events. It is also widely maintained that naturally existing support systems, such as extended families, work groups and communities facilitate better coping. Support systems have the following benefits:

- the individual is provided with a means of expressing his or her feelings
- feedback from others is important in helping to develop an appropriate appraisal of a situation and realistic goals, and they also help the person to establish a sense of meaning
- social contacts can also provide useful information and practical help.

If there is no support then there is no connection to others or self. South Africa has limited support structures for the youth. Organisations, like Lifeline, require a telephone for the youth to make a connection. The facility does not offer a free service. Psychiatric Units in hospitals are over-crowded. Churches, and other religious organisations, that offer free counselling may be seen as judgemental. Schools do not have the staff to focus primarily on counselling and support.

An important component of the stress model involves the actual responses of the individual to the stresses. Responses can be differentiated into two groups. The first group is the adaptive responses. It includes those actions which help to alleviate the stress and return the system back to a state of equilibrium. The second group is the maladaptive responses – those actions which serve to exacerbate existing demands and keep the system in a destabilized state.

Adaptive coping is likely to include:

- recognising the external stressors and demands and being aware of personal resources to cope
- basically understanding what is going on (this can include healthy worrying about the situation while taking a problem solving approach
- taking action to reduce external demands (this may include such strategies as making life changes, setting goals, deciding on priorities, time management, delegating, or being more assertive
- taking action to reduce internal demands (this might include taking time to physically relax, altering unhelpful thinking patterns, ventilating repressed emotion and deliberately trying to change behaviour

Maladaptive coping strategies are those that are likely to produce further problems by failing to recognise and understand what is happening. This may involve catastrophic irrational misinterpretations about the situation at hand leading to a spiralling vicious circle of increased anxiety and increased worry. Maladaptive behavioural responses would include avoidance of situations which produce anxiety, withdrawal from social support, aggression, excessive alcohol consumption, tranquillizer misuse, drug abuse, physical problems. The long-term effect of these maladaptive strategies is a general loss of confidence in the person's ability to cope on their own and the development of secondary problems such as phobic anxiety, tranquillizer dependency,

alcoholism, drug addiction, physical illness and depression (Powell & Enright, 1990). These could be manifestations of suicidal behaviour.

Reports of completed and attempted suicide reflect three disorders as often presenting co-morbidly with the frequency and lethality of attempts – conduct disorders, substance abuse disorders and affective disorders (Frances & Blumenthal cited in Bongar, 1992). Maladaptive coping strategies manifest themselves when the adolescent fails to connect with the outside world and then primarily with herself/himself and turns to destructive behaviour.

Beck's (1967, 1987) cognitive theory of depression proposed that dysfunctional schemas act as vulnerability factors for depression. When stressful events are interpreted in the context of dysfunctional attitudes certain negative actual event perceptions will occur that may give rise to depressive symptoms (Robins and Block, 1989). Beck's negative cognitive triad of depression implies that a negative view of the self increases as a function of depression. The negative view of the self leads to the general hypothesis that depressed people attribute success to forces beyond their control such as easy task or good luck. Under conditions of failure attributions stating lack of skill, ability or lack of effort as reasons for failure, will increase significantly as a function of depression. Under stressful circumstances these global, rigid, negatively toned beliefs create a distorted, negative view of the self, future and world (the negative triad).

When depressed persons find themselves in stressful situations, they tend to focus on and then exaggerate the negative aspects of those situations. Even if the event is truly negative, the depressed person exaggerates the negative aspects of the event, and ignores positive information beyond that which other people would consider appropriate. The negative thinking typical of depressed patients produces a negative cognitive shift in which the patient's cognitive information-processing system changes (Beck, 1987). With the passage of time, enduring sets of negative beliefs and attitudes tend to make a person more vulnerable to depression whenever she/he is in a stressful situation. Particularly salient are events perceived as reminiscent of the past experiences from which the present dysfunctional attitudes evolved.

The distorted cognitions and subsequent behaviours of a depressed adolescent can vary from her/his social skills to her/his concentration ability to her/his attitude towards authority. The depressed individual may not act her/his age or be emotionally distraught or seek too much attention. Socially the depressed adolescent may be isolated and shy and prefer to be

unaccompanied. Cognitively the depressed adolescent may be lazy and incapable of learning and may underachieve. She/He may not be able to sit still in class or have long concentration duration. The depressed adolescent may also be rebellious towards authority as well as stubborn and un-obliging (APA, 2006). Because the depression is masked the depressed adolescent is often punished and this pushes the adolescent even further away from social contact. This straining of a connection or breaking of a connection may lead to suicidal tendencies.

A significant error in the depressed patient's thinking involves high levels of negative expectations about the future (Beck & Lester, 1976). The person sees no connection to anything positive. Beck operationally defined a negative view of the future as hopelessness. The hopelessness theory of depression (Abramson, Metalsky & Alloy, 1989) is a cognitive diathesis-stress model of depression which postulates that individuals who possess particular dysfunctional inferential styles (diathesis) are at increased risk for becoming depressed when they experience negative life events (stress).

Hopelessness is defined as an expectation that highly desired outcomes are unlikely to occur or that highly aversive outcomes are likely to occur, and that no response in one's repertoire will change the likelihood of these outcomes. The individual has connected herself/himself to negative life expectancies. Specifically individuals who explain negative events in terms of internal, stable and global causes are hypothesised to be more likely to develop symptoms of depression or even full blown episodes of depression, than individuals who make external, unstable and specific attributions when confronted with negative life events. If such an individual does not have positive support structures in place it could open the way for destructive behaviour.

A depressogenic attributional style is considered a contributory cause of depression in the presence of stress. Hopeless is seen as the proximal sufficient cause of depression while the two distal contributory causes are negative attributional style (diathesis) and the presence of negative life events (stress).

3.4.2 Attribution Theory

A popular definition of attribution is the perception of causes of behaviour (Harvey, Orbuch & Weber, 1992). Both the approach and method of attribution theory has developed out of the area of social psychology known as person perception. It is concerned with how and why ordinary people

explain events and behaviour. The basic data for any attribution are the actions of persons. People find themselves asking: How are our actions to be interpreted and understood? How does the social environment affect the perceptions of one's own behaviour? What are the underlying regularities in another's personality? Thus the 'primary' focus in attribution theory is on the processes by which the 'person on the street' forms an understanding either of observed or of personal events.

According to the attribution theory proposed by Heider (cited in Radford & Govier, 1991), we tend to attribute people's behaviour to one of two basic causes- either something internal or to something external. Radford & Govier (1991) describe internal causes as physical factors, like health, energy level or hormonal changes, psychological factors like habits, attitudes, abilities or lack of them, and personality traits. External factors can be classified as physical, social or pure chance: economic conditions, climate, temptations, barriers and the like on one hand and the demands of social situations and roles, pressure from other people widely held norms of conduct and so forth on the other.

Attribution theorists therefore look for the causes of behaviour – to what they can attribute the behaviour to. Some contemporary psychologists have adopted a point of view that attributes almost all behaviour to the impact of the situation, swinging the pendulum far in the other direction from the classical point of view that people acted according to their basic temperament and were relatively impervious to situational influences (Papalia & Olds, 1985).

Even though all of us experience a degree of conflict from varying social demands in our daily lives, it seems that some of us are more vulnerable to these pressures than others. Furthermore, we differ in the ways we think about and explain our lives to ourselves. Attribution theory, as stated by McMahon (1982), focuses on the inferences we make, the attribution we give to various events in our lives, the kind of motives we attribute to other people and the kind of causes we attribute to the outcome of a problem.

An elaboration of one such aspect is the degree to which people see themselves as controlled by inner or internal forces versus outside or external ones. This area of study is called locus (place) of control, which refers to where people believe the influence on their lives comes from. For example, some people feel basically in charge of and able to affect the outcomes of events in their lives. For these people, their locus of control is internal, or inside of them. These individuals have a sense of connection with their 'self' and therefore believe that control of the 'self' lies within

their power. On the other side of this coin of course are people who view themselves as generally at the mercy of outside forces: who see their lives as moulded less by their own actions than by things that happen to them. Basically, these people feel that they have less important impact on themselves than do other people, events, or situations. Their locus of control, then, is external, or outside of them. These individuals allow themselves to be controlled by outside forces. When the connection with outside forces is broken the individual is lost – her/his life has no direction.

Obviously, no one is completely internally or externally controlled at all times; but as a general approach, people tend to lean in one direction or the other, and it does make a difference. For instance, internals tend to have a higher level of self-confidence and a lower fear of success, and do better in academic settings, while externals tend to be over anxious and fearful. Furthermore, since externals feel they have little control over their performance, they tend to give up more easily in problem solving, to pay less attention to information that could be helpful, and to generalise expected failure to more situations in the future than internals (McMahon,1982).

One area in which events seem to have a considerable impact is that of learned helplessness. It refers to a situation where the individual has learned that he or she has no control over the outcome of a predicament, can do nothing to change things, and as a result becomes depressed and gives up – a horrible feeling. Once it starts, three things occur. The first is that motivation to keep trying is drastically reduced; the second is that the tendency to see success as a future possibility decreases; the third is that emotions become depressed. A few people become angry or frustrated instead of depressed (McMahon, 1982).

Many consider suicidal behaviour the most severe form of withdrawal (Durkheim, 1999, Bhamjee, 1984). It is, in a sense, the ultimate in removing oneself from day-to-day problems. In general, suicidal behaviour seems to be an outgrowth of depression, but the length, nature, and cause of the depression cannot be pinpointed. Frequently what seems to be a minor setback will trigger the suicidal behaviour. Possibly in these cases there has been a long, slow build-up of problems, and the one that triggers it is the so called last straw.

Reasons for suicide – the oldest theory of why people kill themselves is that they are trying to pay themselves back, that is, they direct their aggression and guilt inwardly onto themselves and do themselves in (Bhamjee, 1984). Obviously, such people would be punishing themselves for some assumed misdeed or series of 'bad' behaviours that they feel they have committed (Klagsbrun,

1976). More recent ideas seem to point toward suicide as being a form of outward aggression in which the individual is trying to pay others back for what they have done, or not done (Kaplan & Sadock, 1998). Suicidal people often feel that others have been very unfair, and they express anger at this situation by showing loved ones just how bad they have been – they have attributed to a suicide.

A fairly substantial number of persons attempt suicide or engage in suicidal behaviour to manipulate others and get others to do what they want. They may, of course, be quite legitimate in what they are complaining about, but the behaviour leaves quite a bit to be desired. Most people who threaten suicide are trying to convey a message - seeking help, rather than really trying to kill themselves. Suicidal behaviour is a warning of a suicide and therefore there is still some hope that they will be 'heard'. Many adolescents who eventually commit suicide feel isolated, alienated, unloved and disconnected. They have suffered a number of losses or deprivations, and cannot seem to find any solutions to their predicament. They have failed to connect meaningfully with others and themselves. A feeling of hopelessness and meaninglessness fills them leading to the possibility of a suicide attempt (McMahon, 1982). They have lost their connection and identity with self and with others.

3.4.3. Personality and Identity Theory

Heavy drinking has been listed as a form of indirect self-destructive behaviour (chapter 2) and alcoholism has been described as 'chronic suicide' by McCulloch (1972). According to psychoanalytic theory the alcohol addict has an oral narcissistic personality. That is to say she/he has been frustrated at the oral stage of development and has become disappointed by her/his mother. Alcohol, because of its sedative and hypnotic effects, helps to relieve mental tension and depression but does nothing to cure them, and therefore the individual develops a need to 'increase' intake to ensure continued relief. The dependence on drugs to relieve tensions and facilitate social relationships produce much the same picture as for alcoholism, and it is known that one of the characteristics of the addict is her/his inability to maintain social relationships. She/He is frequently described as a 'loner' who, when in the company of fellow addicts, tends to live alongside them rather than with them – she/he lacks the social connection.

Adolescents may during times of stress form intense, sometimes passionate attachments (connections), often largely in fantasy, to peers, teachers or other adults (Mack & Hickler, 1981). These relationships/connections, which may have profound meaning for the adolescent, are at times dismissed too casually by adults as 'crushes'. Often these idealised love relationships seem to reflect a desire on the adolescent's part to find once again the parent of early childhood experienced in the first stages in the development of the ego ideal. An exploration of these feelings through therapy and counselling could lead to the development of a healthy self with a strong connection to ones inner self.

The very process of becoming a person, of assuming an individual identity and a separate sense of self, leads to the experience of isolation and loneliness. Erikson (cited in Peterson, 1986) argued that the developmental task of adolescence is the achievement of identity. Adolescents need to establish identities as preparation for the various adult roles. Marcia (cited in Peterson, 1986) articulated identity statuses based on the extent of crisis and commitment in the search for identity. Evidence of some crisis as well as current commitment to an identity is required for the status of identity achievement. The lack of a crisis leads to a premature foreclosed identity. Adolescents without a commitment to an identity, whether or not they have experienced identity crisis, are said to have a diffused identity. Those in active crisis and with vague commitment to an identity are said to be in moratorium. Marcia revealed that the identity status of an adolescent is related to anxiety, self-esteem, authoritarianism, moral development, and autonomy. Adolescents with a fully developed identity have control of their anxiety, higher self-esteem and a stronger connection with self and society.

The process of individuation – which Brennan (1986) believes every normal adolescent must navigate – includes separation from parents, as well as the assumption of increased autonomy and individual decision making. Personal autonomy is demonstrated by taking greater responsibility for one's thoughts, values, decisions and behaviour. Confronting separation and assuming responsibility are major sources of growth, change, and development in adolescence. The assertion of autonomy necessitates moving away from others. Separation and loneliness are bound together in the unfolding process of the development of an individual identity. If the individual does not have a connection with the self, she/he will find the separation from others difficult or in some cases impossible.

Loneliness is a feeling that can lead us towards greater exploration of who we truly are and what we have to give to this world, and thus towards authentic connection – or it can lead to self-destructive actions in our desperate attempt to fill the emptiness inside. Loneliness has been linked to a number of serious mental health and behavioural problems that beset adolescents. The behavioural problems include drug abuse, alcoholism, suicide, delinquency, prostitution, exhibitionism, academic failure and depression. Loneliness, in this study, is viewed within the context of affective disorders and suicidal behaviour. The experience of loneliness for adolescents can be painful, so painful that adolescents will do almost anything to avoid it (Klerman, 1986). Klerman identifies 4 types of loneliness: emotional, social, spiritual and existential.

Emotional loneliness is seen as emerging from deficits in intimate relations: romantic separation, divorce and bereavement. Weiss (cited in Brennan, 1986) sees emotional loneliness primarily as stemming from loss of attachment figures. The individual does not have a close intimate attachment to another, yet desires such an attachment. Emotional loneliness can only be remedied by developing a new intimate attachment or recovering the one that has been lost – establishing or re-establishing a connection.

Social loneliness (Brennan, 1986) stems from deficiencies in social connectedness or social integration into a peer network or community. The individual's needs for a sense of belonging or integration are frustrated. The dominant symptoms of social loneliness are feelings of boredom, aimlessness, marginality and rejection. The need for integration with peers and friends is critically important for adolescents as they move beyond the orbit of their families. There is an intense need for close relations among adolescent peers as family kinship groups are increasingly unable to meet the relationship needs of youth. Social and peer relationships beyond the family provide many important provisions to the adolescent. In some instances, adolescents enlist the support and encouragement of a peer network to help in the often difficult task of separating from parents. Thus, the rewards and payoffs stemming from the tight affiliation with peers are potentially many. The isolation and friendlessness reported by many adolescents may constitute a serious handicap as they confront the developmental challenges of this life stage.

Brennan (1986) describes the term spiritual loneliness to indicate a form of loneliness resulting from perceived deficits in the meaning or significance of a person's life. Spiritual loneliness is perceived as emerging when the need for significant activities or commitments is frustrated. Humans have a deep need or 'will' to seek meanings, purposes, and higher values which extend

beyond egocentric goals. Fromm (cited in Brennan, 1986) uses a synonymous term - 'moral loneliness'- to indicate a lack of relatedness to such values and meanings. Feelings of boredom, aimlessness, emptiness, and despair make adolescents highly vulnerable to spiritual or moral loneliness. Experimentation with drugs, the adulation of heroes and celebrities, as well as the search for meaningful educational and work commitments, may all be seen as reflections of the active search for morality and value (Brennan, 1986).

Existential loneliness is a term used to describe a form of loneliness that is seen as stemming from an awareness of the basic human condition of separateness, a consciousness of mortality, death, and human finiteness, as well as the complete personal responsibility for one's life. It refers to an 'inner sanctum' where each person must stand alone. This form of loneliness is seen as emerging from a reflexive self-awareness of individuality and separateness. According to Brennan (1986) confrontation with this form of isolation is fundamentally tied to the process of individuation and to assuming autonomy and independence. If the adolescent can give herself/ himself a purpose to live then life has meaning and suicidal behaviour is avoided.

Loneliness in whatever form pulls the adolescent away from living and life and towards dying and death. Obviously, differences exist between the motives and methods of young people who engage in suicidal behaviour and those who actually kill themselves. In Klagsbrun's (1976) opinion adolescents who are more determined to die usually use more violent and destructive methods. Many adolescents who turn to suicidal behaviour have no intention of dying. They act out their cry for help consciously, and they choose methods that give them the greatest leeway to be saved. They may take a small dosage of pills that could be barely lethal. They may turn on the gas in a closed room, but leave a leak in a wall or window unplugged. They may make superficial slashes on their wrists. They may turn to delinquent behaviour.

3.5. CONCLUSION

I have drawn on the principles of Sociological and Psychological theories to pull together the theory of Connectivity. The thinking behind these theories also directed the data collection and analysis. We live in a society today that Durkheim (cited in Klagsbrun, 1976) would have classified as anomic, a society in which rapid changes have brought great unrest. The changes have had an especially strong impact on adolescents, and the mushrooming rate of young suicides

reflects that impact. Ways of life that people used to take for granted have changed radically in our society in just a short time. At one time the family served as a centre for the teachings and traditions of society (Peterson, 1986). Today people question the very value of the family itself. Adolescents in South Africa, in the post-conventional stage of development, battle to understand the concept of individual responsibility, the responsibility of the larger society and the relation between the two.

According to Klerman (1986) there is a relation between physical health and mental health. Both are enhanced through the maintenance of strong family ties, the assistance of supportive friends, and the use of community support systems. Overall today, the health of adolescents is very good. This was not true before the 20th century, when problems of poor sanitation and urban crowding contributed to high death rates from infectious disease, nutritional disorders, and other conditions. With the improvements in sanitation, nutrition, and housing in the general society, and with the improvement in general health care, death among adolescents should no longer be a serious problem in modern urban and industrial societies (Klerman, 1986).

However, the increase in the number of deaths today amongst adolescents is for very different reasons. The negative messages about families and children have a double impact upon developing adolescents and young adults. First, as children, they experience the burden of being undervalued and in some cases neglected by the society. Second, as emerging adults, they face a rather bleak future (increase in crime, poor job prospects etc.). The major social tasks of young adulthood include work and family. With high unemployment and intense competition for available jobs, many young people may despair at not being able to find any work, much less meaningful employment.

The normal adolescent is engulfed in a developmental process in which social and intimate relationships are rapidly changing (Brennan, 1986). These transitions inevitably involve faltering beginnings, disappointments, and endings. The exciting possibility of heterosexual relationships also brings a new reality – strong desires, as well as the possibility of failure, rejection, frustration, and consequent feelings of loneliness and loss. Few adolescents escape the pain of loneliness. For most, the duration and intensity of feelings of loneliness, and their ways of coping and responding to these feelings, may be a persistent and ultimately damaging aspect of their lives.

The increased complexity of our society, with the resulting demands upon the adolescents who must learn to live in society as responsible adults, plays a major role in the increased incident of suicidal behaviour (Peterson, 1986). Since it is unlikely that we can transform our society into a simpler one, the task is to find ways to help adolescents, their parents and their schools to cope more effectively with the demands placed on them. The greatest demand on parents and educators is to provide a nurturing environment but with firm guidelines.

It is ironical that black adolescents who have far more opportunity in this country under the present regime are often the ones to indulge in at risk behaviour (Schlebusch, Vawda & Bosch, 2003). It could be that in the fight for liberation adult authority was rejected and a culture of freedom from boundaries set in - the youth do not have the security of a structured society governed by strong moral values or good governance. There is no connection to an ordered larger community so in essence there is no connection to self.

It is clear from the various social and psychological theories that suicide is a multi-dimensional phenomenon. The Theory of Connectiveness forms the common thread across the dominant theoretical landscape. It would have been rather arrogant to just toss aside the decades of research on the topic. In formulating the Theory of Connectiveness, I considered the theories already out there and chose a multimodal theoretical approach. Consideration was given to the various contributory factors: genetic or constitutional factors, family history of depression or suicidal behaviour, specific evidence of biological susceptibilities in infancy, the family or community into which the child was born, the disturbances of development at each period of childhood that might have contributed to the vulnerability towards suicidal behaviour, the reverberation of family life and relationships, of the experiences in the neighbourhood, school, community and larger society (particularly as transmitted through television) and the circumstances and thinking of the adolescent in engaging in the suicidal behaviour. The bio-psycho-social factors and the vast research into them fore-grounded and developed my Theory of Connectivity. In the existing theories the concept of connectiveness is alluded to, it is implied but it is never made the focal point of discussion. This is a fundamental omission and perhaps therein lies the key to unlocking the mystery of suicidal behaviour. It is with this in mind that this study was undertaken.

The methodology chosen is reflective of the exploratory and diverse nature of the study. This will be discussed further in chapter four.

CHAPTER FOUR
RESEARCH METHODOLOGY

4.1. INTRODUCTION

The research methodology for this study is positioned somewhere between the paradigms of postpositivism and interpretivism. The postpositivistic paradigm was used as a springboard for the interpretism. Although it was necessary to pit these two paradigms against each other in explaining the essence of each, I found that combining the two for this study provided an insight into the phenomenon of adolescent suicidal behaviour that neither one could provide alone. This becomes clearer as the chapter develops.

According to Leedy (1989) a method is, very simply, a way of accomplishing something. However, the nature of the data and the problem for research should dictate the research methodology. If the data is verbal, the methodology is qualitative (interpretivism). If it is numerical the methodology should be quantitative (positivism). Durrheim (2002), however, points to the hotly disputed debate of some researchers who question whether it is possible to quantify social and psychological phenomena.

The prevailing research paradigm in the 1970's and 1980's was positivism. Positivism assumes an objective world which scientific methods can more or less readily represent and measure, and it seeks to predict and explain causal relations among key variables. Critics argued that positivistic methods strip contexts of meanings or distort meanings in the process of developing quantified measures of phenomena (Guba & Lincoln, 1994). In particular, quantitative measures often exclude subjects' meanings and interpretations from data which are collected. The experimental or survey methods used by positivists impose a view of the world on subjects rather than capturing, describing and understanding these world views. They impose outsiders' meanings and interpretations on data. Quantitative and positivistic methods tend to exclude discovery from the domain of scientific inquiry.

Post-positivism is a recent evolution of positivism – it is consistent with positivism in assuming that an objective world exists but it assumes the world might not be readily apprehended and that variable relations or facts might be only probabilistic, not deterministic. The structured

questionnaire (a tool of positivism) used in the study was designed with this in mind. The facts gathered on the biographical background of the respondents and the support structures were examined for probable causes of suicidal behaviour.

Interpretive research is fundamentally concerned with meaning and it seeks to understand subjects' definition of a situation (Schwandt, 1994). The primary goal of interpretive (qualitative) research is the generation of theory- rather than theory testing or mere description. According to this view, theory is not a perfected product but an ever-developing entity or process. Qualitative research has an emergent (as opposed to a predetermined) design, and researchers should focus on this emerging process as well as the outcomes or product of the research.

Interpretivists assume that knowledge and meaning are acts of interpretation hence there is no objective knowledge which is independent of thinking, reasoning humans. Interpretive researchers therefore prefer meaning (versus measurement) orientated methods. Data collection and representation are accomplished with informant interviewing (Spradley, 1979). This is in contrast to positivism which is concerned with objective reality and meanings thought to be independent of people (Schutz, 1973).

Thus far there is substantive research in the field of suicidal behaviour based on the positivistic medical model. Suicide, however, still remains very much an enigma. There is an urgent need to engage in research that probes for deeper understanding rather than merely examining surface features - that is more qualitative studies. This study makes a start to fill the gap. It describes, explores and interprets adolescents' feelings and their suicidal experiences in human terms rather than through quantification and measurement.

Mouton & Marais (1990:204) describe the qualitative paradigm as one that is: "based on induction, holism and subjectivism; the researcher attempts to understand a situation without imposing pre-existing expectations on the setting". Mouton & Marais (1990) explain that induction refers to the gathering of specific observations and building towards general patterns, holism suggests that data should be gathered from numerous sources to construct a complete picture of the social dynamics, and data should be subjective in that the focus is on the experimental states of actors and their perceptions of the situation.

Eisner (1991) outlines the six features of a qualitative study:

- it tends to be field focused - those conducting research go out to schools, visit classrooms, and observe adolescents and teachers (I went out and engaged with learners at a particular school).
- the self is considered an instrument. The self is an instrument that engages the situation and makes sense of it (I became the instrument. It was important for a connection to be established between me and the learners so that they became willing participants)
- a third feature that makes the study qualitative is its interpretive character. Interpretive here has two meanings - inquirers try to account for what they have given an account of and qualitative inquirers aim beneath manifest behaviour to the meaning events have for those who experience them (I had to make sense of the experiences of the learners by interpreting what they said and what they did not say – interpretation was based on the Theory of Connectiveness)
- qualitative studies display the use of expressive language and the presence of voice in the text (the voices are the narratives of the learners)
- a fifth feature of qualitative studies is their attention to particulars (the learners' every word, every nuance and every allusion were considered important for interpretation)
- a sixth feature of qualitative studies pertains to the criteria for judging their success. Qualitative research becomes believable because of its coherence, insight and instrumental ability.

Qualitative methods can be used to better understand any phenomenon about which little is known. They can also be used to gain new perspectives on things about which much is already known, or to gain more indepth information that may be difficult to convey quantitatively (through the use of the questionnaire). The questionnaire provided a context or description of the current status of the sample. The case study included as a section within the questionnaire, on the other hand, allowed for the exploration of the learners' feelings around suicidal behaviour. The qualitative methodology proved to be a powerful tool for enhancing our understanding around the phenomenon of suicidal behaviour. The post-positivist paradigm looked at the qualitative details – it provided the background. The interpretative paradigm was utilised to decode and begin to understand how suicidal behaviour manifests itself in different individuals.

4.2 RESEARCH APPROACH AND METHODS

Bongar (1992) notes that there are two approaches to studying suicide: the nomothetic (tabular, statistical, demographic, arithmetic) approach, and the idiographic (clinical, case study, personal document, historical, anamnestic) approach.

A *case study design*, as an evaluation research approach and a generalization from it, builds a basis for valid inferences (Yin, 1994). While survey (tabular) research relies on statistical generalization, case studies rely on analytical generalization. In statistical generalization, an inference is made about a population on the basis of empirical data collected about a sample (i.e. surveys). In analytical generalization, the investigator is striving to generalize a particular set of results to some broader theory. Case study research excels at bringing us to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research. Case studies emphasize detailed contextual analysis of a limited number of conditions and their relationships (Yin, 1994).

Researchers use the case study method to build upon theory, to produce new theory, to dispute or challenge theory, to explain a situation, to provide a basis to apply solutions to situations, to explore, or to describe an object or phenomenon. The advantages of the case study method are its applicability to real-life, contemporary, human situations. It facilitates an understanding of complex real-life situations (Yin, 1993, Stake, 1995, Hamel, 1993). Case study is an ideal methodology when a holistic, in-depth investigation is needed (Feagin, Orum & Sjoberg, 1991).

The use of the case study (qualitative) approach in the exploration of the enigmatic phenomenon of suicide appeared to be most suitable. The methodology in this research also needed to consider the nature of the information required - the complexity and sensitivity of the topic of suicidal behaviour had to be borne in mind. Since this research also aimed at making certain assumptions about learners at the Secondary School chosen for the case study, the survey questionnaire was used. It included a section on biographical details and certain behavioural manifestations. It allowed merely for the description of the sample group and an exploration of adolescent suicidal behaviour. I was constantly aware that the phenomenon of suicidal behaviour could not be adequately examined through the kinds of questions that are posed by hypothetico-deductive methods and addressed with quantifiable answers (Jensen & Jankowski, 1995).

It is solely for this reason that the interview and the open-ended questions (part of the questionnaire) were chosen as instruments. This allowed me to understand behaviour from lived experiences of youth, understand different contexts and to see inter-connectiveness and patterns. The exploratory nature of the research necessitated a qualitative interpretative research approach: a methodology which is seen to be preferred when "attempting to uncover and understand any phenomenon about which little is known" (Van Maanen, Dabbs & Faulkner, 1982:53).

According to Burns (cited in Leedy, 1989:140) qualitative methodology should:

- be an alternative to the experimental method
- consider words as the elements of data
- be primarily an inductive approach to data analysis and
- result in theory development as an outcome of data analysis.

The interpretative paradigm, using the unstructured interview, appeared to be most appropriate in fulfilling the above criteria.

4.3. CHOICE AND DESCRIPTION OF RESEARCH AREA

The Lower Tugela Circuit in the North Coast of Kwa-Zulu Natal was chosen. The area reflected the socio-economic spectrum of South Africa. Some learners came from very affluent backgrounds and other learners lived in shacks. This area also had very limited psychological support from the Kwa-Zulu Department of Education as no psychologists were based in the area. PGSES (psychological and guidance services) had its office in Durban (outside the area of jurisdiction). Support to schools in the North Coast, if any, was largely telephonic. The Lower Tugela Circuit had also reported a high number of adolescents who had successfully committed suicide.

4.4. PROCEDURE TO OBTAIN THE SAMPLE

4.4.1. Selection of school

A study of this nature needed to be dealt with sensitively and compassionately. It was for this reason that I opted for the case study approach - choosing to examine suicidal behaviour amongst adolescents attending a particular secondary school in the Lower Tugela District of Kwa-Zulu Natal. Two schools were initially considered because of their diverse makeup in respect of race, ethnic background and social class. Both schools were within walking distance of each other. The first secondary school approached, granted permission for the research to start immediately.

The learner population at the chosen school shared a similar socio-economic background with the other pre-selected nearby school. This school had also lost a number of adolescents to suicide. Two years ago the staff and Governing Body hosted a one-day workshop on Suicide. The facilitators were two experienced clinical psychologists based in Durban. The number of suicides and attempted suicides did not decrease after this. It was primarily for this reason that it became the number one choice.

A study of this nature was bound to arouse emotions in adolescents who were already suicidal. The research subjects preferred to remain anonymous. The study required intense probing and patience. As a registered psychologist, I made counselling sessions available to those in need of counselling. I resided and worked in the area and counselling was made available during and after school hours.

4.4.2. Seeking permission/consent

Prior to conducting the research, I sent out the following correspondence (see APPENDIX A):

- a letter to the Department of Education requesting permission to conduct the study at the selected schools
- a letter to the principal explaining the purpose and nature of the study
- a letter to the Governing Body Chairperson requesting permission to conduct the research at the school

- a letter to the parents of adolescents requesting their permission to administer the questionnaire to their children

4.4.3. Selection of the sample

In the definition used by various authors (Brink & Wood, 1994, Polit & Hungler, 1995) a population is the entire group of persons or objects that are of interest to the researcher, or, that meets the criteria the researcher is interested on studying (Brink, 1996). Population is sometimes referred to as a target population. According to Burns & Grove (1993), an accessible population is a portion of the target group to which the researcher has reasonable access. The population chosen could be described as 'accessible' to me as I was not only an educator and a psychologist in the area but also a resident. Consent was granted by the governing body and principal of the chosen secondary school.

Dempsey & Dempsey (1992) defines sampling as the process of selecting a number of individuals from the delineated target population in such a way that the individuals in the sample represent as nearly as possible the characteristics of the whole target population. Although there is no simple formula that indicates how large a sample should be in a given study, Polit & Hungler (1995) advised that the larger the sample, the more representative of the population it is likely to be. Dempsey & Dempsey (1992) become more specific when they state that a sample of 10% of the population is considered a minimum for a descriptive study.

I decided to use grade 10, 11 and 12 adolescents. Grades 8 and 9 adolescents were excluded from the study. This was because during the baseline and pre-test procedures it was discovered that grade 8 and 9 learners had a 10% or greater rate of reading disorders and/ or reading difficulties. Many of them had problems identifying basic words like 'had' and 'the'. It was alleged by some secondary school personnel in the Lower Tugela Circuit that primary schools were not focussing sufficiently on teaching reading skills. (Interestingly enough, a masters student conducted her research on reading disorders with grade 8 learners at the school at the same time this research was being done.) The choice to exclude grades 8 and 9 from the study appears to be a prudent one in hindsight as the results may have been distorted considering the reading difficulties experienced by learners in the Lower Tugela District. I did not have the luxury of time to conduct an oral administration of the questionnaire with the grade 8 and 9 learners.

4.5. RESEARCH INSTRUMENTS USED

The survey questionnaire (post-positivist paradigm) and an unstructured interview (interpretative paradigm) were used in the study to obtain data to answer the critical questions.

4.5.1. The survey questionnaire

Burns & Grove (1993) define a questionnaire as a printed self-report form designed to elicit information that can be obtained through written responses of the subjects. Polit & Hungler (1995) found that personal presentation of questionnaires to individual respondents have a more positive effect on the rate of questionnaires returned. It was solely for this reason that I chose to personally conduct the administration of the questionnaires.

The study made use of a structured questionnaire where the questions were presented in exactly the same way with the same wording and in the same order for all the subjects. The questions could have been asked by me or could have been given to the subjects as a 'paper and pen test'. In either case, the questions would have been asked in the same order for all the subjects so that the order of questions would not have affected the subject's responses (Brink & Wood, 1994). I elected to go with the 'paper and pen test' for all respondents because of the time factor and the large number of respondents.

Closed questions were designed to limit the respondents to a set of standardised responses. Schools in the Lower Tugela District, including the case study school, have a majority of learners who have English as a second language. The wording in the questionnaire needed to be simple and unambiguous. The respondents were asked to tick responses that applied to them. Closed questions were used where complete lists of possible answers were available. These responses were analysed statistically. This was a great advantage. Responses were standardised. There were no difficult and irrelevant responses that were problematic to analyse. The disadvantage of the 'closed' questions, however, was that it produced superficial information. The responses were limited to my choice of categories and the responses were not in the respondents' own words.

The open-ended part of the questionnaire (based on a fictitious character 'Sarah') was short and uncomplicated. This was done so as not to frustrate the second language learners. The open-ended questions were intended to reflect the words of the respondents and not my words. It was framed to

support the discovery of new information. It provided an opportunity for the respondents to test the strength of their ideas and opinions. It was designed to give respondents complete freedom of choice in answering and thus allowed me to derive in-depth information on suicidal behaviour. This method was also adopted because there was insufficient information available on the topic to permit complete lists of alternative answers.

The advantage of the open-ended questions based on 'Sarah' was that they produced extensive information. The responses were free from bias of predetermined or suggested answers. Many facets of the respondents' behaviour were revealed. The disadvantage of the open-ended questions was that they could not be analysed statistically like the rest of the questionnaire. There were many incoherent answers and much irrelevant information was received. The grouping of answers may have resulted in some loss of meaning.

The questionnaire was administered during the second week of the third term in 2005. This time was considered most convenient and appropriate by the principal and staff of the school as third term tests were due to begin the following week and learners would be fully occupied in the academic programme of the school. The participants completed the questionnaire over a period of three days. Grade 12 completed it on Tuesday, Grade 11 on Wednesday and Grade 10 on Thursday. The school hall was chosen as the venue as it was able to accommodate all learners in the particular grade at the same time. I was able to conduct the administration of the questionnaire with the assistance of a postgraduate student in Psychology. The answering procedure was explained to all participants prior to assessment. The participants were assured that their responses would be anonymous and confidential. No members of school staff were present during the administration of the questionnaires. Care was taken to ensure that learners were seated such that they could not see the responses of their classmates. I was available during the testing to clarify any test-related questions.

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The questionnaire consisted of five sections. The first section required adolescents to fill in personal details. The second section required information about parents. The third section examined the adolescent's problem solving skills and the resources used in problem solving. The fourth section questioned the adolescent's relationship with his/her parent or guardian. The last section was an open-ended section depicting an individual (Sarah) with family and school problems. The adolescents were required to respond to the problem solving skills in the scenario.

Following the completion of the questionnaire, the participants were granted the opportunity to raise any questions related to adolescent issues and problems. The participants were then invited to volunteer for the participation in the unstructured interview. I provided my contact details so that adolescents could consider the invitation. It also allowed for the anonymity of participants to be sustained.

4.5.1.1. Process of validation of questionnaire

The questionnaire was constructed and then face validity established by requesting a Research Psychologist, an Educational Psychologist, a Secondary School Life Orientation teacher and a Grade 12 learner to comment individually on the questionnaire.

The Research Psychologist advised that the formatting, layout and numbering of the questionnaire needed to be revised. The Educational Psychologist advised that the addition of an open-ended section to the questionnaire may yield rich and useful information. The Life Orientation teacher and the learner were comfortable with the questions and felt that they were relevant, sensitive, straight-forward and thought provoking.

Since there were no major problems with the questionnaire, the minor changes were effected and it was then administered.

4.5.1.2. The pilot project

One method used by researchers to test practical aspects of a research study is to conduct a pilot study. A pilot study is a small-scale study which is conducted before the main study on a limited number of subjects from the same population as the intended for the eventual project (Brink, 1996). The function of the pilot study is to obtain information for improving the project or for assessing its feasibility. The pilot study may reveal that revisions are needed in one or more aspects of the project (Polit & Hungler, 1995).

According to Nieswiadomy (1993) there is no set number of persons needed for the pilot study, but a fairly common number is about 10 subjects. The pilot study was conducted at my consulting

rooms. The participants were 10 adolescents in grade 10, 11 and 12 who were engaged in therapeutic and counselling sessions with me because of problematic behavioural patterns as defined by their parents or by school personnel.

During the pilot study one word (bullying) created a problem. A couple of respondents had never heard of the word. The meaning of 'bullying' was briefly discussed during the actual data collection in the hope that every participant would attach the same meaning to the item. The pilot sample was not included in the main sample.

4.5.2. The interview – qualitative research

The Interview formed the basis of the case studies. The case study approach was chosen because it helped to illuminate the Theory of Connectivity. The interviews allowed for qualitative data to be collected.

Qualitative research, broadly defined means any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. Where quantitative researchers seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead illumination, understanding, and extrapolation to similar situations. Qualitative analysis therefore results in a different type of knowledge than quantitative inquiry.

An interview, according to Brink (1996) is a method of data collection in which an interviewer obtains responses from the subject in a face-to-face encounter or through a telephone call or electronic means. Interviews are central to the qualitative research process. They take various forms, including those which are highly structured through the use of a questionnaire, and informal exchanges in which the interviewer is working with a set of guidelines but allows the respondent considerable scope to move the discussion in different directions. Whatever form it takes, the quality of the interview will strongly influence the validity of the information obtained. Good interviewing calls for qualities such as warmth, empathy, sensitivity – that is, an aptitude for establishing relationships with others – as well as listening and observational skills.

Before conducting this qualitative study I had to adopt the stance suggested by the characteristics of the interpretive paradigm – I had to develop the level of skill appropriate for a human

instrument or the vehicle through which the data could be collected and interpreted. The credibility of this qualitative research report relied heavily on my ability to be sensitive to the data. My training as a psychologist was of great help.

At first glance qualitative research appeared to be the easier way of data collection. However unlike positivist research where one can rely on tried and tested assessment instruments to collect data, and on proven statistical techniques to analyse data, in this interpretative research it was I who was the primary instrument for both collecting and analysing data (Blanche & Kelly, 2002).

In grounded, qualitative research one often begins with sensitising or orienting concepts which provide the researcher with a general sense of reference and guidance in approaching empirical instances (Blanche & Kelly, 2002). Data in this case was collected with an interest in surfacing a focus around adolescent suicidal behaviour. Sensitising concepts like connectiveness, death and loneliness acted as theoretical lenses to help me find patterns in the meanings represented in the data.

Recording data proved to be a matter of concern. The basic decision going into the interview process was how to record interview data. It was a question of written notes versus a tape recorder. A tape recorder could have proved intrusive and writing copious notes could have been distracting. This would have also possibly destroyed the therapeutic process. I chose to keep the tape recorder (after getting permission from the learners to use one) out of sight and write down only non-verbal observances. The recordings had the advantage of capturing data more faithfully than hurriedly written notes might have, and it was easier for me to focus on the interview.

Other difficulties that I encountered included time consuming transcriptions, lengthy interviews that were difficult to analyse and many incoherent responses. A large volume of irrelevant information was received. The answers in the case study, which formed part of the questionnaire, required to be grouped according to themes and this may have resulted in some loss of meaning.

The interview was not just a form of social interaction that required a number of social skills on my part (the interviewer). It was also a therapeutic process that called for a different approach and technique, governed by different norms and values. The roles of the interviewer and interviewee evolved gradually to that of therapist and client.

I had to ensure that the place at which the interview took place was convenient for the interviewees, and that there was a minimum of interruption. Some of the interviews took place in the privacy of the deputy principal's office. It was not always convenient for the respondents to meet in my office (a kilometre away from the school) as some of them attended tuition classes after school or used public transport to get home. The times for the interviews were therefore flexible to accommodate the respondents' schedules.

It was apparent that qualitative research is a creative, scientific process that necessitated a great deal of time and critical thinking, as well as emotional and intellectual energy (Mariano, 1989). Fortunately I had a true desire to discover new meaning, develop greater understanding and explain the phenomenon of adolescent suicidal behaviour in the most thorough way possible.

The task of the qualitative researcher is one of analysis *and* synthesis. Miles (1979) warns that qualitative data can have serious weaknesses, and the researcher should beware of vast reams of information which is not coherent – the sheer volume of data overloads the research worker and analysis is extremely time-consuming. I could not agree more. Data collection was indeed problematic. Material was inter-related and needed to be contextualised. Blanche & Kelly (2002) state that data collection should be viewed as a process rather than a procedure. Data during the various interview sessions arrived in bits and pieces – isolated events, dates and individuals. Synthesis was indispensable and the pieces had to be put together to form a meaningful matrix (Leedy, 1989).

Qualitative data analysis involved working with data, organising it, breaking it into manageable units, synthesising it, searching for patterns, discovering what was important and what was learned and deciding what to report. It proved to be a challenge to place the raw data into logical meaningful categories; to examine them in a holistic fashion; and to find a way to communicate this interpretation. I used the inductive analysis of data and several critical themes emerged out of the data.

4.6. CONCLUSION

The limitations on the methodology used and the data collection are listed in chapter seven. However, I would like to repeat at this stage that although the study made use of the questionnaire

which is generally used in the collection of quantitative data, the analysis of data was interpretative – the data allowed for the exploration of the topic of adolescent suicidal behaviour. This becomes clearer in the next chapter. Chapter Five presents the data analysis of the questionnaire.

CHAPTER FIVE

DATA ANALYSIS: QUESTIONNAIRE

5.1. INTRODUCTION

In this chapter data that was collected through the questionnaire is presented and analysed. The main focus in this study was trying to explore adolescent suicidal behaviour. The discussion thus commences with the quantitative presentation and then proceeds to the exploratory interpretative analysis of results from the questionnaires. This includes the section on the fictitious case study of 'Sarah'.

In order to choose the best way to analyse the data, I needed to re-examine the critical questions, evaluate the data collected, and decide what the nature of the data was.

5.2. CRITICAL QUESTIONS

This study first made an attempt at defining what adolescent suicidal behaviour is (chapter two). This was done by carefully examining the literature research already carried out, nationally and internationally, and then reformulating a definition that was broad enough to clear away the ambiguities and yet narrow enough to make the identification of adolescent suicidal behaviour easier for parents, teachers and adolescents themselves. The study then, through the use of questionnaires and unstructured interviews, engaged in drawing out the suicide risk behaviours of adolescents. It also identified the factors that contributed to the adolescent suicidal behaviour and explored the support systems that were available to adolescents with suicidal behaviour.

5.3. INTERPRETATIVE ANALYSIS OF THE QUESTIONNAIRE

5.3.1. Biographical information of respondents

The school chosen for the case study has 675 learners in the senior phase. A break down per grade is as follows:

TABLE 1 : Grade Distribution

Grade	No. of girls	No. of boys	Total
10	148	107	255
11	145	98	243
12	120	57	177
	413	**262**	**675**

Of the 675 learners 156 did not participate in the study, either because they did not get parental consent or because they chose not to participate. 519 Learners completed the questionnaire. There were 413 girls and 262 boys. 76 boys and 80 girls did not participate.

The tables indicating the number of responses and percentages in each category of the biographical variables follow.

5.3.1.1. Distribution of learners according to grade

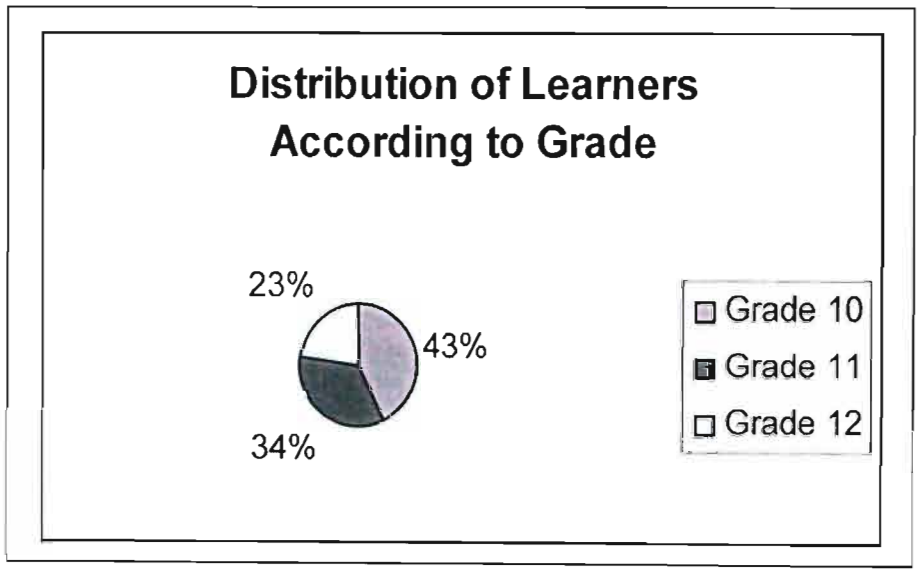


FIGURE 1

The grade 10 respondents made up the largest group (43%). The smallest group of respondents was the grade 12 learners (23%). One entire Grade 12 class chose not to participate although they were given time off by their subject teacher. Possible reasons could be that they may not have requested or obtained permission from their parents or they could have chosen not to participate.

5.3.1.2. Distribution of learners according to gender

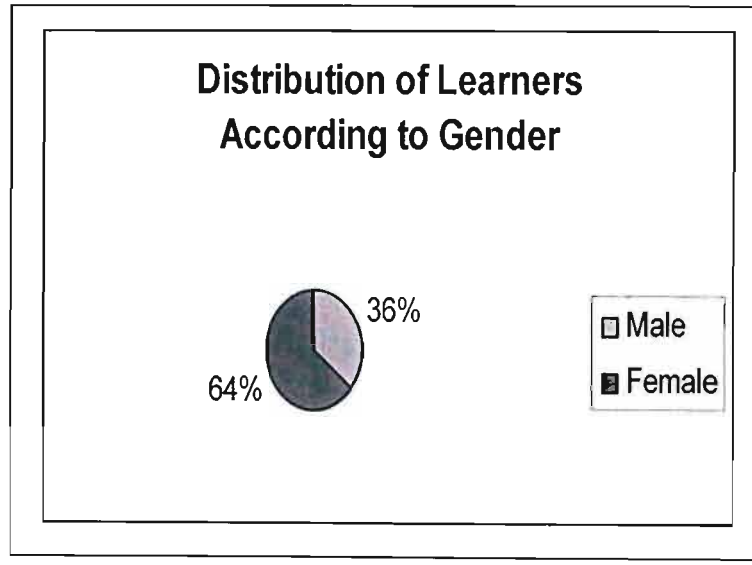


FIGURE 2

The female group made up 64.3% of the respondents while the male group made up 35.7% of the respondents. This was reflective of the gender make-up of the school in general and did not necessarily indicate that the female group was more willing to participate.

5.3.1.3. Distribution of learners according to religion

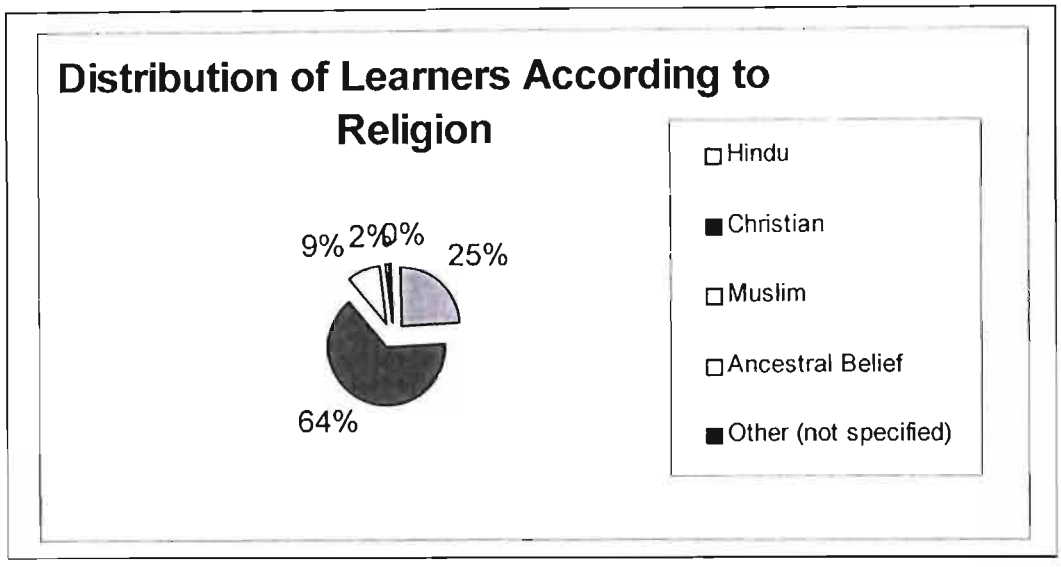


FIGURE 3

Majority of the respondents were Christians (64%). Twenty five percent of them were Hindus. The Muslim respondents and the ancestral belief respondents made up 9% and 2% respectively. The perspective on suicidal behaviour of all four of these religious groups was discussed in chapter two. All four groups share the same view – they condemn suicide (see pages 25 – 27). Their individual view, on suicidal behaviour itself, however, is not very clear or well researched – and was beyond the scope of this research.

5.3.1.4. Distribution of learners according to frequency of praying

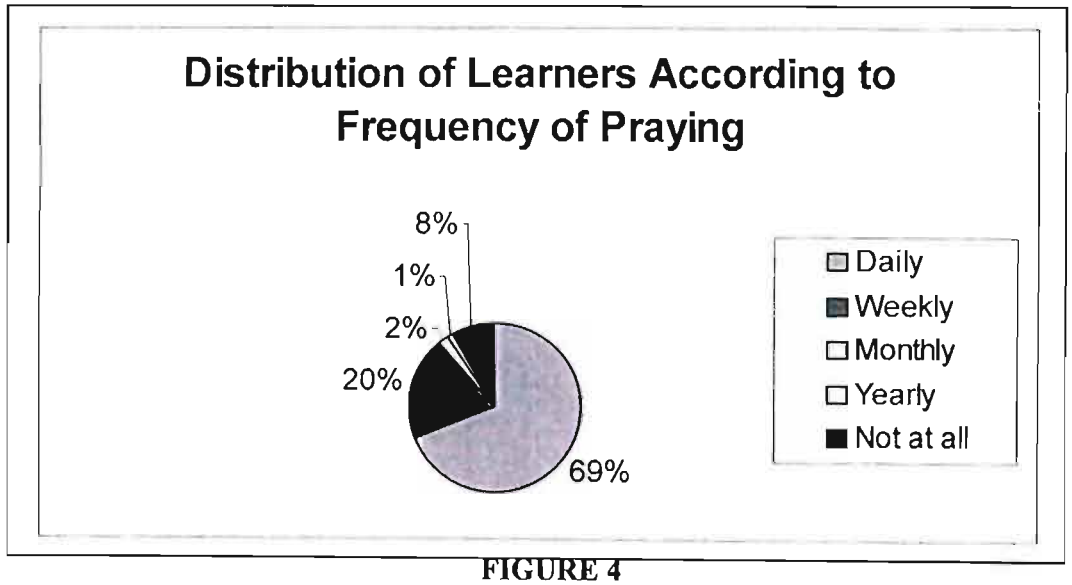


FIGURE 4

About 69% of the learners indicated that they prayed daily. Twenty percent prayed weekly. About 8.1% of the respondents indicated that they did not pray at all. There does however appear to be a high level of spirituality. When individuals lose the emotional connection with the physical world and with the self, the spiritual connection is still there to give them the will or strength to stay alive.

5.3.1.5. Distribution of learners according to age

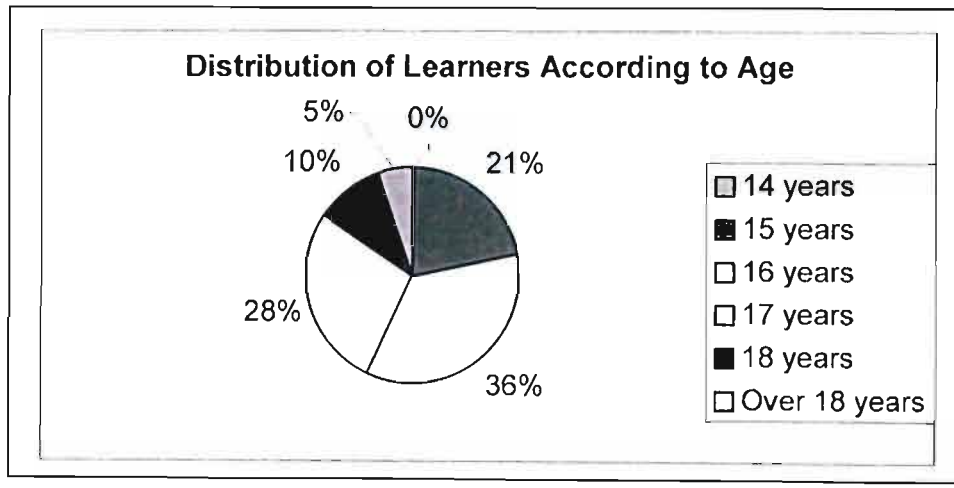


FIGURE 5

The majority of respondents (36%) were 16 years old. The 17 year-olds made up 28% of the respondents and the 15 year olds made up 21%. The 18 years and older learners made up 15.6% of the group. In South Africa, suicide ranks third as the cause of death among adolescents aged between 15 and 24 (Green, 2005). The sample group in this study is reflective of the age group cited.

5.3.2. Multiple Responses

Some questions allowed the respondents to select more than one option. Since there are multiple responses, the total count in the remaining responses will be more than the sample size of 519. For this reason I have chosen to reflect only the percentage of responses.

5.3.2.1. Details of mother and father

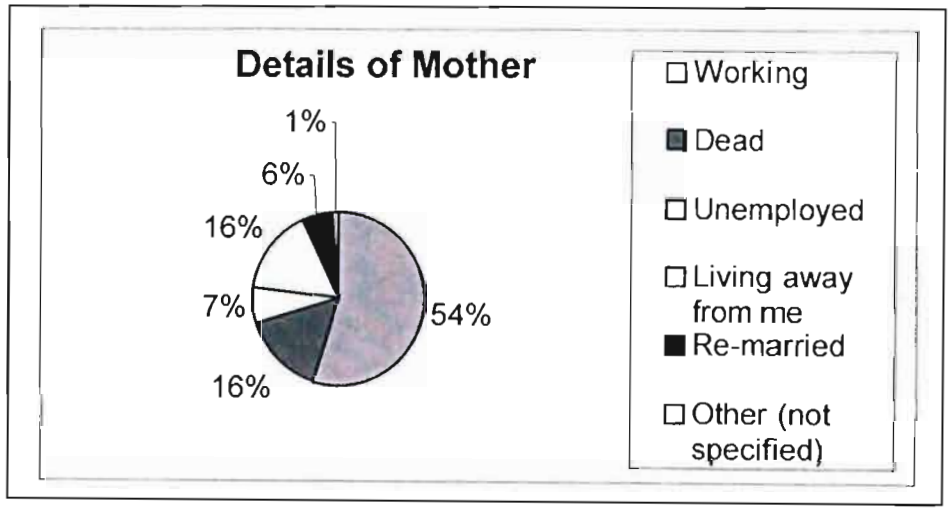


FIGURE 6

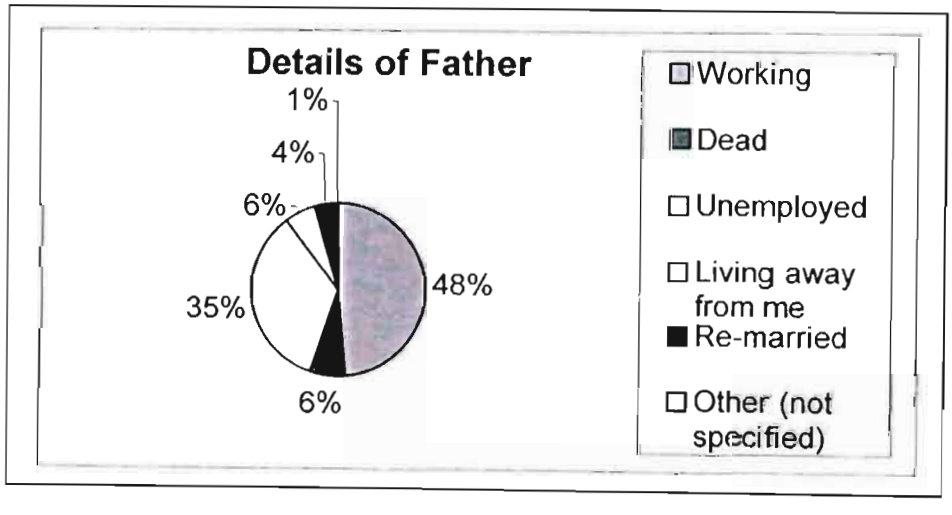


FIGURE 7

Fifty four percent of the learners indicated that their mothers were working. Seven percent of the mothers were unemployed. Forty percent of the learners indicated that their fathers were working. Thirty five percent of the fathers were unemployed.

Sixteen percent of mothers and 6 % of fathers were dead. Sixteen percent of mothers and 6 % of fathers were living away from their children. This translates roughly to a quarter of the sample group living without the active daily participation of a parent or in some cases both parents in the adolescent's life. This becomes highly significant if the separation from the parent figure was traumatic. Bowlby (cited in Powell, 1990) has stressed the importance of the formation of early attachments, particularly with parent figures as it is crucial to the development of later relationships and psychological health. The adolescents who did not have healthy participation of parent figures during their formative years may develop coping difficulties and problems connecting with new parent figures. Parent figures may be step-parents, foster parents, relatives or even teachers. This in turn may lead to delinquent behaviour and then suicidal behaviour.

5.3.2.2. Learners' place of residence

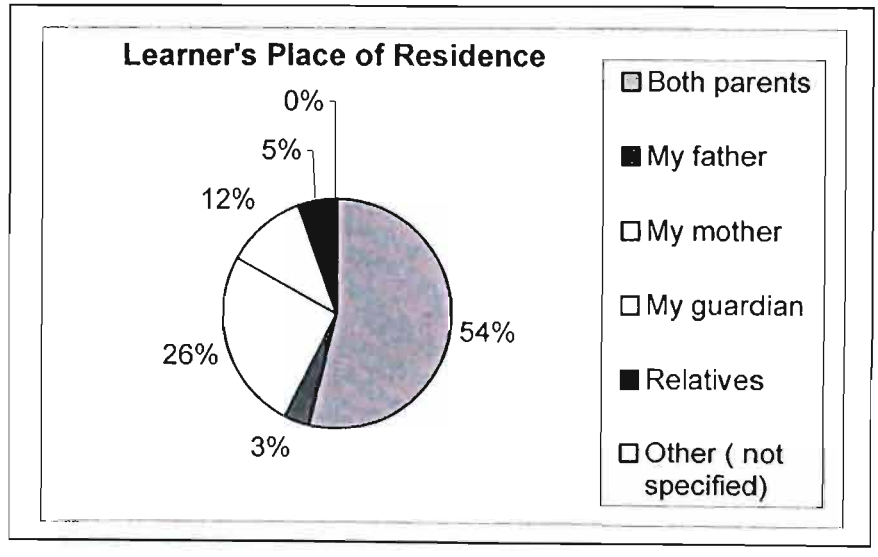


FIGURE 8

About 54% of learners lived with both their parents. Twenty six percent lived only with their mother and 3 % lived only with their father. The rest of the learners (17%) lived with a guardian or relatives.

Just over half of the sample group lived with both parents. This does not however imply that learners had stable homes and good support structures. Other factors that needed to be considered would be the kind of connection/relationship the adolescent shared with each parent and how well the adolescent's problems and concerns were understood by the parents and other adults.

5.3.2.3. Learners' response in times of sadness

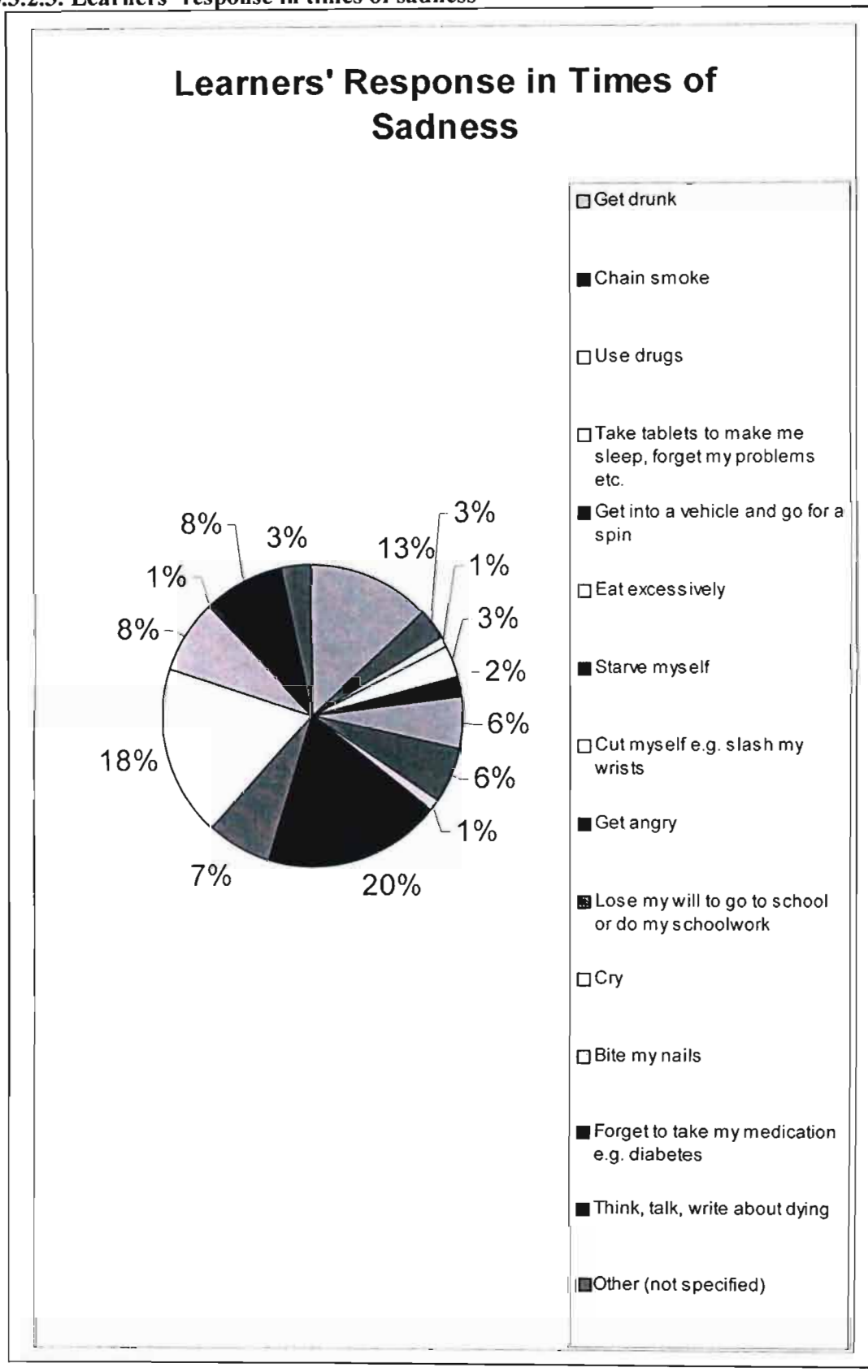


FIGURE 9

The suicide risk behaviours of adolescents in the sample group start emerging here. It is interesting to note that certain behaviour that is usually characterised as delinquent behaviour and therefore punishable behaviour e.g. drinking, smoking, taking drugs, aggressive behaviour or lack of interest in schoolwork are manifestations of learners' sadness.

Thirteen percent of learners indicated that they get drunk when they are sad, 3 % chain smoke, 20 % get angry, 1 % use drugs and 7 % lose interest in their schoolwork. Eight percent of them revealed that they have thought, spoken or written about dying in moments of sadness. One percent of the learners indicated that they cut themselves. The 8 % of learners who take tablets to sleep or forget run the risk of overdosing. The 18 % of learners who cry when sad are releasing their emotions.

5.3.2.4. Who do learners turn to when they have a problem:

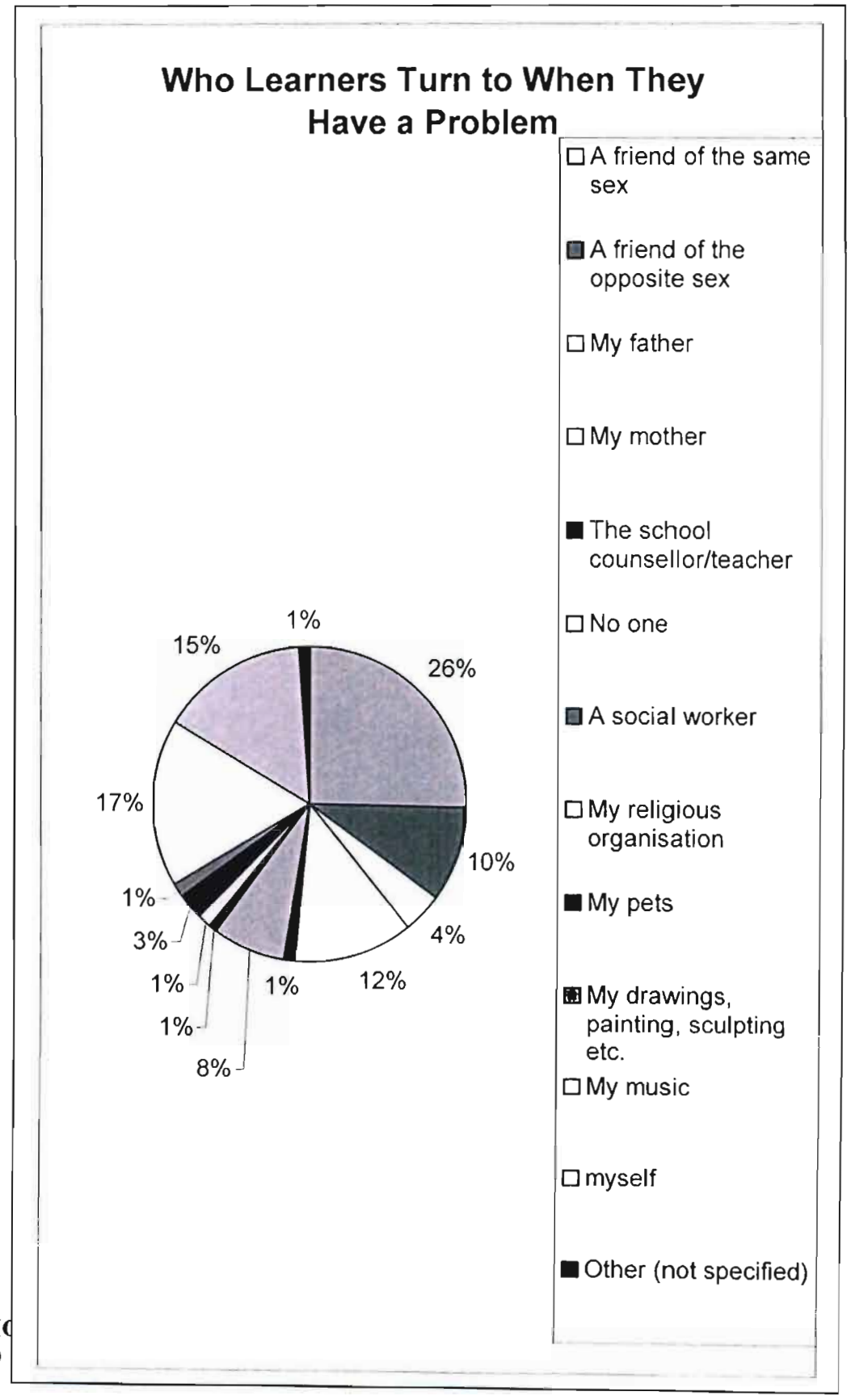


FIG
10

Majority of the learners (26 %) turn to same sex friends for support when they have a problem. Ten percent of them turn to friends of the opposite sex. What needs to be explored further here is the quality of support provided.

Twelve percent of them indicated that they will turn to their mothers and 4 % of them indicated that they would turn to their fathers. On a superficial level this indicates a good connection with parents. However it may also indicate that the adolescents have not achieved a healthy identity or sense of independence that is separate from parents (Marcia cited in Peterson, 1986).

Only 1 % of learners indicated that they would turn to their teachers. Very few learners turned to professional health workers. The social workers and religious organisations had a vote of 1 % each. These are support structures within the society of the adolescent outside of the home. They could play a vital role in identifying the impulse leading to suicidal behaviour and the early manifestation of suicidal behaviour itself. However very few learners turn to their social structures.

Music appeared to play a significant role in assisting learners as 17 % learners used it in times of sadness. At face value the learners who turn to music when they have a problem could have good coping skills. The music could be inspirational, connecting them with feelings of hope and happiness. On the other hand, the type of music they turn to could lead them further into the abyss of depression.

Some learners turned to pets (3 %) or art (1 %) to express their sadness and release their pain. A large number said that they will turn to themselves for support (15 %) or that they will turn to no one (8 %). The learners that turned to themselves or to 'no one' could have good connections with their inner selves and therefore good coping skills or it could be that they do not feel comfortable discussing their problems with anyone – they bottle it up.

5.3.2.5. Support systems that are readily available to learners when they have a problem:

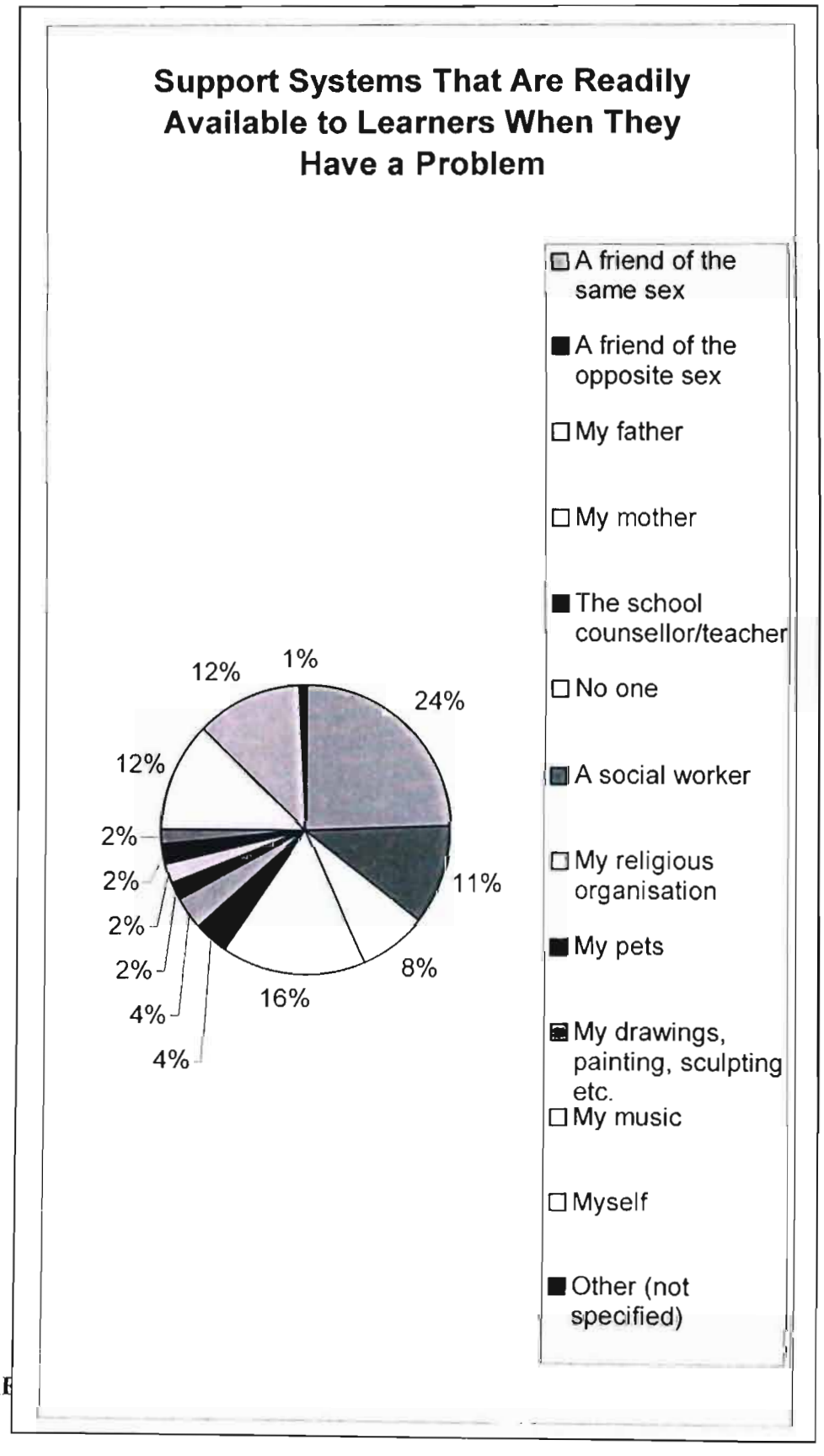


FIGURE 11

The support system that appears to be most readily available are same sex friends (24 %), friends of the opposite sex (11 %), mothers (16 %), fathers (8 %), and music (12 %). The learner is available/able to provide support to herself/himself 12 % of the time. The support systems in the form of teachers, social welfare and religious organisations are available but many learners chose not to turn to them. Only 4 % of learners indicated that teachers were readily available to them and 2 % indicated that social workers and religious organisations were readily available to them. Since these support structures are vital in helping to identify suicidal behaviour in adolescents the reason for their unavailability needs to be explored further.

5.3.2.6. What has helped learners cope with a problem

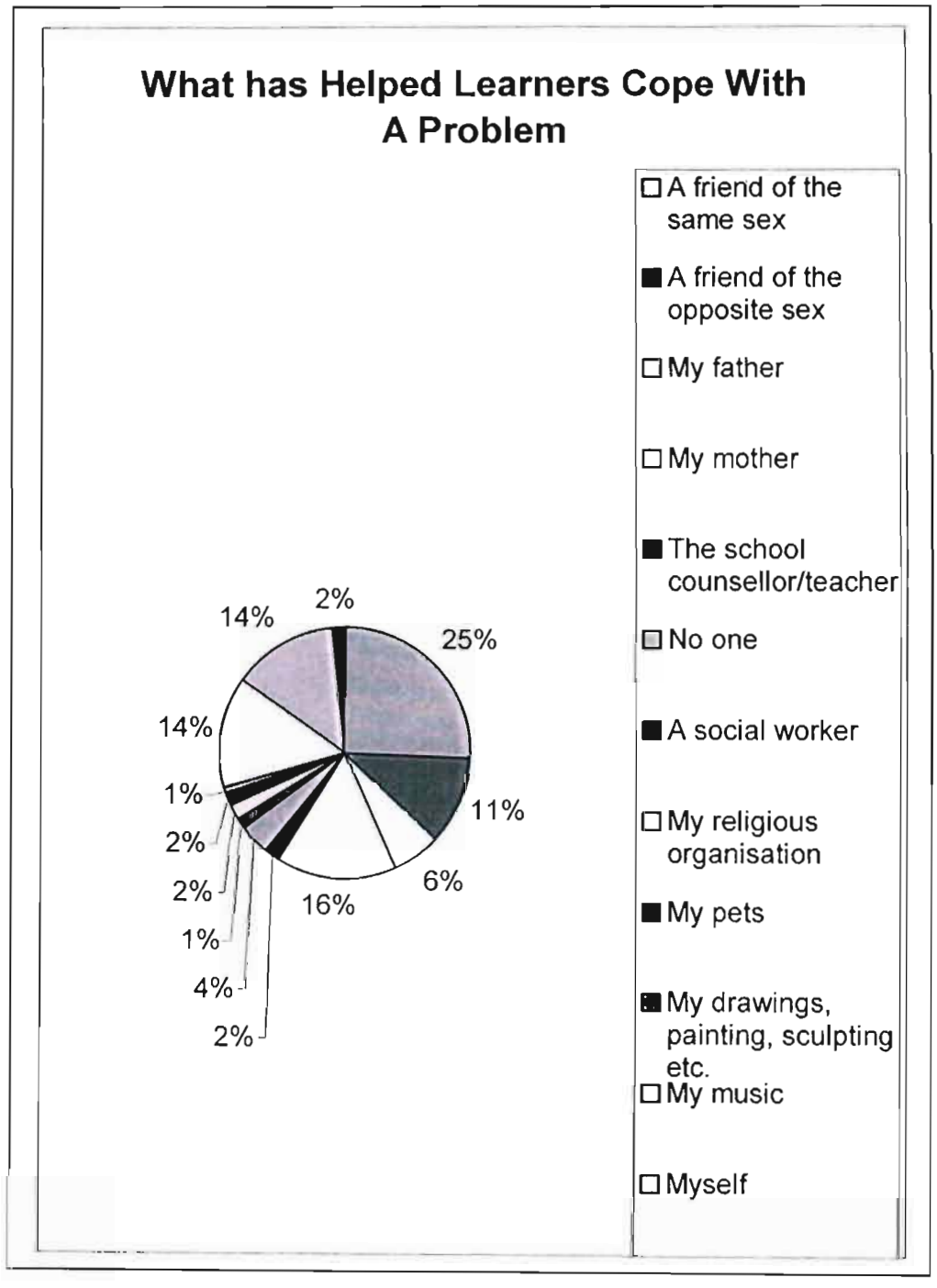


FIGURE 12

The resources that helped learners cope with a problem the most are friends of the same sex (25 %) and friends of the opposite sex (11 %). This stresses the important role that friends play in the lives

of adolescents. The peer connection (even if it is through the cell phone) creates a social identity for the adolescent. The influence of friends however can also be detrimental.

Mothers helped 16 % of the adolescents and fathers helped 6 % of the adolescents. The teacher helped 2 % of them, the social worker helped 2 % of them and the religious organisation helped 2 % of them. The learners indicated that in 14 % of the cases they helped themselves and music assisted in 14 % of the cases. In 4 % of the cases no one was able to assist.

This type of information is vital for parents, teachers (especially the Life Orientation teachers), the local social welfare and religious organisations to enable them to become more available, approachable and understanding of the adolescent's world.

5.3.2.7. Sexual Behaviour of learners

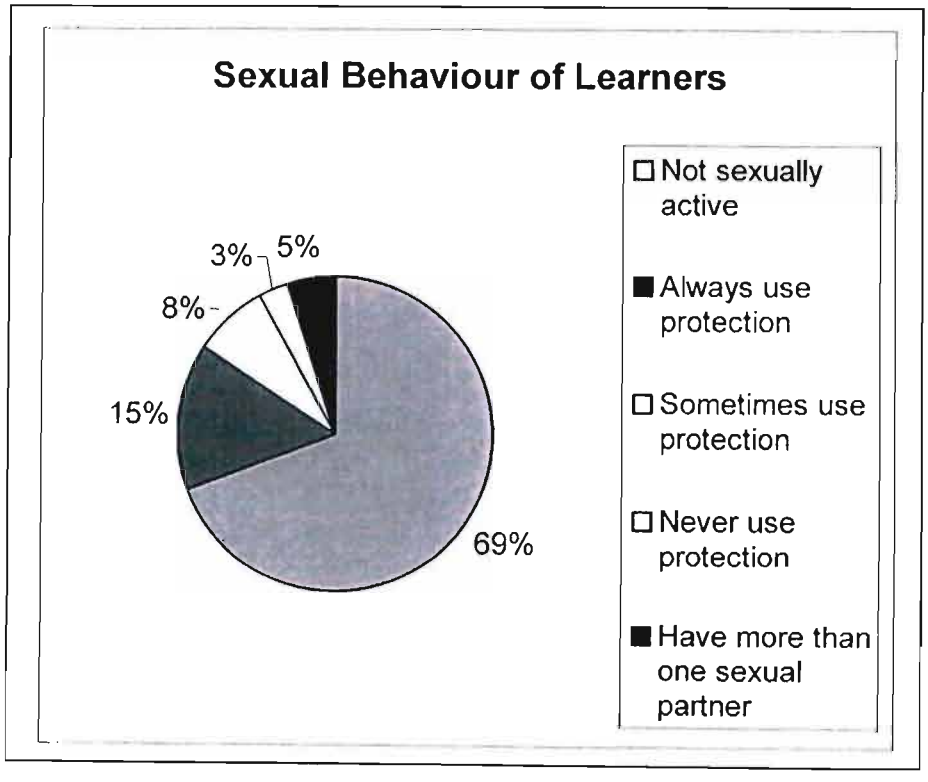


FIGURE 13

Active sexual behaviour of learners without protection is defined in chapter two of this study as self-destructive/suicidal behaviour.

Despite Sex Education, and especially Aids Education, being a compulsory part of the Life Orientation programme for all grades at all secondary schools, 8 % of learners responded that they **sometimes** use protection. An alarming 3 % **never use protection** and an even more alarming 5 % of the learners have **more than one sex partner**. The findings suggest that these learners show a blatant disregard for their lives. They tempt death. Parents and teachers need to, with empathy, delve deeper into these adolescents' behaviour to determine the reasons for them placing so little or no value on their lives.

5.3.2.8. Smoking habits of learners

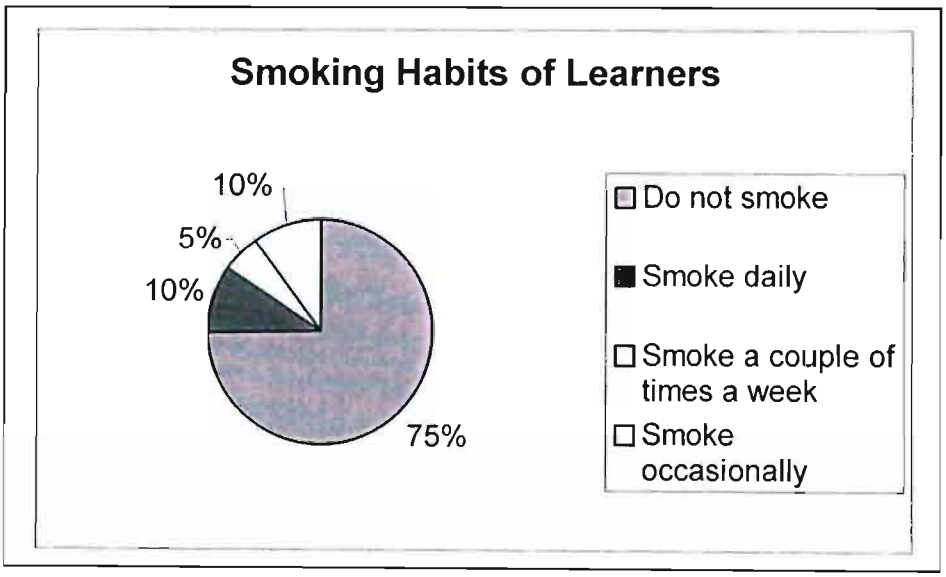


FIGURE 14

About 10 % of learners are daily smokers. It was not clear whether they smoked in school or out of school. It was also not ascertained as to the number of cigarettes they smoked daily. Again, despite the knowledge that smoking is linked to lung cancer and other related respiratory illnesses, learners continue to smoke. They appear not to value their lives. They do not connect the knowledge about smoking with their own bodies or if they do, they do not appear to care.

The age of learners who smoked daily is reflected as follows:

TABLE 2 : Daily Smokers

Age	14-15 years	16 years	17 years	18 years and over	Total
	2 %	3 %	4 %	1 %	10 %

The gender of learners who smoked daily is as follows:

TABLE 3 : Gender of Smokers

Gender	Males	Females	Total
	8 %	2 %	10 %

School rules prohibit smoking. Cigarette packaging carries warnings of lung cancer and related diseases. Yet 10 % of the learners indicated that they are daily smokers. This statistic included 2 % of girls and 8 % of boys. This shows a defiance of authority. It also reflects a group of individuals who do not value their lives. Learners as young as 14 years are daily smokers. Smoking is an expensive habit to sustain. This addiction could lead to other delinquent behaviour like stealing and bullying to get money to buy cigarettes.

5.3.2.9 Use of alcohol by learners

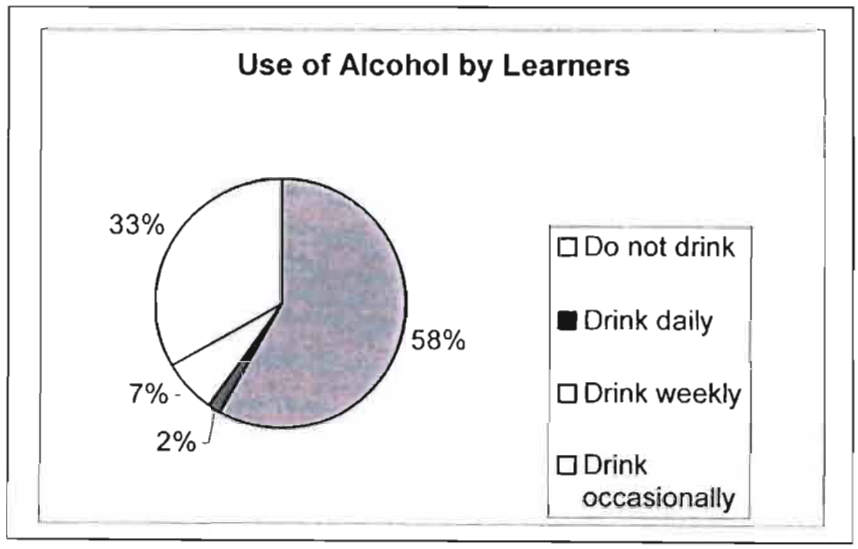


FIGURE 15

About 2 % of the learners were daily drinkers, while 7 % of them drank weekly.
The gender of daily drinkers was as follows:

TABLE 4 : Gender of Daily Smokers

Gender	Males	Females	total
	1.2%	0.8%	2 %

The daily drinkers lived with the following people:

TABLE 5 : Who Daily Drinkers lived with

I live with	Both parents	My father	My mother	My siblings	Total
	0.7%	0.4%	0.4%	0.5%	2 %

The age of the daily drinkers was:

TABLE 6 : Age of Daily Drinkers

Age	14-15 years	16 years	17 years	18 years & over	Total
	0.7%	0.5%	0.4%	0.4%	2 %

There is very little difference between the genders in respect of the use of alcohol. The total of 2 % may be a conservative number but when you examine the ages of the learners (0.7 % in the 14-15 age group) and the fact that 0.7 % live with both parents – it clearly sends out warning signals. Parents appear to have lost touch/connection with their children or they may not be fulfilling their roles as parents and caregivers. Daily drinking is self-destructive behaviour. These individuals need professional help yet their behaviour appears to go undetected or uncontrolled by adults.

5.3.2.10. Use of drugs by learners

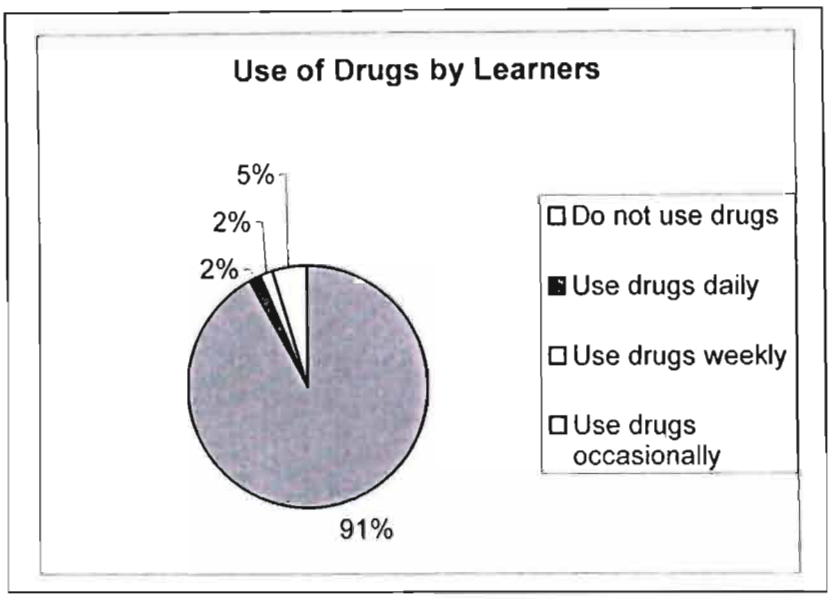


FIGURE 16

About 2 % of the learners admitted to using drugs daily. Another 2 % of them admitted to using drugs on a weekly basis. The type of drugs and the quantity used were not requested in the questionnaire.

The gender of learners who used drugs daily is as follows:

TABLE 7 : Gender of Learners who used drugs daily

Gender	Males	Females	Total
	1.4 %	0.6%	2 %

The learners who used drugs daily lived with the following people:

TABLE 8 : Who daily drug users lived with

I live with	Both parents	My mother	Siblings	Total
	1.4 %	0.3 %	0.3 %	2 %

The age of learners who used drugs daily is as follows:

TABLE 9 : Age of daily drug users

Age	14-15 years	16 years	17 years	18 years & over	Total
	0.8 %	0.3 %	0.6 %	0.3 %	2 %

The statistics here mirror those for the use of alcohol. Again the statistics reveal that parents and school authorities appear not to be aware of the suicidal tendencies of adolescents (as defined in chapter two). It may also indicate that adolescents are not making effective use of support structures that are in place.

5.3.2.11. Bullying in school

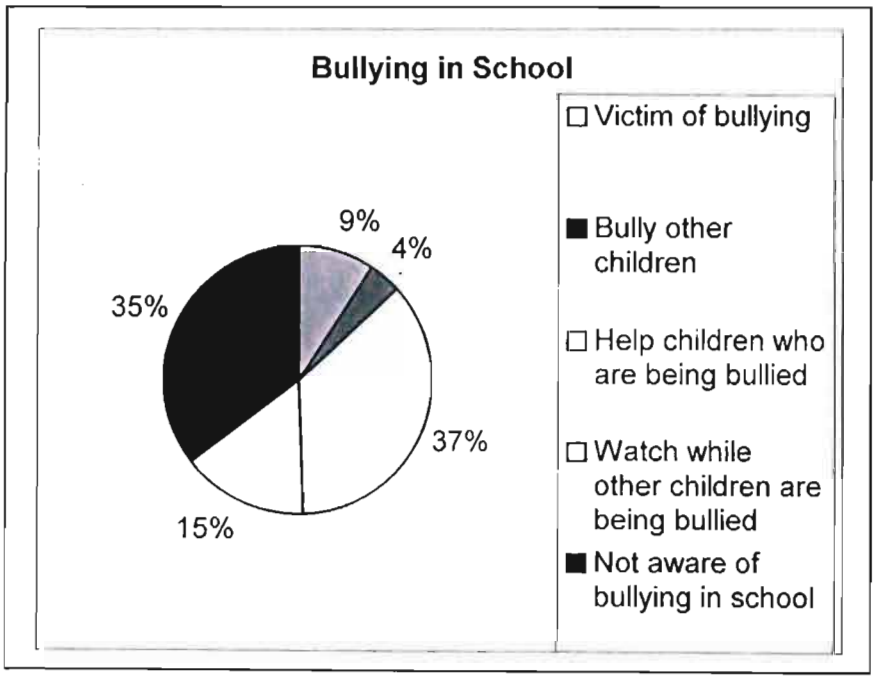


FIGURE 17

Bullying has been cited as a reason why some adolescents attempt suicide or resort to suicidal behaviour (Ryan, 2006, Dawkins, 1995). About 9 % of the learners revealed that they were victims of bullying. About 4 % stated that they bullied other children and 15 % of the learners indicated that they watched while other children were being bullied. All three groups of learners are vulnerable to suicidal behaviour.

According to Espelage (cited in Portner, 2001) victims of bullying often have low self-esteem and self-images. They do not report the acts of bullying. They often turn to destructive or self-destructive behaviour to escape the pain and shame inflicted by the acts of bullying. The 15% of learners who watched while others were being bullied could end up as future victims. They need to develop empathy and moral responsibility. Learners appear to have disconnected themselves from their peers – abandoning them in times of need – this alienation pushes the victims further over the edge – they may resort to desperate measures (suicidal behaviour) to escape from a world that appears to be cold, punishing and loveless.

5.3.2.12.Bad behaviour by learners

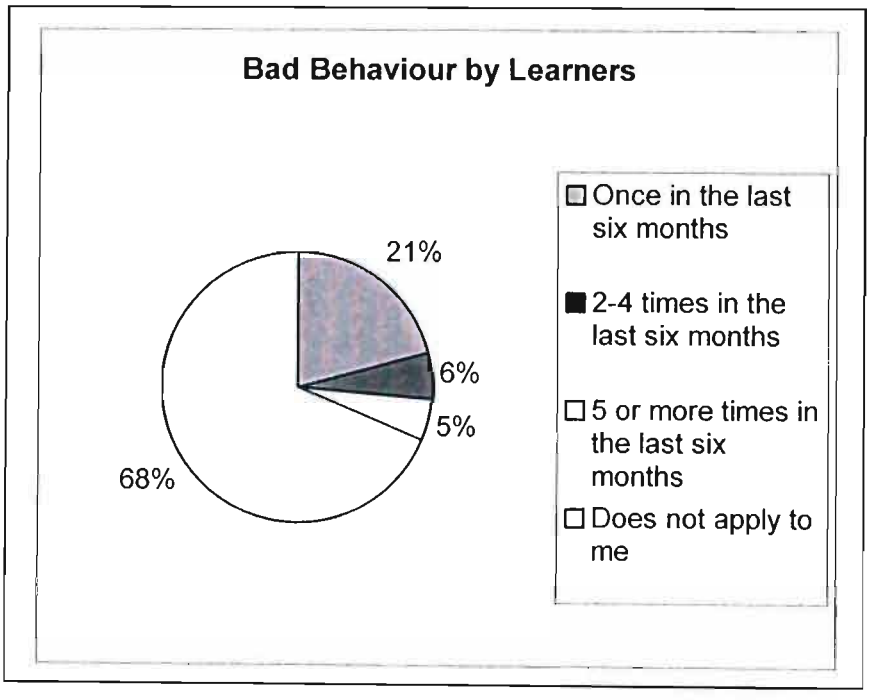


FIGURE 18

About 5 % of the learners admitted to manifesting bad behaviour in school five or more times in the six months preceding the study while 6 % admitted to manifesting bad behaviour 2 –4 times in the same period.

Gender of learners who manifested bad behaviour 5 or more times in the six months preceding the study is as follows:

TABLE 10 : Gender of learners manifesting bad behaviour

Gender	Males	Females	Total
	2 %	3 %	5 %

The learners lived with the following people:

TABLE 11 : Who learners lived with

I live with	Both parents	My mother	My guardian	My siblings	Total
	2.2 %	1.4 %	0.9 %	0.5 %	5 %

The age of learners who manifested bad behaviour 5 or more times in the six months preceding the study is as follows:

TABLE 12 : Age of learners

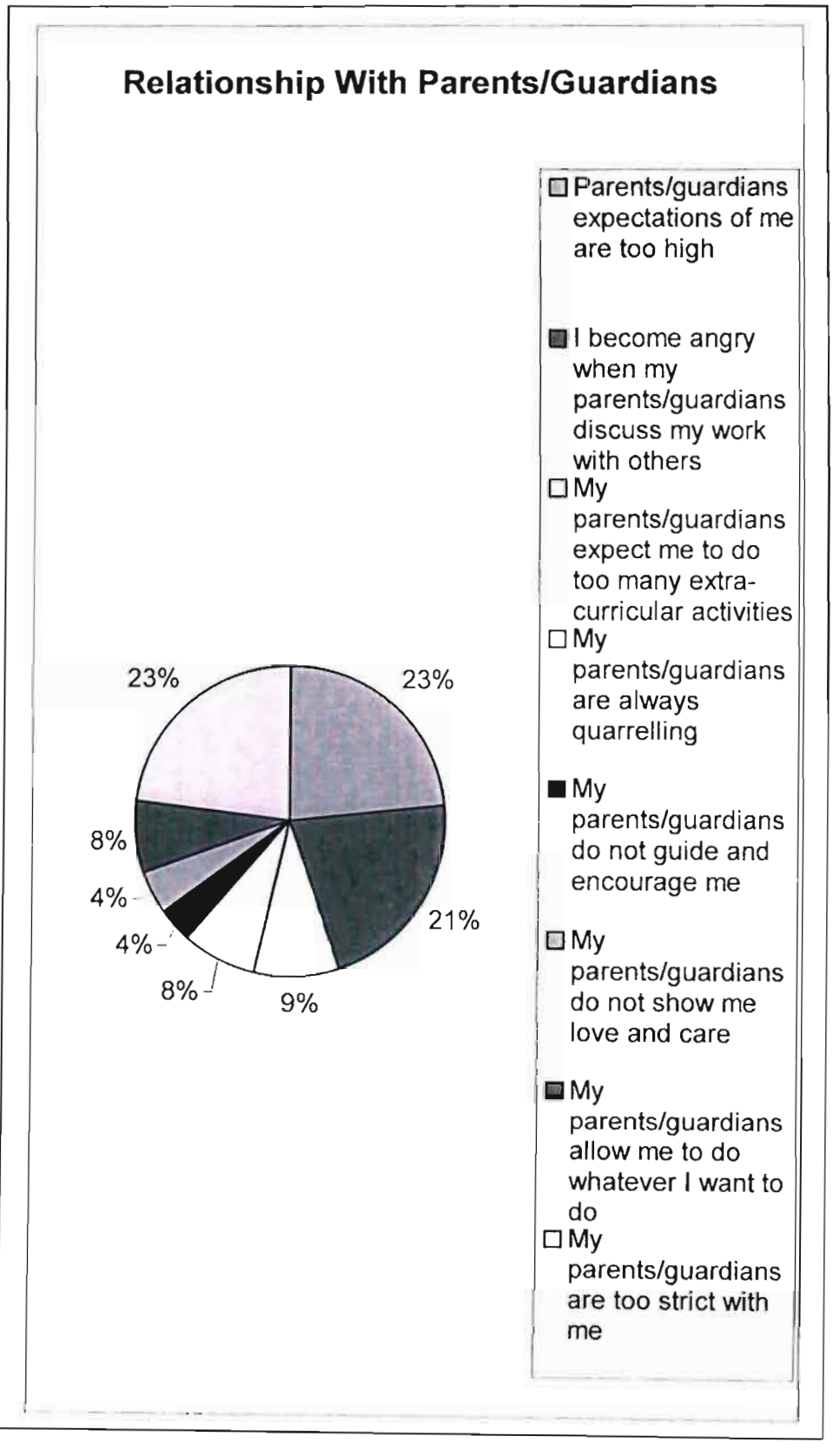
Age	14-15 years	16 years	17 years	18 years & over	Total
	1.8 %	1.8 %	0.5 %	0.9 %	5 %

The report not clearly defining 'bad behaviour' is a limitation of the study. However it does appear as if learners have a sense of what 'bad behaviour' is. Over 1/3 of the learners belong to the 14-15 age group. Three percent out of the 5 % of the learners are girls. The study did not ask for the description of the bad behaviour. It could however range from not completing tasks to the taking of banned substances – all this is included to some degree or the other in the definition of suicidal behaviour in chapter two. The results in this study reflect reports by Portner (2001) that state that girls engage in suicidal behaviour more than boys. Previously boys were classified as delinquents. With the acceptance of a wider definition of suicidal behaviour it would not be surprising to find delinquents who are girls. According to Schlebusch (2005) school-related and academic problems in adolescents can be a significant risk factor for suicidal behaviour. A survey by Rutter & Behrendt (2004) show that adolescents with mood disorders and disruptive behaviours have a

significantly increased risk of suicide. Caution needs to be heeded here not to classify all bad behaviour as manifestations of suicidal behaviour. What needs further examination by school authority and parents is why learners, despite being sent to the office or suspended, continue to default in some way. Is it a 'cry for help' or is it just 'brat' behaviour? What needs to be considered here is the type of behaviour modification implemented and the counselling services available to learners (if any). If this is a cry for help then punishment with no counselling could push learners with the suicidal impulse in the direction of more overt suicidal behaviour.

Over ½ the learners who have defaulted 5 or more times in the last six months live with both parents. Here again the support structures appear to be weak – if and when the suicidal behaviour manifests itself the learner may not be able to turn to parents for appropriate and positive support.

5.3.2.13. Relationship with parents/guardians



FIGU
19

Yet again the structures at home do not appear to be very supporting to the adolescents. Many parents and guardians appear not to be attuned to the adolescents' needs and feelings.

About 23 % of the learners indicated that their parents/guardians expect too much from them while 23 % of them indicated that their parents/guardians were too strict. About 8 % of them said that their parents/guardians were always quarrelling, 4 % said they are not shown love and 4 % said that their parents/guardians do not encourage and guide them. Rigid parents with strict, uncompromising standards put their children at risk for suicidal behaviour (Roy, 1986).

In my experience as a psychologist, many adolescents whom I have worked with, who fail to fulfil parents' and guardians' expectations, believe that they are failures and disappointments. This has in many cases led to the belief that death is an option to escape from this life. The overall findings of the survey indicate that adolescents may be grossly misunderstood and may be often punished when they express their sadness in unconventional (deviant or delinquent) ways. This validates the purpose of the study which is to redefine adolescent suicidal behaviour to include deviant and delinquent behaviour. Adolescents may be silently crying out for help but are misunderstood because the language of communication is coded and unconventional.

5.3.3. Analysis of case study of 'Sarah'

The justification to include the case study of a fictitious character 'Sarah' in the structured questionnaire has already been explained in chapter four (p84). A copy of the questionnaire appears in APPENDIX B. Respondents were given the following case study:

Sarah is 15 years old and in grade 10. Her father is an alcoholic. He often beats her mother. When Sarah tries to help she is also beaten. Her father is the breadwinner of the family. Her mother only has a Grade 7 qualification and has never had a job. Sarah's schoolwork has suffered because of poor attendance (due to injuries from beatings) and not being able to do homework (hiding from a drunk father or disturbed by noise made by father). Her classmates tease her because of her low marks and her father's behaviour. Sarah feels sad and alone. She has already tried to kill herself. A group of local teenagers who drink and smoke have asked her to join their group. Sarah wants to join them.

The respondents were asked three questions based on the case study.

5.3.3.1. The first question

What do you think of what Sarah has done (trying to kill herself)?

TABLE 13 : Response to first question

RESPONSE	TOTAL
Agree with Sarah's decision	4 %
Disagree with Sarah's decision	74 %
Neutral response	19 %
Response omitted	3 %
TOTAL	100%

The case study depicts a socio-economic scenario that is common in the Kwadukuza area. Some of the learners come from a similar background.

The majority of the learners (74 %) disagreed with Sarah's decision to try to kill herself with only 4 % of the learners agreeing with her decision. This may indicate that most adolescents do not consider suicide an option. What is significant is that 19 % of the learners were neutral on this question. Their decision not be have a 'for' or 'against' opinion may be grounds for developing an environment around someone like Sarah that creates more detachments and disconnections.

The 4 % of learners who indicated that they agree with Sarah's decision to kill herself may have identified with Sarah and may perhaps have themselves contemplated the act of suicide - they may not have considered the other options to the problem situation she is in or may not have faith in the other options available. If Sarah had turned to any one of the 4 % of learners, they may not have been able to give her constructive advice and may in fact have encouraged her by not pointing her in the direction of healthy options.

One option could have been seeking professional help – engaging the services of social welfare. The choice not to use helping services in the area needs to be looked at more closely. Only 1% of learners in the first part of the questionnaire indicated that they will turn to social welfare for help (table 5.3.2.5.). Learners who would turn to religious organizations and teachers in school were also 1% and 1% respectively. Is it because learners are not aware of the full function of organisations in the area or is it that they are not happy with the type of service provided? They could also be influenced by the possible stigma attached to using welfare services and approaching

teachers with emotional and psychological problems. This needs to be explored further in another study.

5.3.3.2. The second question

What do you think of what Sarah is thinking of doing (joining a group that drink and smoke)?

TABLE 14: Response to second question

RESPONSE	TOTAL
Agree with Sarah's decision	5 %
Disagree with Sarah's decision	80 %
Neutral response	11 %
Response omitted	4 %
TOTAL	100 %

The 5 % of learners that agreed with Sarah's decision to join a group that smoke and drink have poor problem solving skills. She has already tried to kill herself. Alcohol is a depressant. It may encourage her to try suicide again. The 5 % of learners may or may not be aware that alcohol is a depressant. It appears that they turn to alcohol and cigarettes and possibly other drugs to drown their sorrow and escape from life's problems. They need other more helpful options to be easily accessible and appealing to them.

5.3.3.3. The third question

What would you do if you had been in Sarah's situation?

TABLE 15 : Response to third question

RESPONSE	TOTAL
Drink, smoke	4 %
Kill myself	5 %
Run away from home	3 %
Hit, kill my father	2 %
Have sex to drown my sorrows	0.5 %
Ignore, deny my problem	2.5 %
Pray to god	5 %
Try to solve problem	12 %
Turn to others to solve problem	61 %
Neutral response	1 %
Response omitted	4 %
TOTAL	100 %

The learners that indicated that they would drink, smoke, kill themselves, run away from home hit or kill their father, have sex or deny their problem have no coping skills and therefore at risk. The 1 % of learners who had a neutral response appear to detach themselves from the lives of those around them. They have disconnected themselves. Is this because they do not have skills to assist those learners in need or because they have too much to deal with in their own lives that they do not want to get involved in the emotional issues of others?

Sixty one percent of the learners indicated that they would turn to others to help them solve the problem. This sounds positive. There are social structures, including the school structure, in place to assist learners. What is not clear is who these learners will turn to if they had Sarah's problems. Will the support system they turn to help them better their situation or will the advice and help they receive lead to more problems?

What also needs to be addressed is the large number of learners who chose destructive behaviour as a solution. Running away (3 %) for these adolescents is a way to escape the problem. They do not realise that they are financially dependent. They may become street children, resort to selling their bodies or lose themselves in drugs and alcohol. Four percent had already indicated that they would turn to alcohol (further manifestations of suicidal behaviour).

Two percent would kill their fathers to solve their problem. They do not take into consideration the consequences of their actions - or is it that they do not care what happens to them after the act of murder – they see no future for themselves – they just want to escape from the pain?

Of greatest concern is the 5 % of learners who indicated that they will kill themselves if they had been in Sarah's situation. They did not consider that family counselling, possibly joining AA, her mother getting some job training through the assistance of social welfare and Sarah choosing friends who are mature, empathetic and supportive could be steps in the direction of rebuilding the lives of Sarah and her family. This is all within reach of adolescents and structures are already in place in the KwaDukuza area to assist with problems of this nature. Learners have to realise them and make more informed and constructive decisions.

5.4. CONCLUSION

The statistics obtained through the questionnaire provided information that allowed for the probing into possible manifestations of adolescent suicidal behaviour. It is not important that a clear distinction be drawn between suicidal behaviour and non-suicidal self injurious behaviour. What is important is that if there is a chance, no matter how slight that the behaviour (impulse) may evolve into a suicide, then attention needs to be given to it. There is a need for parents, teachers and society at large to reconsider the definition that they have on adolescent suicidal behaviour. They need to broaden their thinking around this phenomenon by examining the various ways in which adolescents manifest their sadness (table 5.3.2.4) and the reasons behind their deviant and delinquent behaviour.

The conclusion drawn from the statistics in this study is that majority of the learners at the secondary school are not presently at risk for suicidal behaviour but there is a disturbing pattern with the number of learners who have no idea how to cope and who chose neutral responses. In times of crises and in the absence of good support structures these individuals could meander into difficulties. Suicidal behaviour is layered with complexities and adolescents need to be prepared with inner and outer resources to avoid becoming another statistic in a list of victims of suicide.

The next chapter looks at an interpretation of the interviews.

CHAPTER SIX

DATA ANALYSIS: THE UNSTRUCTURED INTERVIEW

6.1. INTRODUCTION

The participants in the unstructured interview were adolescents who approached me (either telephonically or personally) after the administration of the survey questionnaire and volunteered to be interviewed because they perceived themselves to have 'emotional issues'. I had requested for such participation and agreed to provide counselling for those in need of it. There were fifteen individuals in total. However, only five met the criteria for this study – they had to manifest some form of suicidal behaviour as defined in chapter two. Three of them were confused about their career choices, four of them had problems communicating with their parents, two of them had conflict in sexual relationships and one had concerns about health. While these ten cases were not included in the study, I realised that these adolescents had reached out for help - they wanted to 'make a connection'. Their cases were treated just as seriously as the other six. They were counselled, empowered with information, provided with basic coping skills or referred to other agencies for further assistance.

The selection of the five individuals for this study was based on the prevalence of overt suicidal behaviour as defined in chapter two or a suicide impulse that hinted at developing into suicidal behaviour in the near future. I had to bear in mind that there is no guarantee that the so called 'suicidal impulse' would lead to suicidal behaviour. This is what makes the phenomenon of suicide so perplexing. A thematic content analysis, using procedures suggested by Krippendorff (1980), was conducted.

The full narratives of the five interviews appear in APPENDIX C. I constructed the narratives by using the actual words of the adolescents wherever possible so as to keep authentic the feelings/emotions. The adolescents were given the opportunity of editing the stories and verifying the facts. What follows in this chapter are extracts from the narratives and a discussion on each one. I chose parts of the story for the extracts that I considered most suitable to encapsulate and project the emotional turmoil and disconnection of each of the adolescents.

6.2. THE INTERVIEWS

6.2.1. Janice's story

Janice is a grade twelve learner who has problems connecting with her mother and other members of her family. She drinks, smokes and takes sleeping tablets. Her school work has also suffered.

I am sixteen years old, in grade twelve and should be excited about my future. Yet I often feel sad. What is the purpose of my life? I feel so confused. ..... The situation at home is unbearable.... ...
I was sick on Thursday. I felt weak. I had a stomach-ache. I did not go to school. I asked my mother to take me to the doctor. She went shopping .....She left me alone at home. She promised to take me to the doctor when she returned. She got back late in the afternoon. It was too late to go to the doctor. I felt that she did not care about me. She did not even ask me if I had had something to eat. I took a handful of sleeping tablets and went to bed. I often do that. It helps me forget. I have nobody to talk to. .....

I have been a daily smoker for over a year. I get up in the morning and start my day with a shot of neat brandy. I want to stop smoking and drinking because I do not want to cause my father any more pain. However, I cannot sleep. I have taken my mother's sleeping tablets again.....
My exams are around the corner. No one seems to care.....
I took some sleeping tablets and went to bed.

Suicide is a disease of helplessness and hopelessness - helpless because you feel that nothing you can do will ever make a difference – and hopeless because you see no choices (Gaines, 1991). Janice was one of those adolescents who perceived life as so ungratifying, so unfruitful and so futile that she felt powerless and trapped. The decision to engage in suicidal behaviour (drinking, smoking and overdosing on sleeping tablets) was a statement that life was worthless and not worth the pain and suffering.

Her *para-suicidal* acts of consuming pure alcohol and swallowing an undisclosed number of sleeping tablets fortunately turned out to be nonfatal. She appeared not to have the wish to die.

Her inner turmoil and stress was so great that she was not sure whether she wanted to live or die. Life appeared to be too much for her. Suicidal behaviour, and maybe eventually suicide, was viewed as the only alternative after a period of longstanding personal problems.

The crisis that constantly precipitated the suicidal attempt in Janice's case was a conflict situation with her mother *('We have not been close in a long, long time ... she uses me to get to him (father)'* – see APPENDIX C). It indicated often an impulsive step in a progressive failure of adaptation, to sharing her mother with others or fore-going a relationship with her mother because of others. This led to her withdrawing from social contact. She felt expendable.

She believed that both her parents were oblivious to her feelings. They believed (according to her) that they provided for her adequately financially and she should have no excuses to perform academically. In the absence of a meaningful relationship with her parents, Janice was drawn into a culture in which drugs and alcohol had come to be substitutes for love, feelings, and shared understandings.

Despite Janice's on-going suicidal behaviour, her mother denied that there was a problem saying that *'she was a spoilt child who was attention seeking'*. Her father considered his business to be more important than joining Janice in therapy. Her mother stopped her from continuing with therapy (see APPENDIX C).

This scenario is typical of those in the study by Engelbrecht (1978) where young persons who committed suicide found that their efforts to express their feelings of unhappiness, frustration, or failure, were totally unacceptable to their parents. Such feelings were ignored or denied by parents, or were met by defensive hostility. When Janice was stopped from continuing with therapy, she continued her suicidal behaviour of smoking, drinking and abusing sleeping tablets.

Her parents' attitudes and the quality of her family life appeared to have an enormous impact on Janice's emotional development (*'My parents fight all the time. I am torn between them. I don't like to take sides. I also don't like to be around when then fight'* – APPENDIX C). More than anything else, her family background and experiences during the early years of her life played a major role in creating her suicidal wishes. The loss of Janice's younger sister and the failure of the family to deal with the trauma in a positive way had scarred the family dynamics. It had left Janice

feeling abandoned, lonely – and disconnected from her family. She was filled with anger at her mother and to a lesser extent her father.

She turned to drugs to relieve tension when pressures were intense. According to Stuart & Sundeen (1991) it may have been a way of obtaining gratification of instinctual needs at a regressed level or it may indicate an effort to come to grips with feelings of vulnerable and emptiness.

Durkheim (cited in Schoombee, 1978) saw society as an entity which is more than the sum of its constituent members. Society in Janice's case manifested itself as an external force which exerted a coercive pressure upon her. Janice could not escape the coercive pressure created by her mother and consequently her actions were largely determined by collective social patterns and practices within the family over which she had little or no control.

She existed within a vacuum of social isolation. She had detached herself to an extent from close and stable social relations with others. Social loneliness according to Brennan (1986) stems from deficiencies in social connectedness or social integration into a peer network or community. Janice spoke about her predicament for the first time when participating in this study. She shared no close bond with girlfriends. They all lived away from her, in Stanger. She was bussed daily to school and had no time to linger. This affected the intensity of her friendships.

Her need for a sense of belonging or integration was frustrated. The need for integration with peers and friends was critically important for Janice to allow her to move beyond the orbit of her family, especially since her family was increasingly unable to meet her relationship needs ('*I have nobody to talk to. My father works till late. My sisters are away at university. I get on very well with Melissa's boyfriend. But we had a misunderstanding and now we do not talk'* – APPENDIX C).

Janice's threshold to engage in suicidal behaviour was impinged upon by her emotional state of hopelessness and her lack of ongoing support systems. Her triggers included alcohol and other substance abuse, and interpersonal rejection. The starting of a diary had hopefully given her some sustainable vent for her feelings and a connection with her inner self.

6.2.2. Natalie's story

Natalie is an 18 year old girl in grade 12. She had an abortion 12 months ago. She suffers from severe depression and has given up the will to live. She appears totally disconnected from people around her.

I felt helpless, alone. I didn't know what to do, whom to turn to.....I was sent to my older sister's house in Durban. We do not have a close relationship. I could not talk to her. She did not understand me.....No one in school knew about the abortion. They thought I had the flu. I had no 'best friend' to confide in. I was always the loner - I kept aloof. I spent my breaks completing my schoolwork. I was not allowed to talk about the experience to anyone. My mother forbade it..... I felt abandoned, alone..... I feel as if I stopped living 12 months ago.
I constantly have thoughts of killing myself ... to punish me for what I have done ...I have lost over 10 kg in the last year. I can't eat. My classmates think that I am stressing over matric. They keep wishing that they could lose weight like me. If only they knew!.....
I used to cry but now I can't cry even though I want to. I don't see a future for myself. I have lost all interest in life. I don't have friends. I have nobody to talk to. I don't feel like going to school. I feel I do not fit in anymore. What's the use? There is nobody to talk to at home.

When Natalie aborted her baby she needed comfort more than anything else. Instead she was forced by her mother to pretend that it had never happened - a reality that Natalie could only acknowledge in silence. She soon became an emotional kettle on the boil. Her feelings overwhelmed her.

Natalie was in a state of helplessness and hopelessness. '*My mother threatened to kick me out of the house and never talk to me again if I continued with the pregnancy. I felt helpless, alone. I didn't know what to do, whom to turn to. I allowed my mother to take over'* – see APPENDIX C). She felt that there was nothing she could do to make up for the loss of her baby. She felt she had run out of choices in life. Life for her had become so ungratifying, so unfruitful and so futile that she feel powerless and trapped. Death for her promised comfort and a re-connection with her baby ('*I dream about Jared. He is calling me. He is all alone* – see APPENDIX C).

Natalie was in a state of *parasuicide*. Since her abortion, she had not engaged in overt suicidal acts but she had ceased to live. She was merely in a state of existence. She had stopped eating – lost a great deal of weight and lost all interest in life around her. Her life just revolved around her dead baby.

She had lost all connection with the living. Her mother, her ex-boyfriend, her father, her sisters and even people at school had no link with her. She was in a vacuum. Her own ability to relate to others was minimal. Her participation in this research appeared to be her last cry for help. She had broken the connection with her outer world because of her anger. She felt cheated and betrayed. A large part of this anger appeared to be directed at her mother. Her mother 'robbed' her of connecting with her father by not remaining married to him. Her mother robbed her of connecting with a 'mother'. Her mother 'robbed' her of the opportunity to connect with her peers and her school by preventing her from sharing her torment. Her mother 'robbed' her of connecting with her baby. Natalie's suicidal behaviour could be conceived of as inverted homicide because of her anger towards her mother. She expressed the wish to kill, the wish to be killed, and the wish to die (Kaplan & Sadock, 1998).

Natalie turned this anger inwardly – transforming it into hopelessness, desperation and guilt. She had lost the ability to solve problems in a rational and effective way. Her isolation and withdrawal from social interaction and her anorexic behaviour and her obsessive thoughts of her baby, Jared, alluded to a desire to reconnect with him. This was only possible if she died. She appeared trapped in her human body.

She has over the years allowed her mother to make decisions for her. The decision to abort however is not one that she is willing to accept, albeit in hindsight. She could not explain that to her mother at that point because their relationship lacked the connectiveness of understanding, tolerance and acceptance. Her efforts to express her feelings of sadness, frustration, or failure, were totally unacceptable to her mother. Her feelings were met by hostility. This response drove Natalie into further isolation. She had trouble communicating with significant others. There was no one to turn to when she needed to talk to someone. She had no emotional support. Her concern for her baby and her wish to take care of him should be interpreted as of grave significance in terms of suicidal intent as her only connection appeared to be with him. Her intense depression was one of the strongest predictors of suicide according to Klagsbrun (1976) and Smith (1993).

In becoming anorexic, Natalie had taken control of her body. Lack of normal sources of interest, warmth and comfort led her to turn to her body. Her suicidal behaviour of staving herself took on symbolic meaning. She had gained power over her life. Her mother manifested herself as an external force which exerted a coercive pressure upon her. She could not escape the coercive pressure. At the same time Natalie placed herself in social isolation, detaching herself from close and stable social relations with others.

Natalie's suicidal behaviour related to this social isolation represented both an aggressive impulse towards others and also turned back against the self in the form of a feeling of guilt. The feeling of guilt was the dominant motivational source of the tendency towards suicide. The depth of her depression outweighed her ability to cope.

Her profound sense of loss, of her baby - of someone that she deeply loved and connected with- was so significant to her that it led to overwhelming sorrow along with feelings of weakness and unworthiness.

Her maladaptive coping strategies led to irrational misinterpretations, increased anxiety and increased worry. She believed that Jared would be okay if he was with her or she with him. The maladaptive strategies led to her phobic anxiety and depression.

Natalie saw herself as controlled by forces that were outside or external ones. She felt powerless, isolated and alone. She experienced learned helplessness. She learned that she had no control over the outcome of her predicament, could do nothing to change things, and as a result became depressed and gave up. Her bereavement left her emotionally lonely and disconnected.

She caused herself to be socially lonely by not creating a social connectedness or social integration into a peer network or community. The need for her integration with peers and friends was critically important for her. In therapy Natalie worked on ego strengthening. She started to connect with herself and her spirit and this gave her enough confidence to attempt to make connections with others.

6.2.3. Lenny's dilemma

Lenny is in grade 10. He is fifteen years old. He is soft-spoken and intense. He has issues with his identity and seems desperate to find out who fathered him. His identity crisis has caused him to hate his body image and question the meaning of his existence. His emotional disconnection with his mother intensifies his torture.

> I feel lost, alone, abandoned. Is life worth living? I have lost count of the number of times I have asked myself that question. I still do not have an answer but life keeps getting bleaker..... I don't feel that I fit in. I am the odd one. Mum and I don't really talk. I can't express my feelings to her. I feel unwanted. I feel like a burden. I am worthless. I think of committing suicide all the time – of ending this misery – I could overdose – there is no point in carrying on. Mum has her other children. She would not care if I died. She does not care about my life.....I have no identity. I feel that I have no future. I have no friends. How do I make friends if I don't know who I am..... My school-work has deteriorated. I can't concentrate on my work..... I am no longer an 'A' student. Teachers are starting to complain. They don't understand my situation. They just think I am lazy..... Can't my mother feel my need? I am desperate! I just need to know. I need to feel whole. Nothing else matters anymore. I can't concentrate on anything else... It is driving me crazy ... I don't know how much longer I can hold on ...I want to just end this...the world will be better off without me...

Lenny felt trapped in a vacuum – 'I feel lost, alone, abandoned'. He had made no admitted attempts to express his feelings to his mother – 'Mum and I don't really talk. I can't express my feelings to her'. If his mother did sense his sadness she ignored it. There was no connection between them. This drove Lenny into further isolation, reinforced by the feeling that something was terribly wrong with him. He could not connect with his half-brothers. He saw himself as different from them, inferior, 'odd' – he did not 'fit in'. He felt unwanted. He felt like a 'burden'. He felt 'worthless'. He believed that his mother loved his younger brothers more. This caused him to withdraw from the family circle.

He started questioning the value of his existence and his parentage. His older brother did not appear to share his burning quest to know about their father. He and his brother shared no bond.

They interacted as relative strangers. His mother's silence on the identity of his father fueled his belief that he was 'worthless'. He had no identity.

His obsession with the idea of suicide was an indicator that life was worthless and not worth the pain and suffering – 'I think of committing suicide all the time – of ending this misery – I could overdose – there is no point in carrying on'. Suicide promised him comfort - an escape from confusion.

Lenny did not feel close to anyone. There was no one, in school or out of school, whom he could turn to when he needed to talk. His school-work suffered. He was no longer the 'straight A student'. Teachers failed to recognise the signs of depression. They labelled the deterioration in his work as laziness.

According to Owen (1995), early separation from the father could prevent masculine identification from occurring and could create a disruptive effect on learning masculine gender-role behaviours. The absence of a clearly defined identity affected his social relationships in school. A factor distinguishing adolescents prone to self-destructive behaviour is also related to problems in the development of self-esteem. Self-esteem as a person enters adolescence is often based on their ability to fit in with their peers. Low self-esteem leads to school difficulties and/or lack of confidence in success at school or in the future (Bronheim, 1986). Lenny could not fit in with his peers. He could not identify or bond with the boys. Spending time alone in class or with the girls made him an easy victim of bullying. The need for him to have integrated with his peers and friends was critically important for him. This would have given him the emotional support that he desperately needed. Instead he helped widen the gap – 'the boys call me a sissy' – 'I don't know what to talk to the boys about'.

Lenny was deprived of both his mother and father's affection. Lenny was deeply depressed. He had a very negative view of himself. Lenny's identity crisis caused him to have low self- esteem. He battled with his self-image. He wanted an extreme makeover. Lack of normal sources of warmth and comfort led Lenny to turn to his body. The idea of the extreme makeover put him into a fantasy world where he could escape from his painful reality. He hated himself physically. He could not connect with his inner self.

He withdrew from family and peers - keeping silently to himself. His need for a sense of belonging or integration had been frustrated by his mother and significant others. This led to his feelings of aimlessness, marginality and rejection.

Lenny experienced spiritual loneliness – He felt a deep need or 'will' to seek meaning or purpose in his life. He needed to know where he had 'come' from in order for him to plan where he was going. He experienced a lack of relatedness to any family values and meanings. This loneliness caused him to become desperate and was slowly pulling him away from living and life and towards death – '*I am bursting with questions? Can't my mother feel my need? I am desperate! I just need to know. I need to feel whole. Nothing else matters anymore. I can't concentrate on anything else... It is driving me crazy ... I don't know how much longer I can hold on ...I want to just end this...the world will be better off without me...*'

According to Reynolds (1991), suicidal behaviour can be plotted on a continuum varying in severity from ideation to intent, attempt and completion. Therefore, suicide ideation constitutes one aspect of suicidal behaviour (Reynolds, 1991). Lenny's suicide ideation, which refers to his thoughts and cognitions about suicide, may be considered an early marker of more serious suicidal behaviour (Bonner & Rich, 1987, Reynolds, 1991, Shea, 1998).

6.2.4.Isha – life's torment lives on ....

Isha had been sexually molested by her maternal uncle and aunt when she was younger. The family refused to acknowledge it and labelled her a liar. Her younger brother had similar experiences. This has scarred her emotionally and tainted her relationship with her parents. She sees no reason to continue living.

I find difficulty in sleeping, although I am very exhausted..... I used to go to the night-clubs..... ran away to Cape Town last year.....I am just trying to understand why I feel the way that I do. Is it even possible to feel unloved or not loved enough by your parents? Did my mother ever at once consider how I was feeling? .....I just want to be in peace. I don't want pain to control my life. When I look back and think about the fights that my mother and I used to have. It was not good. I actually hated my mother at a point. Every time that she tried to separate me from my boyfriends the more she alienated me from her ..... many times did I tell you that I

wanted to kill myself. Well years later and that part hasn't changed, I still am suicidal..... I wish I could have been stronger and stood up for myself. But I was always afraid of my mother. How could I have been afraid of my own mother? The person that brought you into this world, the person that you know is supposed to love you unconditionally and protect you, you are not supposed to be afraid of. But I was. Is it my fault? It's like my mother was ashamed of me because of what happened to me (*the sexual molestation by uncle)*.....I am so tired of analyzing my life, and putting everything into context. I just want to stop questioning..... I just want to take all the pain and anger that I have felt in all my life and bury it. I just want to have peace. I sometimes wonder if I will ever have peace. Last night I was thinking about suicide again. I sometimes feel that by death I will never have to feel anything again. No one knows what a struggle life is for me or how difficult it is just for me to get up in the mornings. I don't want to do anything, I just want to sleep and don't want anyone to come near me.

Isha's sexual molestation as a child, alienated her not only from her family, but also from herself. This scarred her emotionally and tainted her relation with all individuals she came in contact with. Her life became meaningless – *'I did not do anything in my life that gave me meaning'.*

Isha had difficulty relating with her parents. They were always fighting. She loved them both and did not want to take sides. However, she was also consumed with anger and hurt because of her mother's response or rather lack of response to her revelation of being sexually molested. She believed that her mother's loyalty to her family was misplaced and a betrayal to her own children.

Her mother labelled her a liar. She felt helplessness and hopelessness. As a child in an adult's world she felt powerless and trapped. She could not defend herself. Turning to Child Welfare was a desperate cry for help but her mother's suicidal threats cut the cord of hope – '*My mother's happiness was everything to me – it came above my own. And it hurts so much because I know that my happiness never mattered as much to her'.*

Isha was deprived of her mother's affection through maternal rejection. This deprived her of a sense of security and love. Her behaviour soon bordered on promiscuity. She was desperate for love – to be loved. She went from boyfriend to boyfriend. Her mother did not understand her need or chose not to understand. This drove Isha further away from her mother – '*Every time that she tried to separate me from my boyfriends the more she alienated me from her'.*

Isha's efforts to express her feelings of unhappiness, frustration, or failure, were totally unacceptable to her mother. Her father's silence in the matter did not assist her. It provided no support. In standing back, her father had also betrayed her. This drove her further into isolation – she was getting no protection from the adults that were supposed to care for and protect her. This isolation and alienation and a lack of a support system increased the suicidal ideation. She felt a great sense of loss.

This loss was so significant to her that it led to overwhelming sorrow along with feelings of weakness and unworthiness. She punished herself. She felt isolated, alienated and unloved. She could not find any solution to her predicament. Isha's need for a sense of belonging and integration are frustrated. She felt marginalized and rejected. She was filled with shame. This demanded a change in the self, that is, a moral 'rebirth'. The suicidal act may be the 'rebirth' for her. Isha lost the special feeling of being needed and wanted

Isha appeared to have a genetic predisposition towards depression (her mother's mental status). This combined with her emotional state of hopelessness, and the absence of ongoing support systems were sufficient triggers to the act of suicide.

She loved her mother dearly. She could not express her anger towards her. She turned those feelings inwards. The hopelessness, desperation, guilt, shame and humiliation became some of the predisposing factors that led to her suicidal ideations. She viewed suicide as the only alternative after a period of longstanding personal problems. Her mother's constant reference to suicide reinforced Isha's belief that it was a solution.

It had all become too much for Isha - *'I just want to take all the pain and anger that I have felt in all my life and bury it. I just want to have peace. I sometimes wonder if I will ever have peace. Last night I was thinking about suicide again. I sometimes feel that by death I will never have to feel anything again.'* The decision to end her life is a statement that life is worthless and not worth the pain and suffering. Suicide promised her release - comfort.

6.2.5. The life and times of …..Kay

Kay is a fifteen year old girl in grade 10. She has been an 'A' average student. She now battles to keep ahead academically. She feels she has no control of her life. She has experimented with alcohol and drugs causing her parents to further disconnect themselves from her. She has been a secret cutter since grade 7. She questions her sexual orientation. Kay enjoys writing in her journal. She sees it as her release – her private world.

My earliest recollection is asking God to let me die …. I remember asking god to give me Aids so that I can die. I did not know what Aids was……I had an acute panic attack when I was writing my grade 7 mid year exam. I was 12 years old. I received some medical treatment. I started cutting myself soon after….my sadness was unbearable. I could not take the inner pain. Death was the easy way out. I felt tainted. I cursed myself for feeling things so intensely. Why couldn't I be like others? Why did I have to feel things so deeply? I was angry with myself. Cutting was my punishment. In July last year, after three years of cutting I finally realised my 'foolishness'. I stopped cutting.

I often think about when I shall be gone
When the day of my death
Shall inevitably dawn

There was a time
When it had brought me to tears
When my very salvation
Had been so near…

The pleasure of knife against skin
My life flooding before my eyes
And while I may say…
Those days are long gone
One can never truly say
When matters of the mind
Are called upon.

Now I sit here
As the days go by
Watching the sun
Slowly fade and die.

Grade 9 was when I changed, I stopped caring about school and really began to rebel. A lot

happened. I started smoking and really lost control.

Every once in a while
When my mind goes well
I look back at the days that have passed by
To shed a tear or two
And often I sigh

To mourn the passing of those that have gone
And often those who have stayed
To regret the choices which I so readily made
And the beds in which I laid

I shall always regret
That is just who I am

Some say it is easier to forget
To bid farewell
To the thoughts that forge my hell

But then I always wondered
What to do when my mind goes well.

I started drinking. One evening, three months ago I walked into the house drunk and shocked my conservative, rigid, non-drinking parents (both teachers).....I stopped talking to my father two months ago because he scolded me for giggling uncontrollably after I had answered the telephone.....That was the excuse to put distance between him and me.

Dear god

I would just love to take this opportunity to say how F@#ed up life is..... The same fA*# story over and over. How about some answers god because my life is f@*#ed up and I do not know what to do.*

Dear diary

My relationship with my parents is putrid. Will everything really be okay? This shit makes me sad. Still have to lose weight! Have to get good marks in exams. Have to understand maths. Does it really matter? What is going to become of my life? Does all this shit really matter? .....I feel depressed. Why do I have so many problems?

I feel sad all the time. I started feeling like a real failure. I felt that I let myself down and would stop talking to my friends as punishment. I punish myself by 'spacing out' – being with friends and family but not talking to them. I have ostracised myself. I don't enjoy things the way I used to. I feel guilty most of the time. I expect to be punished. I am disappointed in myself. I blame myself all the time for my faults. I cry more now than I used to. I become depressed to punish myself. I really want to die. I feel all alone, abandoned.

Oh, how you left me
Alone and without hope

I cry now
My soul in despair
Of the way you left me without a care

For the pain I shall feel
The tears my eyes shall infinitely steal

The anger within me is no longer disguised
From my darkened depths, it shall rise
From deep within my being
It is the you in me leaving

Why, dear spirit, did you go
The answer, in truth, I already know
For you and I are one and the same
And in this tragic truth I feel no shame
For it is my imperfection in which I revel

Yet I ask once again
Why, dear spirit, did you go
And leave me here all alone
To cry, to die
The death of a crow.

.

I experience frequent headaches. I sleep a lot.

I met someone in the internet chat-room. I think I have found my soul-mate. I have made a profound discovery .... I am a lesbian!

They said the pain would go away
That I would awake one day
And walk in the breeze

They said my mind would be free

That day never came

Now I sit here
As the days go by
Watching the sun
Slowly fade and die

I often think
About when I shall be gone
When the day of my death
Shall inevitably dawn

There was a time
When it had brought me to tears
When my very salvation
Had been so near

And while I may say
Those days are long gone
One can never truly say
When the matters of the mind
Are called upon...

Kay battled to keep afloat. She was severely depressed. She was suicidal. She was a cutter. Her journal entries and her poetry (which she offered to me at the end of the interview) created a flimsy connection between her soul, her spirit and her physical self.

Kay felt that nothing she could ever do would make a difference with her father. He was extremely rigid in his thinking. His uncompromising standards yielded helpless and hopeless feelings within Kay. She felt that she could not measure up to his standards. There were only two ways of doing anything – his way and his right way. Kay was a free soul. She failed to sustain a connection with him. She felt powerless and trapped in her father's presence. Life for her was not worth the pain and suffering. Suicide promised her comfort.

Her mother was too passive. She loved her daughter but was too weak to stand up and oppose her husband's method of parenting. Kay failed to communicate her feelings to her mother.

Her intense depression made her decision making irrational. The act of cutting herself provided her with a sense of release.

She was confused about her sexuality. She manifested extreme anti-social behaviour. She showed signs of anorexia. She felt trapped or expendable. It led her into a culture in which alcohol and delinquent behaviour became substitutes for love, feelings, and shared understandings.

Gaines (1991) believes that adolescents kill themselves to get attention or revenge. Suicide, for Kay, could have been the final resistance to her father's authority, a last stand against his conformity. By choosing to die she would gain power and control. She would be able to master life by mastering death, and in that way she would achieve a sense of immortality. Death could also be a way to punish her parents and force them to express love towards her.

Kay's father believed that Kay was a spoilt adolescent who did not appreciate all that he did for her. He did not believe that she was mentally ill and needed help. The solution for him was a few slaps, a period of grounding and the confiscation of the cellphone. For Kay this was tantamount to solitary confinement. It cut all ties with her outer world. Even the lesbian 'lover' that appeared to be safe to have was out of her reach.

Her father stated that her sessions with the psychologist were a waste of money. He did not however stop them. Kay's efforts to express her feelings of unhappiness, frustration, or failure, were totally unacceptable to her father. Such feelings were ignored or denied by him and met by defensive hostility. Such response drove her into further isolation, reinforced by the feeling that something was terribly wrong with her.

Kay's drinking 'spree' was a cry for help. It was a manifestation of suicidal behaviour. She turned to alcohol to relieve tension when internal and external pressures were intense. It was rebelliousness with the support of a friend. It also indicated an effort to come to grips with feelings of emptiness. Kay's closeness with her friend created a connection that kept her from total loneliness and maybe even suicide.

According to Klagsbrun (1976) and Smith (1993) depression is one of the strongest predictors of suicide. Kay's use of anti-depressants led to a demonstrated reduction in suicidal behaviour. There are also challenging new findings with the more recently available anti-depressants. Thus there

has been a demonstrated reduction in suicidal behaviour in patients with repeated suicide attempts but without major depression or another axis one diagnosis when treated with an anti-depressant with central serotonergic functioning (Verkes et al, 1998).

Kay showed a number of the signs of depression. She ate very little. She wanted to be alone most of the time. She withdrew from her family and friends. She experienced a profound feeling of worthlessness and a lack of self-esteem. She tended to act out her feelings rather than talk about them. She switched from being a pleasant, well-behaved student to a wild and unruly one.

Kay's very process of becoming a person, of assuming an individual identity and a separate sense of self, led to her experience of isolation and loneliness. Her father failed to understand that the process of individuation included not only separation from parents but also the assumption of increased autonomy and individual decision-making.

Kay created for herself a world of social loneliness. She experienced severe deficiencies in social connectedness or social integration into a family or peer network or community. The need for her to have integration with her peers and friends was critically important for her. They would have provided the support system that she needed.

She had a great need to find meaning in her life. Initially she did not appear to have serious intentions of dying. The panic attacks she experienced when she was twelve years old received some medical attention and nothing more. The superficial slashes on her wrists were a cry for help. When these cries were unnoticed and unheard the nature of her intentions changed subtly.

Her sadness became unbearable. She could not take the inner pain. She blamed herself for her suffering. Cutting was her punishment – but death seemed to lurk –

The pleasure of knife against skin
My life flooding before my eyes
And while I may say...
Those days are long gone
One can never truly say
When matters of the mind
Are called upon.

Before starting on the anti-depressants and under going psychotherapy Kay believed that she was in a state of helplessness. She was of the opinion that she had no control over the outcome of a predicament and that she could do nothing to change things. As a result she became depressed and gave up. Three things then happened. The first was that motivation to keep trying was drastically reduced; the second was that the tendency to see success as a future possibility decreased; the third was that emotions became depressed.

They said the pain would go away
That I would awake one day
And walk in the breeze
They said my mind would be free
That day never came

Kay was disjointed, not just from her family and friends but also from herself, her spirit and her soul.

I cry now
My soul in despair
Of the way you left me without a care

Why, dear spirit, did you go
Yet I ask once again
Why, dear spirit, did you go
And leave me here all alone
To cry, to die
The death of a crow.

6.3. CONCLUSION

All five adolescents interviewed showed clear signs of being disconnected from their outer and inner worlds. They battled with inner demons and saw no solution or help that could ease the emotional pain. Many of them were aware of support structures but did not turn to them. Suicide or suicidal behaviour appeared to be the better choice.

The merit of using the bio-psycho-social model of interconnectiveness is made visible here. With support, therapy and medication some of them started to see life differently. The medication

helped them deal with the severe depression and they became more open to the suggestions made in therapy. They became aware of alternate action that they could take or support structures that existed around them. They started to look within for support. They formed connections with their outer and inner worlds. For those who started making connections, their journey took them in the direction of the living – those who were still disconnected continued on a journey towards death.

Chapter seven presents the pulse of connection – the possible key to unlocking the enigma of adolescent suicidal behaviour.

CHAPTER SEVEN

THE PULSE OF CONNECTION

7.1 INTRODUCTION

After a perusal of the literature on suicide and suicidal behaviour, the analysis of different theories on suicide and the statistical and case study analysis, it became clear to me that what is required for psychological and emotional stability and balance – and therefore no engagement in risk or suicidal behaviour is a feeling of connection. Gispert (1987) and Schlebusch (2005) both pointed out that one of the ways of preventing suicidal behaviour is to recognise symptoms in those who become suicide prone. However, if the signs and symptoms are not clearly identified then suicidal behaviour cannot be easily recognised. Social isolation, alienation, lack of support systems or unavailability of somebody to turn to certainly increases risk of suicidal behaviour for the young person in extreme distress (Garfinkel & Northrup, 1989).

7.2. EMERGING FINDINGS

The following have emerged as findings from my exploration into adolescent suicidal behaviour in a case study at a particular secondary school in KwaDukuza on the North Coast of Kwa-Zulu Natal:

- There should be a shift in thinking about suicide – from suicidal behaviour to suicidal impulses. We should be more concerned with identifying the suicidal impulse in those who are unhappy or dissatisfied without actually having made an attempt on their lives, but who are nevertheless a suicide risk (Engelbrecht, 1978). With the exception of the suicide prevention programme of the South African Police Services, there is no national suicide prevention programme in place at present (Schlebusch, 2005). I hope that this study will be the catalyst for the Department of Education and individual schools and communities to take a more pro-active role in suicide prevention amongst adolescents.

- Deviant behaviour should be a cue or sign of possible suicidal manifestations. None of the adolescents expressing suicidal behaviour in the case studies had good communication or connections with adults or peers. They experienced conflict - had no faith or trust in anyone, including themselves. They could no longer express their feelings without resistance and anger as the feedback from adults. The adults in their world failed to realise that the adolescents expressed themselves in deviant and delinquent suicidal behaviour (as defined in this study) when other ways of communicating with the adults had failed. Parents and teachers need to broaden their definition of suicidal behaviour so that they are more attuned to adolescent cries for help. If the parents and teachers of the adolescents in the case studies had been more attuned to the adolescents, they would have connected better with them, guided them better and allowed for the expression of anger, pain, fear and aggression in a more productive and constructive way.

- The five adolescents interviewed were struggling to have control over their world. Parents and to a lesser degree other adults failed to hand over the desired control. These individuals needed to express themselves so that their own identity could emerge. Because this was not happening, adolescents sought destructive ways – it became a Dance of Power. They perceived the best form of defence to be 'attack' – against the world or themselves. In most cases the adolescent had failed to connect meaningfully with her/his parents, her/his environment, and herself/himself. Adolescents need to be given gradual control over themselves so that they can have the power to make positive connections in their world.

- there is a need for a concerted effort from parents, educators and adolescents to form a network of connections with adolescents and for adolescents. This network should be based on the bio-psycho-social model. Adolescents should be informed of support structures that will assist them in being productive participants in society by having a sound mind in a sound body. The secondary school chosen for the case study had not connected with at risk adolescents. This is despite the fact that they had hosted a workshop two years ago on suicide. They did not even have an awareness corner in the school resource centre or a display of support structure numbers in the community that adolescents could call if they were distressed. Suicidal behaviour of learners at the school was not documented. The school had no records of learners who had attempted suicide or completed suicide.

7.3. LIMITATIONS

The information/data gathered in this research has the following limitations:

- this was a case study of adolescents at a particular school and therefore generalisation of all adolescents cannot be made
- the survey questionnaire did not have adequate validity or reliability data and the findings could have been unintentionally biased on the basis of the nature of the survey items
- the data was limited to the information provided by volunteers – this prevented an accurate analysis
- although anonymity was assured, adolescents with confidentiality issues may have withheld certain information or distorted other bits of information

7.4. RECOMMENDATIONS

Good mental health and therefore good life skills in adolescents are enhanced through healthy connections - the maintenance of strong family ties, the assistance of supportive friends, and the use of community support systems, including the school.

Support systems have the following benefits:

- the adolescent is provided with a means of expressing her/his feelings – connecting with the outer world
- it provides feedback from others which is important in helping to develop an appropriate appraisal of a situation and set realistic goals – allows the outer world to connect with the adolescent
- it helps the adolescent establish a sense of meaning – the adolescent connects with her/his spirit
- the social contacts also provide useful information and practical help – a connection is created that helps other adolescents in need.

Because of the status that school personnel hold within the community, they carry an especially effective networking credibility – the ability and opportunity to connect 'at risk' adolescents with helping organisations and personnel. Schools have a unique opportunity for crisis intervention because of three particularly important aspects of their normal function and curricular (Nelson & Slaikeu, 1984):

- they are in regular, ongoing and lengthy contact with the crisis-experiencing adolescent
- there is a high compatibility between the problem-solving orientation of crisis services and the normal approach to meeting the demands of living as espoused by the schools
- principles of sound growth and healthy development are all based on effective learning: schools are in a position to help adolescents learn about crisis solving because they are already teaching them to learn, and they are used to learning in a school situation.

Life Orientation was made a compulsory subject in the FET phase (starting with grade 10 in 2006 and grade 12 in 2008). Learners have to pass Life Orientation in order to progress to the next grade. The syllabus focuses on life skills. This is a highly commendable move by the Department of Education in South Africa. However the down side of this is that by making it an examinable subject, learners see it as another academic subject and not an opportunity for them to connect with others and themselves and express and release their emotions. The other problem is the prevalent attitude surrounding suicide that construes it as being a matter of social taboo (Schlebusch, 2005). This then holds the troubled adolescent back from admitting in a class situation that she/he has had the suicidal impulse. Educators, especially those involved in the teaching of Life-skills and Life Orientation have to be trained to identify signs and nonverbal messages of distress.

Educators can help adolescents by:

- teaching them skills of generalization and divergent thinking which help the individual seek out new or alternative solutions to problems
- teaching them how to reduce the exacerbating effects of narrowed perception, constricted thinking, and too intensely focused problem solving which accompanies the anxiety of stressful situations
- focusing attention to aspects that enhance positive growth in individuals
- being flexible and sensitive to adolescents

- being receptive to adolescents' attitudinal input
- having positive academic expectations of adolescents
- providing counselling services
- setting up a student-helping network
- adequately discriminating problems and referring to specialists
- providing opportunity for individual creative expression
- encouraging adolescents to become participants in extracurricular and community services as a deterrent to withdrawal and feelings of isolation and disconnection at times of crisis
- structuring the curriculum to include a more positive study of society, with the emphasis on problem solving and the building of a society that is connected and interdependent upon each other for support and assistance
- developing personalised and therefore connected rather than institutionalised teacher-learner relationships
- creating a 'friends network connection' where everyone in the school has at least one friend upon which to call for help so that everyone may expect assistance to be available in times of need.

Berkovitz (1985) has suggested five separate activities or goals for schools if they are to contribute effectively to the primary prevention of suicide and suicidal behaviour:

- a healthy general mental health atmosphere of the individual school and school district
- optimum psychological services staff
- an organised and active suicide prevention program
- an organised and active suicide intervention program
- an organised and active suicide postvention or rehabilitation program.

Schools should be able to provide ongoing informational and training workshops for both staff and learners (Johnson & Maile, 1987).

Suicide is something no one wishes to face alone, and school personnel are no exception. The concept of networking and creating supportive connections is strongly supported when facing problems of suicide and suicidal behaviour. Networking may be formal or informal. Duraj (1984)

suggests that there is a strong parallel between the function of the family and school system in terms of suicide risk and social relations. As a result, their functions informally become intertwined and mutually supportive. In creating a connection with the parents teachers are able to better connect with learners because they will be more aware of the stressors that adolescents in individual situations are experiencing. This would lead to lessons being designed to provide coping skills for those situations without isolating and at times embarrassing the individual learner. This may also lead to empathy for learners in such situations and the connection in the class grows stronger and the support base for learners expands.

Johnson (1985) suggests that networking concepts be taught to adolescents so that they may become familiar with both the need for networking and the available resources for help in their own community. The wisdom here is that networking creates the connections that a suicidal adolescent lacks. Since evidence indicates (Snyder, 1971) that potential suicide victims typically turn first to family and everyday friends and to the more traditional and perhaps formal sources such as clergy, psychiatrists, social workers only later, the need for the school to be more ready to play the role of referrer to other established sources of help is apparent. Treatment of potentially suicidal adolescents must be prompt. Treatment should deal both with the immediate events and life circumstances that are troubling the young person and with longstanding problems and conflicts (Conger, 1991). Teachers in schools will only be able to do this if they themselves are connected to the adolescents – where they are able to read the signs accurately – where they do not mistake adolescent suicidal behaviour for just delinquent 'brat' behaviour. Warning signs of impending suicidal behaviour come from verbal, behavioural and situational cues. In each instance, school personnel (including fellow learners) are in an excellent position to be among the first to become aware of such important precursors of actual suicidal behaviour (Johnson & Maile, 1987).

7.5. CONCLUSIONS

There are a number of ways in which adolescent suicidal behaviour can be prevented. Broad social issues can be influenced by firm advocacy for change in appropriate areas in different countries, such as by restricting access to specific means of suicide and by enhancing health and social services in general.

There should be regular screening for the presence of specific mental disorders and suicidal tendencies, which, if present, should be treated vigorously. If medication is indicated, the safest drug should be prescribed, although it is emphasised that even if drugs are utilised, non-drug treatment is important in every suicidal person. The focus of supportive therapy should be the provision of hope for the future, the enhancement of independence, and the learning of different ways of coping with the inevitable stressors of everyday life.

Shneidman and Farrow (cited in Klagsbrun, 1976) popularised the term 'cry for help' mostly in regard to suicide attempts, where help can still prevent tragedy. In many situations adolescent suicidal behaviour becomes a way of communicating with others after all other forms of communication have broken down – when connections with the outer world is tenuous or non-existent.

Every adolescent has the potential to become master of his or her own life (De Leo, Schmidtke & Diekstra, 1998). The ultimate goal of psychological help or of mental health care therefore should be to connect adolescents with their world – to empower them, to increase their sense of competence, their belief in self-efficacy. Educating adolescents to help themselves, educating families to deal with the ebb and flow of conflicts in a healthy way, educating communities such as schools, and neighbourhoods to foster self-efficacy in their children could eradicate feelings of hopelessness/helplessness that form the breeding ground of demoralization, fatigue of life, depression and self destruction.

Although the intrapsychic and interpersonal factors are undoubtedly significant and often predominant in suicidal crises, the relationship between biological, physiological and genetic forces should also be explored and evaluated. Intervention, therapy and postvention in adolescent suicidal behaviour therefore require a multidisciplinary approach. The adolescent may not, for example, be able to make connections with her/his outer and inner world until she/he is medicated and treated for biological and /or physiological problems.

Adolescent suicidal behaviour should be perceived as a public health problem rather than an act by an individual. There is unfortunately still a stigma attached to suicidal behaviour and this leaves affected adolescents and families in isolation. Stigma also keeps adolescent suicidal behaviour from being identified as a public health problem that is preventable. This could be the reason (besides financial ones) why the Department of Education has not seen the urgency to strengthen

counselling services in schools. In the absence of such support parents, educators and adolescents need to join forces – create a network of connections – both physical and emotional – so that desperate cries of adolescents are heard, interpreted and eliminated.

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APPENDIX A

CORRESPONDENCE

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (FRANCIS STOCK BUILDING)
HOWARD COLLEGE
TELEPHONE NO.: 031 – 2603587

28 APRIL 2005

MRS. A GOVENDER (7709873)
EDUCATION

Dear Mrs. Govender

ETHICAL CLEARANCE

I wish to confirm that ethical clearance has been granted for the following project:

"Adolescent suicidal behaviour – a desperate cry for help"

Yours faithfully

.....
MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Faculty Officer
cc. Supervisor

P O BOX 391

UMHLALI
4390

Department of Education and Culture
Research Department

ATTENTION: GORDON GUMEDE

Sir

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL SCHOOLS.

I am conducting research towards a PhD at the University of Kwa-Zulu Natal. The focus of my study is Adolescent Suicidal Behaviour.

South Africa is rapidly becoming one of the major suicide capitals of the world. Suicide claims more adolescents than any disease or natural cause. The presence of suicidal behaviour among adolescents however has received relatively little attention in South Africa.

I will therefore appreciate it if permission is granted to me to conduct research at two secondary schools in the Lower Tugela District. The choice of schools will depend on the responses of principals and Governing Bodies. The tools of my research will take the form of structured questionnaires and interviews.

A study of this nature is bound to stir up emotions in adolescents who may already be suicidal. I am a registered educational psychologist employed by the department of education. I reside in the chosen area and will make available my services to those adolescents who may need counselling during and after the research process.

It is hoped that this study will provide valuable information for parents, educators and society at large to assist adolescents cope with the increasing stresses and demands of life.

I hope that this request to conduct research is met favourably. Please find attached the following:

- a copy of the letter from the University granting ethical clearance for the study
- a research proposal
- a copy of the questionnaire
- a copy of the letter to be sent to principals/governing bodies
- a copy of the letter to be sent to parents seeking permission for their children to participate in the research.

I thank you in anticipation.

A Govender

Persal No: 10960295
Email: annegovender@tiscali.co.za

P O BOX 391
Umhlali
4390

Dear Parent

I am a student at the University of Kwa-Zulu Natal, currently studying towards a PhD.

My research requires me to administer a test to adolescents at a selected school.

The purpose of my study is to examine the behaviour of adolescents, establish the contributory factors and make recommendations to improve negative behaviour patterns and the prevailing conditions around adolescents that may influence destructive behaviour.

I am an Educational Psychologist. I will make myself available to adolescents who may experience problems during and after the research process.

The information gleaned from the research will remain strictly confidential and used only for research purposes. I will appreciate it therefore if you will grant me permission to administer the research instrument to your child.

Yours faithfully

A GOVENDER

PARENT'S REPLY SLIP..... PLEASE TEAR AND RETURN.....

I, Mr/Mrs ..... parent/guardian of

..... in grade .....hereby grant permission for my

child/ward to complete the questionnaire as a participant in the research project. I

understand that the information obtained from the research will remain strictly

confidential and used for research purposes only.

.....
Parent's/guardian's signature

P O BOX 391
Umhlali
4390

18 July 2005

The Principal
Stanger Secondary School

Dear Mr Sambiah

REQUEST TO CONDUCT RESEARCH

I am a student at the University of Kwa-Zulu Natal, currently studying towards a PhD.

My research requires me to administer a test to adolescents at a selected school.

The purpose of my study is to determine the prevalence of suicidal behaviour in adolescents, establish the contributory factors and make recommendations to improve the prevailing conditions.

I am an Educational Psychologist. I will make myself available to adolescents who may experience problems during and after the research process.

I will appreciate it therefore if permission can be granted to me to conduct my research with learners from grade 10 - 12. I enclose a letter from the Department of Education and Culture granting me permission to conduct my research at a department school.

If you require further information, please contact me at the following numbers:

032 9472381
0844554433

Yours faithfully

A GOVENDER

Email: annegovender@tiscali.co.za

P O BOX 391
Umhlali
4390

18 July 2005

The Chairman
School Governing Body
Stanger Secondary School

Dear Sir

REQUEST TO CONDUCT RESEARCH

I am a student at the University of Kwa-Zulu Natal, currently studying towards a PhD.

My research requires me to administer a test to adolescents at a selected school.

The purpose of my study is to determine the prevalence of suicidal behaviour in adolescents, establish the contributory factors and make recommendations to improve the prevailing conditions.

I am an Educational Psychologist. I will make myself available to adolescents who may experience problems during and after the research process.

I will appreciate it therefore if permission can be granted to me to conduct my research with learners from grade 10 - 12. I enclose a letter from the Department of Education and Culture granting me permission to conduct my research at a department school.

If you require further information, please contact me at the following numbers:

032 9472381
0844554433

Yours faithfully

A GOVENDER

Email: annegovender@tiscali.co.za

APPENDIX B

INSTRUMENTS

QUESTIONNAIRE FOR ADOLESCENTS

Dear Adolescent. The aim of this questionnaire is to gather information to determine the factors that influence and affect adolescent behaviour and to determine what support systems are available. Information disclosed in this questionnaire will be treated with strict confidentiality and will be used solely for research purposes. Please fill in the appropriate details by ticking
( ) the blocks that apply to you. Thank you.

A. BIOGRAPHICAL DETAIL

1. Grade:

1.1	Gr10		1.2.	Gr11		1.3.	Gr12	

2. Gender

2.1.	male		2.2.	female	

3. Religion

3.1.	Hindu		3.2.	Christian		3.3.	Muslim		3.4.	Ancestral belief		3.5.	Other (specify)	

I pray

4. How old are you?

4.1.	14yrs		4.2.	15yrs		4.3.	16yrs	
4.4.	17yrs		4.5.	18yrs		4.6.	Over 18yrs	

B. FAMILY DETAILS

(You may tick more than one block)

5. My father is

5.1.	working		5.2.	dead		5.3.	unemployed	
5.4.	Living away from me		5.5.	Re-married		5.6.	Other (specify)	

6. My mother is

6.1.	working		6.2.	dead		6.3.	Unemployed	
6.4.	Living away from me		6.5.	Re-married		6.6.	Other (specify)	

7. I live with

7.1.	Both parents		7.2.	My father		7.3.	My mother	
7.4.	My guardian		7.5.	Relatives		7.6.	Other (specify)	

C. Problem Solving (You may tick more than one block)

8. When I feel sad or have a problem I: TICK

8.1.	Get drunk	
8.2.	Chain smoke	
8.3.	Use drugs	
8.4.	Take tablets to make me sleep/forget my problems	
8.5.	Get into a vehicle and go for a 'spin'	
8.6.	Eat excessively	
8.7.	Starve myself	
8.8.	Cut myself e.g. slash my wrists	
8.9.	Get angry	
8.10.	Avoid people	
8.11.	Lose my will to go to school or do my schoolwork	
8.12.	Cry	
8.13.	Bite my nails	
8.14.	Forget to take my medication e.g. diabetes, asthma	
8.15.	Think/Talk/write about dying	
8.16.	Other (specify)	

9. When I have a problem I turn to:

9.1.	A friend of the same sex	
9.2.	A friend of the opposite sex	
9.3.	My father	
9.4.	My mother	
9.5.	The school counsellor/ a teacher	
9.6.	No one	
9.7.	A social worker	
9.8.	My religious organisation	
9.9.	My pet/s	
9.10.	My journal/diary	
9.11.	My drawing/painting/sculpting	
9.12.	My music	
9.13.	Myself	
9.14.	Other (specify)	

10.Which of the following support systems are readily available to you when you have a problem:

10.1.	A friend of the same sex	
10.2.	A friend of the opposite sex	
10.3.	My father	
10.4.	My mother	
10.5.	School counsellor/ a teacher	
10.6.	No one	
10.7.	Social worker	
10.8.	My religious organisation	
10.9	My pet/s	
10.10.	My journal/diary	
10.11.	My drawing/painting/sculpting	
10.12.	My music	
10.13.	Myself	
10.14.	Other (specify)	

11. Which of the following has helped you cope with a problem

11.1.	A friend of the same sex	
11.2.	A friend of the opposite sex	
11.3.	My father	
11.4.	My mother	
11.5.	School counsellor/ a teacher	
11.6.	No one	
11.7.	Social worker	
11.8.	My religious organisation	
11.9.	My pet/s	
11.10.	My journal/diary	
11.11.	My drawing/painting/sculpting	
11.12.	My music	
11.13.	Myself	
11.14.	Other (specify)	

12. **(Sexual Behaviour)**

At the moment I

12.1.	Am not sexually active	
12.2.	Always use protection	
12.3.	Sometimes use protection	
12.4.	Never use protection	
12.5.	Have more than one sexual partner	

13. **(Smoking)**

At the moment I

13.1.	Do not smoke	
13.2.	Smoke daily	
13.3.	Smoke a couple of times a week	
13.4.	Smoke occasionally	

14. (Use of alcohol)

At the moment I

14.1.	Do not drink alcohol	
14.2.	Drink daily	
14.3.	Drink weekly	
14.4.	Drink occasionally	

15. (**Use of drugs**)

At the moment I

15.1.	Do not use drugs	
15.2.	Use drugs daily	
15.3.	Use drugs weekly	
15.4.	Use drugs occasionally	

16. (**Bullying**)

At the moment I

16.1.	Am a victim of bullying	
16.2.	Bully other children	
16.3.	Help children who are being bullied	
16.4.	Watch while other children are being bullied	
16.5.	Am not aware of bullying at school/in my environment	

17. (Bad behaviour)

I have been scolded by a teacher/sent to the office/suspended

17.1.	Once in the last six months	
17.2.	2 – 4 times in the last six months	
17.3.	5 or more times in the last six months	
17.4.	Does not apply to me	

D.RELATIONSHIP WITH PARENTS/GUARDIANS (you may tick more than one)

18.

18.1.	My parents'/guardian's expectations of me are too high	
18.2.	I become angry when my parents/guardians discuss my work with others	
18.3.	My parents/guardians expect me to do too many other extra-curricular activities	
18.4.	My parents/guardians are always quarrelling	
18.5.	My parents/guardians do not guide and encourage me	
18.6.	My parents/guardians do not show me love and care	
18.7.	My parents/guardians allow me to do whatever I want to do	
18.8.	My parents/guardians are too strict with me	

19. Read the following case study and then answer the questions that follow:

Sarah is 15 years old and in grade 10. Her father is an alcoholic. He often beats her mother. When Sarah tries to help she is also beaten. Her father is the breadwinner of the family. Her mother only has a Grade 7 qualification and has never had a job. Sarah's schoolwork has suffered because of poor attendance (due to injuries from beatings) and not being able to do homework (hiding from drunk father or disturbed by noise made by father). Her classmates tease her because of her low marks and her father's behaviour. Sarah feels sad and alone. She has already tried to kill herself. A group of local teenagers who drink and smoke have asked her to join their group. Sarah wants to join them.

19.1.What do you think of what Sarah has done (trying to kill herself)? I think that....

_____

_____

_____

_____

_____

_____

19.2. What do you think of what Sarah is thinking of doing (joining a group that drink and smoke)? I think that.... _____

_____

_____

_____

_____

_____

19.3.What would you do if you had been in Sarah's situation? I would ...

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR TIME!

BECKS INVENTORY

Please read each group of statements carefully, then tick the one statement in each group, which best describes the way you have been feeling during the past week, including today.

NAME: _____ DATE: _____

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10.	0	I don't cry anymore than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worst than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 3 kg.
2 I have lost more than 5kg.
3 I have lost more than 10 kg.

I am purposely trying to lose weight by eating less. Yes ____ No _____

20. 0 I am no more worried about my health than usual.
2 I am worried about physical problems such as aches and pains; or upset stomach or Constipation.
3 I am worried about physical problems and it's hard to think of much else.
4 I am so worried about my physical problems, that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX C

INTERVIEWS

THE INTERVIEWS

1. JANICE'S STORY

Thursday, 28 July 2005. My phone rang at 15h13. It was Janice. She had met me two days ago at her school when I there administering the questionnaire. She wanted to make an appointment to see me. An appointment was made for Saturday at 10h30.

Saturday, 30 July 2005. Janice was dropped off, at my office, by her mother. She appeared to be a friendly, articulate individual who spoke about a wide range of topics.

I am sixteen years old, in grade twelve and should be excited about my future. Yet I often feel sad. What is the purpose of my life? I feel so confused. My parents fight all the time. I am torn between them. I don't like to take sides. I also don't like to be around when then fight. My mother likes to shop. She is a shop-a-holic. She buys unnecessary things. My father wants me to go shopping with her so that I can control what she buys. I don't like to play watchdog for my dad. I love him a lot.... I live for him.... But I don't like guarding my mum. We fight all the time because of this.

The situation at home is unbearable. Our three bed-roomed house has become a hostel for all. My mother gave permission for her long time estranged brother and his pregnant wife to move in with us three months ago. This was supposed to be a temporary arrangement. My mother did not consult with my father or us the children. My sisters, Jennifer and Melissa are both studying in Durban. They live in Durban during the week. My sister Melissa's boyfriend lives with us. He is younger than her. He was in my class but he dropped out of school. Now he works for my father. He is my friend but we had a fight over something stupid (I can't remember what) and we are not talking. I am very stubborn. I miss talking to him but I don't want to apologise. The last time we fought he sms'ed me and we made up.

My sister, Jennifer, was forced to give up her room. When she comes home for the weekend she has to sleep in the lounge. Melissa's boyfriend also sleeps in the lounge.

I have no peace and quiet to do my homework. My aunt is always watching DVD's. She eats whatever we buy but she and my uncle do not share what they buy. My dad loves chocolates. She sits in front of him and eats chocolates. She offers nobody. Yet when we leave chocolates in the fridge she helps herself.

I was sick on Thursday. I felt weak. I had a stomach-ache. I did not go to school. I asked my mother to take me to the doctor. She went shopping with my aunt for non-essentials. She left me alone at home. She promised to take me to the doctor when she returned. She got back late in the afternoon. It was too late to go to the doctor. I felt that she did not care about me. She did not even ask me if I had had something to eat. I took a handful of sleeping tablets and went to bed. I often do that. It helps me forget. I have nobody to talk to. My father works till late. My sisters are away at university. I get on very well with Melissa's boyfriend. He has problems with his family. He has no contact with them. We share a lot but we had a misunderstanding and now we do not talk. We sit in the same room and stare in opposite directions. I don't know what the misunderstanding was all about.

I suggested to Janice that she sms her sister's boyfriend, not an apology but a friendly message. She was quite keen on the idea. It was also agreed that she would start keeping a diary. She was cautioned about overdosing herself with sleeping tablets.

Saturday, 6 August, 11h00. Janice' second session.
She is very upset. It has not been a very good week. The only good thing has been the end of the 'fight' between her and her sister's boyfriend. She had her friend back, someone to talk to. She had also started a diary.

I have been a daily smoker for over a year. I get up in the morning and start my day with a shot of neat brandy. I want to stop smoking and drinking because I do not want to cause my father any more pain. However, I cannot sleep. I have taken my mother's sleeping tablets again. My mother cares more for my two sisters and her family than she does for me.

Maybe I need to explain my relationship with my mother a little more in detail. We have not been close in a long, long time. When I was six years old my family was involved in a motor vehicle-accident. My younger sister died. My mother has never been the same since. My father was driving. It was not his fault but my mother has never stopped blaming him. My sister was sitting on my mother's lap. I was always my father's favourite. She uses me to get to him...

My mother has done it again! On Wednesday she was forty minutes late to pick me up from the bus stop. She picks me up every day because it is a very busy and dangerous area. Last week the shopkeeper was attacked. I could not wait there. I walked home alone. It is a three kilometre stretch. My mother did not even apologise for being late.

My aunt's baby is due in two weeks time. My aunt is not going to her mother's place after the baby is born. She has made arrangements for her mother to stay with us. Where is the place? My uncle suggested she shares my room. Heaven forbid! She suggested that her mother share the bed with her and the baby and my uncle sleep on the floor. My mother is silent in all of this. So too is my father. I am being kicked out of my room. My exams are around the corner. No one seems to care.

Thursday was parents' evening. My mother was not happy with my marks. She told my teacher that I watch videos all the time. I do not study. The truth is my aunt watches the videos. The sound disturbs my studying and I end up watching the videos. When I got home I asked my sister's boyfriend to disconnect the DVD player. I took some sleeping tablets and went to bed.

Janice continued to take sleeping tablets. It was an escape. Her parents refused to join her in therapy. Her father was too busy to take time off work. Her mother felt that Janice was a spoilt child who was attention seeking. She stopped Janice from continuing with therapy.

2. NATALIE'S STORY

Natalie is an 18 year old girl in matric. She had an abortion 12 months ago. She looked like a 12 year old – tiny body with big, sad eyes.

It was August 2004 – the happiest time of my life. I had a boyfriend. I felt part of something, needed and loved. I am an intelligent person. I knew about sex and the consequences. But the need for someone to hold me close, kiss me and tell me how loved I was blinded my judgement. I gave in willingly. I fell pregnant.

My boyfriend was 21 years old, unemployed and living with his parents. I was blind to his faults. I only saw someone who could put his arms around me and make me feel wanted. He wanted me to keep the baby but he was not working and showed no inclination to find a job. He just sat at home, smoking, drinking and being dependent on his family. He could not support himself, let alone the baby and me. His family was not prepared to take me in. I don't blame them. We would have been additional burdens.

My mother threatened to kick me out of the house and never talk to me again if I continued with the pregnancy. I felt helpless, alone. I didn't know what to do, whom to turn to. I allowed my mother to take over. She arranged for me to have an abortion when I was fifteen weeks pregnant – that is one year ago. I was sent to my older sister's house in Durban. We do not have a close relationship. I could not talk to her. She did not understand me. The abortion was carried out at the Rose Clinic in Durban.

I returned to school and completed my grade 11. No one in school knew about the abortion. They thought I had the flu. I had no 'best friend' to confide in. I was always the loner - I kept aloof. I spent my breaks completing my schoolwork. I was not allowed to talk about the experience to anyone. My mother forbade it.

I am still not allowed to talk about it. I have no contact with my ex-boyfriend. When my boyfriend heard about the abortion, he beat me up. He refused to listen to my reasons. He became a monster. There was no love in his eyes – no compassion for what I was going through. I felt abandoned, alone. I instituted a restraining order against him and broke off all ties with him.

It is like I imagined the whole experience. It is all in my mind. I can't even talk about it to my mother. She pretends that it never happened. But my mind tortures me with the memory. I feel as if I stopped living 12 months ago.

My father wanted me to have the baby but I don't know whether he could have helped me much. When my mother met my father she was an unwed parent to a baby girl. She later married my father and had two more daughters. Unfortunately he became unemployed early in their marriage. He is still not working. He moved out when I was 10 years old. He is living with another woman. I do however see him from time to time.

Since the abortion I have tortured myself with guilt. I keep thinking of my baby (I call him Jared). I imagine myself holding Jared. I long to be with him. I feel I have sinned and should be punished (I am a Christian). I blame myself for everything bad that happens in my life. I should have saved my baby. I killed Jared. I could have given him up for adoption. I constantly have thoughts of killing myself ... to punish me for what I have done ...but I am not so stupid to carry out the

thoughts. I have lost over 10 kg in the last year. I can't eat. My classmates think that I am stressing over matric. They keep wishing that they could lose weight like me. If only they knew!

Who's with my baby's spirit? Is he okay? Does he eat? If he had been allowed to live, what would he be doing now? I used to cry but now I can't cry even though I want to. I don't see a future for myself. I have lost all interest in life. I don't have friends. I have nobody to talk to. I don't feel like going to school. I feel I do not fit in anymore. What's the use? There is nobody to talk to at home. Mum will not talk to me. I sleep a lot. I dream about Jared. He is calling me. He is all alone.

Natalie scored 45 on the Beck's Depression Inventory. She started a course of antidepressants. Grief counselling was put in place. She did not sit for all her papers in matric.

3. LENNY'S DILEMMA

Lenny is in grade 10. He is fifteen years old. He is soft-spoken and intense.

I feel lost, alone, abandoned. Is life worth living? I have lost count of the number of times I have asked myself that question. I still do not have an answer but life keeps getting bleaker...

Who am I? Really who am I? Why is my mother so afraid to tell me? How can I move on in life if my identity is incomplete? Is it asking too much to know who fathered me? Don't I have a right to know? All I was told was that Suren and I share a father. Suren is fifteen years older than me. Even he does not talk about our father – I am not sure whether he knows who he is. Is he not troubled by this mystery? I don't know because we have this distance between us. We don't talk about 'deep' things.

My mother married when I was three years old. My stepfather is okay and I tolerate my two younger brothers – but I don't feel that I fit in. I am the odd one. Mum and I don't really talk. I can't express my feelings to her. I feel unwanted. I feel like a burden. Mum does not work. My stepfather supports me. I am worthless. I think of committing suicide all the time – of ending this misery – I could overdose – there is no point in carrying on. Mum has her other children. She would not care if I died. She does not care about my life.

I have no identity. I feel that I have no future. I have no friends. How do I make friends if I don't know who I am. I spend my breaks in class. The boys call me a sissy because only the girls stay in class during breaks. I don't know what to talk to the boys about.

My school-work has deteriorated. I can't concentrate on my work. I am no longer an 'A' student. Teachers are starting to complain. They don't understand my situation. They just think I am lazy. After school I go straight home. I don't even go to the shop. I don't play sport. I am too fat. If I had the money I would have plastic surgery. My nose is too big. I have dark rings around my eyes. My eyes are discoloured. My hair is funny. My ears are pronounced. I have a scar on my eyebrow. My fingernails are off shape. I have pimples. My skin tone is bad. I need an extreme makeover!

Am I like my father? Does he know me? Does he know of me? Why did he leave me? Does he wonder about me? Does he have a family of his own? Does he hate me so much that he can't stand the sight of me? Does he live locally?

I am bursting with questions? Can't my mother feel my need? I am desperate! I just need to know. I need to feel whole. Nothing else matters anymore. I can't concentrate on anything else... It is driving me crazy ... I don't know how much longer I can hold on ...I want to just end this...the world will be better off without me...

Family counselling was put in place to help Lenny come to terms with his identity and build up his self-confidence.

4.ISHA – LIFE'S TORMENT LIVES ON....

Isha had been sexually molested by her maternal uncle and aunt when she younger. The family refused to acknowledge it and labelled her a liar. Her younger brother had similar experiences. This has scarred her emotionally and tainted her relation with all individuals she came in contact with.

I am doing a little better. Yesterday after school I managed to do some of my homework. I couldn't do that the entire weekend.

However, this morning, I found it extremely difficult to get up. I didn't feel like coming to school again. I did not even feel like going to aerobics today, but I brought my gear along. Just thinking about him*(her ex-boyfriend*) this morning, I cried so much. I find difficulty in sleeping, although I am very exhausted.

While walking to work, two strangers greeted me, and it made me feel so good. Even a couple of weeks ago, at the local shop, I accidentally dropped two products on the shelf, and I picked it up and placed it back. A complete stranger was watching what I did, and he thereafter told me that that was very kind of me. It made me feel so good. I mean sometimes when I do things I do it unconsciously and not always for people's approval. But when strangers treat you in a warm way it makes you feel so good.

I have also stopped writing. It's been weeks since I've written. I don't feel like it. Right now it is an effort for me to get up in the mornings, let alone do things.

Having a boyfriend is not the be all and end all of everything. Yes, I love him but there is so much more to life than just him. And when he was in my life, everything evolved around him. I did not do any thing else. I used to go to the gym once in a while, or I used to go to the night-clubs, with my cousin. I did not do anything in my life that gave me meaning. I mean being with him was meaningful and it brought me happiness. But I did not and do not want to live a life where, I go to school, go home, do chores, visit friends and family, or have the same set of friends as my boyfriend.

I want a life where inspite of all my responsibilities, I can be myself, I can do things that make me happy, where I can take a breather. I also want a life where my boyfriend and I both have lives outside of us. Where he can do things for himself, go out with his friends, without asking me for

permission, or me phoning up on him to check up on where he is. We both must not be afraid to do things. If he says he is going to see his friends, I must not question it and neither must he ask his friends to cover for him because he wants to be with them.

I don't know if these things are ever possible in a relationship. But when I look at the relationship that my parents had (the time that I remember), my mother always expected my father to be with us. She expected him to come straight home after work. And because he didn't, that used to be a problem. My mother's life evolved around my father. She didn't believe that they had separate lives. I don't want a life like that. My mother also never trusted my father. There was a time when she actually thought that he was having an affair – with his boss. Just because she was a woman and they worked closely together – she thought the worst. They used to go marketing and shopping and stuff together. My mother couldn't stand that. My father must have found a friend, in her, and she was also a widow, it did not mean that they were having an affair. If he really was having an affair, he would have been with her from the time that my parents divorced.

Before all this happened, my parents used to fight. I remember, when I was very little, my parents were fighting in front of my grandmother and my mother was crying and she threw shoes at my father. Even when we were older, I must have been in standard 4 or 5, and she locked herself in the room, and threatened to kill herself. My brother and I were crying and we tried to beg her not to do it, she came out of the room, and sat next to us, we held on to her and cried and cried. There were many outbursts like that. Even after they divorced, when she was ill, one day something was said over the phone, she made my uncle and aunt to take her to my father's place of work, and she removed her shoe and she hit my father with it. I wasn't there to see but they told me about it. I was not too happy about it, although I never told them about it. For one, he was my father, secondly, how could my mother ever do such a thing to anyone. I didn't understand the anger and violence inside of her.

I know that I have the same anger inside of me, and I hope that I don't ever have the violence. I mean I love my mother, but I simply am finding it very difficult to forgive her for things that she had done to me. I mean if it wasn't for her, I would have sorted my issues out a long time ago, and it would not have built up inside of me all these years. I think that she was being so unfair. It proves again that she loved her brother and family more than she loved me. I am so tired of people loving others more than they love me. Can't someone love me implicitly?

When the child welfare came up to me again, and said that they wanted to open up the case again, she confided in one of my uncle's and told them that if I went through with it, she was going to kill herself. I obviously did not want anything to happen to my mother. So it was because of her that I stopped. I always put everyone else's feelings above my own. As much as I love my mother and miss her, the truth is, if she was alive, I don't know when I would have started sorting my issues out or if I ever would have done it. For one I know, I would never have ran away to Cape Town last year. My mother's happiness was everything to me – it came above my own. And it hurts so much because I know that my happiness never mattered as much to her. Maybe that is where my strength to love and to tolerate and to take in so much comes from. I mean, I always put Sanjay's happiness (*ex-boyfriend*) above my own, in the same way that I always put my mother's happiness above my own. These are two people that I love so intensely and yet their constant approval of me always meant so much. Yet what about what I felt, and what I was going through. I sometimes wonder how my mother would always tell her family that her family is very important to her, but what about me. Did she ever love me? Is it not the love that exists between a parent and child supposed to be the greatest love of al?

Maybe, because I never felt that kind of love from my parents, I am jealous about his baby (*ex-boyfriend's*). I mean I am sure that if he had my baby, I would not have felt that way, or maybe I still would have. I love the baby. I wish that I could hold her and take care of her. But the other part of me is scared, that when I see him with her, I will see the love that he has for his child, I will hurt because he will never feel that way about me, and also because she (*his wife)* gave him something so precious, he will love her more and more each day. I always think about how he must be with his baby. If anything, I know that his baby will always put a smile on his face, I know that she will always make him happy. She would even do so much for his mother in dealing with his father's death. She would now have something to look forward to. And she most certainly is a blessing. When I found out about her conception, I wished that she was dead, and I also wished that the baby was not his. What kind of a monster am I? Something that is a part of him, I wished were dead, it's like wishing that he was dead too. I remember how I hated myself for those thoughts and asked God for forgiveness. I didn't mean to. I was just hurt and upset and angry. If he ever found out about those thoughts, I am sure that he would have never spoken to me again, and he would have called me psychotic or something.

I am just trying to understand why I feel the way that I do. Is it even possible to feel unloved or not loved enough by your parents? Did my mother ever at once consider how I was feeling? I

know that as much as my family is important to me, but when it comes to my children, I will always listen to what they are saying, and I will always put them first. That is the kind of mother that I know that I will be. I will love and adore my children more than anything else in this world. And they would be my life. They would be my world, my everything, and I would always do everything that I can to love, protect and honour them. Something that I never had. I just want to be in peace. I don't want pain to control my life. When I look back and think about the fights that my mother and I used to have. It was not good. I actually hated my mother at a point. Every time that she tried to separate me from my boyfriends the more she alienated me from her and the closer I drew to him. He (*Poobalan – first boyfriend*) was the only person, that was there for me, and he really understood how I felt, and he wanted me to sort out my issues because he did not want it to affect me later on in life. Well, hey Poobalan, I can go back to that moment in the past and tell you that it has affected me, and you were the only one that could see it, as young as we were. And I am also very sorry because I always took it all out on you - I mean how many times did I tell you that I wanted to kill myself. Well years later and that part hasn't changed, I still am suicidal.

There are all these things from the past that I have started to question, that I wish I could have done differently. I wish I could have been stronger and stood up for myself. But I was always afraid of my mother. How could I have been afraid of my own mother? The person that brought you into this world, the person that you know is supposed to love you unconditionally and protect you, you are not supposed to be afraid of. But I was. Is it my fault? It's like my mother was ashamed of me because of what happened to me (*the sexual molestation by uncle).* It was not my fault. I was a child. I did not know any better. If anything she was supposed to be angry at him, and not at me. Maybe, that is why, I am still trying so hard to fight for love, to fight for someone to believe in me and to approve of me because I never got the approval of my own mother.

My mother should have just left my father to be the way that he was, instead of always getting frustrated because he was not the ideal husband that she had in her mind. She wanted him to be someone that he was not and ideally I feel that that is why her marriage failed. She never sorted out her issues from the past. She was really a very insecure person. She had a chance of happiness when I brought my abuse out in the open. All that she could have done was support me and be honest, not just with me but with herself. She should have said to herself, that yes she was raped. Maybe she and I could have gone to therapy together, and we could have forgiven and healed together. But no, all that she wanted was to protect her family. I am still trying to figure out why they were so important to her that she put them above us. I guess I will know the answers to that

one day when I die. As much as she has put them above us, they have never and will never put my brother and I first. That is what makes me so angry. I think that she put them first and yet they have up to now treated us so badly.

I am so tired of analyzing my life, and putting everything into context. I just want to stop questioning. Why can't I stop questioning?

I just want to take all the pain and anger that I have felt in all my life and bury it. I just want to have peace. I sometimes wonder if I will ever have peace. Last night I was thinking about suicide again. I sometimes feel that by death I will never have to feel anything again. No one knows what a struggle life is for me or how difficult it is just for me to get up in the mornings. I don't want to do anything, I just want to sleep and don't want anyone to come near me.

5.THE LIFE AND TIMES OF .....KAY

K is a fifteen year old girl in grade 10. She has been an A average student. She now battles to keep ahead academically. She fears that her grades are slipping. She has no control of her life. She feels a sense of hopelessness - 'what's the sense of trying'. K enjoys writing in her journal. She also writes poetry. She sees it as her release – her private world.

I was born on the 9th January 1990... individual... daughter... friend... scholar... sister.
The world never knew what it had coming. An acclaimed playwright once said that there were two paths and he had taken the one less travelled ... that he claimed had made all the difference. I did not take the path less travelled ... I created my own.

As tempting as it is to base this biography on my likes, dislikes, favourite colours and food I have chosen to base it on things that are of relative importance to me... these things I feel compose the person that is ME ...KAY.

As blunt as this may sound my earliest recollection is asking God to let me die and while this may indicate an unhappy or scarred childhood, I think I was just angry with my parents. I remember asking god to give me Aids so that I can die. I did not know what Aids was.

The happiest years of my life were undoubtedly those spent at North Coast Primary. I excelled academically and in hindsight it was my deepest desire to be the person I was all those years ago. The world was my oyster and no feat, as difficult as it may seem, was impossible.

It was however in my last year at North Coast Primary that the cracks in my now seemingly perfect life began to reveal themselves. Now that I think about this it contradicts the theory of my imposing all my messed- up- ness on myself.

I had an acute panic attack when I was writing my grade 7 mid year exam. I was 12 years old. I received some medical treatment. I started cutting myself soon after. I have kept this secret from my family. They still do not know. My friends tried to talk me out of it but my sadness was unbearable. I could not take the inner pain. Death was the easy way out. I felt tainted. I cursed myself for feeling things so intensely. Why couldn't I be like others? Why did I have to feel things so deeply? I was angry with myself. Cutting was my punishment. In July last year, after three years of cutting I finally realised my 'foolishness'. I stopped cutting.

I often think about when I shall be gone
When the day of my death
Shall inevitably dawn

There was a time
When it had brought me to tears
When my very salvation
Had been so near...

The pleasure of knife against skin
My life flooding before my eyes
And while I may say...
Those days are long gone
One can never truly say
When matters of the mind
Are called upon.

Now I sit here
As the days go by
Watching the sun
Slowly fade and die.

I can't deny that a part of me will always blame myself for what I have become.

When my years at North Coast Primary ended I was brilliant. Then high school came along. I worked hard in the beginning although I began to lose interest.

Throughout grade eight I was very messed up. I remember being very angry at the world. My friends noticed that too. I won the award for technology in grade 8 but I never really acknowledged my success. It never meant much.

Grade 9 was when I changed, I stopped caring about school and really began to rebel. A lot happened. I started smoking and really lost control. My older brother, 21 years old, found out. He advised me to stop. I refused to take his advice. The next time he caught me smoking he slapped me. I stopped talking to him. It was the excuse I needed to distance myself from him. I still do not talk to him. He is my only sibling. I stopped smoking soon after that.

Every once in a while
When my mind goes well

I look back at the days that have passed by
To shed a tear or two
And often I sigh

To mourn the passing of those that have gone
And often those who have stayed
To regret the choices which I so readily made
And the beds in which I laid

I shall always regret
That is just who I am

Some say it is easier to forget
To bid farewell
To the thoughts that forge my hell

But then I always wondered
What to do when my mind goes well.

I started drinking. One evening, three months ago I walked into the house drunk and shocked my conservative, rigid, non-drinking parents (both teachers). My friend, and co-drinker, had passed out in the incomplete building that we had chosen as the venue for our drinking adventure. My parents' reaction was hilarious. My father screamed. My mother cried. I was warned of the consequences of walking drunk on a deserted road at twilight. I was grounded. I continued to drink secretly.

I stopped talking to my father two months ago because he scolded me for giggling uncontrollably after I had answered the telephone. I could not help it. The caller sounded so serious. The call was for him. That was the excuse to put distance between him and me.

Dear god

I would just love to take this opportunity to say how F@#ed up life is. Mum just cried in front of me now because of that f@*# bastard who you put here for us to live with. He f@*#ed me up. He f@*#ed her up and now she is telling me in tears to get my like together. Something I have been trying to do for so f@*# long. Don't go to the party, stay at home, learn hard, and get nowhere. The same fA*# story over and over. How about some answers god because my life is f@*#ed up and I do not know what to do.*

My father is like his family – cold, distant, detached. We have very little contact with them. They are not the visiting type. They keep very much to themselves. I like my mother's family. I have a warm relationship with her sister but she recently moved to Johannesburg with her family. I am waiting to finish school and go live with my aunt.

Dear diary

My relationship with my parents is putrid. Will everything really be okay? This shit makes me sad. Still have to lose weight! Have to get good marks in exams. Have to understand maths. Does it really matter? What is going to become of my life? Does all this shit really matter? I am going to be okay!

I feel depressed. Why do I have so many problems?

I always thought when I reached grade 10 everything would work out. I would work hard and my life would come together. That never happened!

Dear diary

I sit here in my darling room contemplating whether to start a new, posher, more well-designed diary. Could this be my subconscious lack of commitment issue re-surfacing? I think I will though. I would very much like to make myself a better person. I shudder to think what I shall tell god when we meet.

I got to grade 10 and I worked really hard but things weren't coming together. I feel sad all the time. I started feeling like a real failure. I felt that I let myself down and would stop talking to my friends as punishment. I punish myself by 'spacing out' – being with friends and family but not talking to them. I have ostracised myself. I don't enjoy things the way I used to. I feel guilty most of the time. I expect to be punished. I am disappointed in myself. I blame myself all the time for my faults. I cry more now than I used to. I become depressed to punish myself. I really want to die. I feel all alone, abandoned.

Oh, how you left me
Alone and without hope

I cry now
My soul in despair
Of the way you left me without a care

For the pain I shall feel
The tears my eyes shall infinitely steal

The anger within me is no longer disguised
From my darkened depths, it shall rise
From deep within my being
It is the you in me leaving

Why, dear spirit, did you go
The answer, in truth, I already know
For you and I are one and the same
And in this tragic truth I feel no shame
For it is my imperfection in which I revel

Yet I ask once again
Why, dear spirit, did you go
And leave me here all alone
To cry, to die
The death of a crow.

.

I sit here in my room once again, devoted to filling the pages of this journal, devoted to cataloguing my life. I sit here still in confusion of the person that I am.

I experience frequent headaches. I sleep a lot.

Wrote physics and it was good, yet I still wait for the results - unsure. I had the flu during the June exam and had to be assessed. I had a cold before the 3rd term tests.

I feel it is important to acquire skills at this point in my life. I have resolved to practice articulate speaking among other things. Weight has really become a problem *(K is a size 30)* . I need a foolproof plan, the fool in case being me!

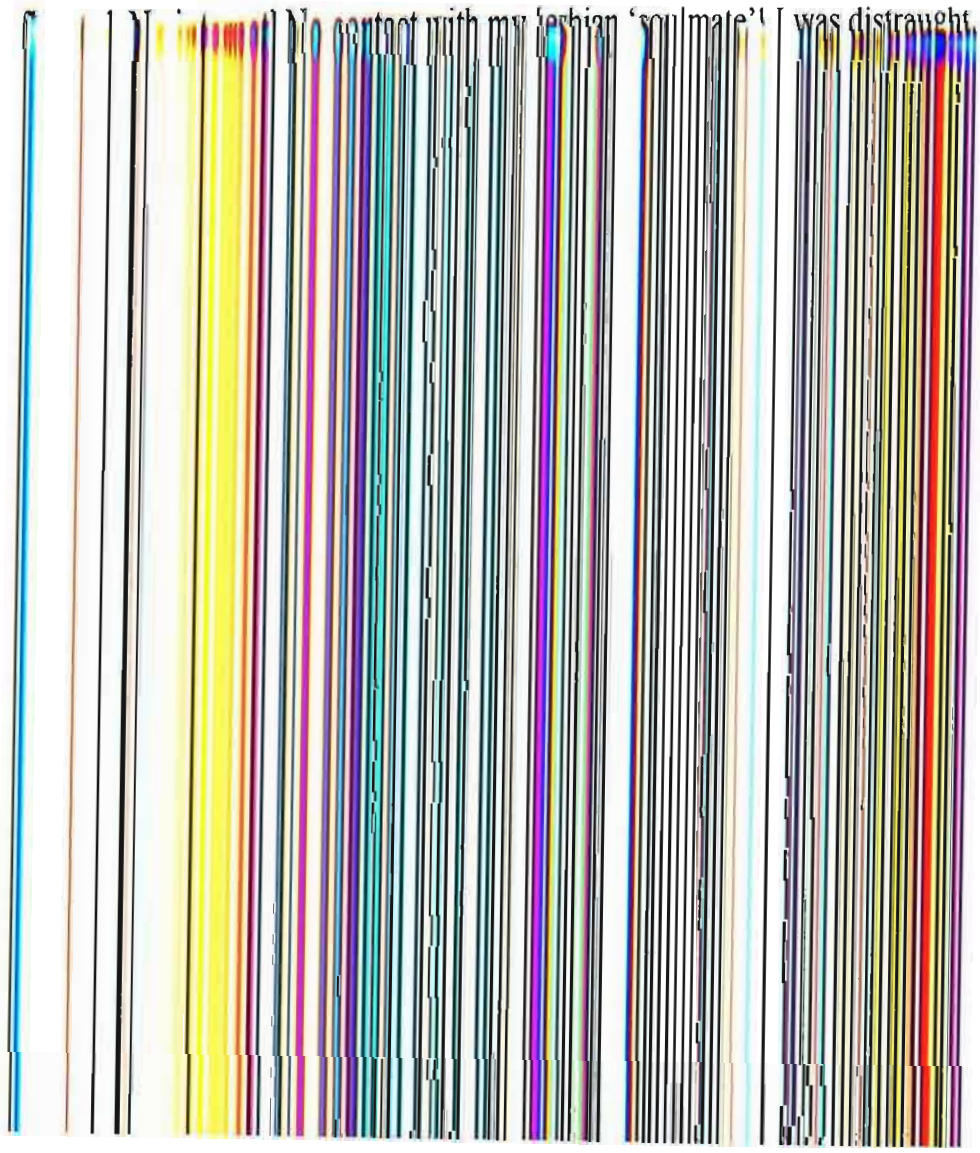
I got 61% for the physics test which had me spiralling to the depths of 'I don't care less'. I cried in class. Perhaps now is the perfect time to announce the arrival of King Daryn – a real knight in

shiny armour. Daryn believes in me. He told me that if I applied myself in matric I can be in the top ten lot in the region. I am very uneasy about the fact that I just quoted him. It's like I am so happy to hear someone believe in me but I'm full of shit and I know I will never do it. I wish I were dead – saying I want to commit suicide is too blunt and not the entire truth.

I haven't gone out in eons. I feel tempted to list all that I have forgone yet I shall not, my mind performs that talk enough already.

I met someone in the internet chat-room. I think I have found my soul-mate. I have made a profound discovery …. I am a lesbian! Is this why I have had no interest in boys? My best friend is a boy. I confided in him. Lo and behold – he told me that he was gay. This will freak my teacher-parents. Their 21 year-old, unmarried, unemployed son has made a girl pregnant and their daughter is a lesbian!

Things are very tense at home. Two friends and I went back to the abandoned house. It was mid-afternoon and a cool place to hang out in. We just sat there and talked. My father discovered where I was. When I got home my father gave me a hiding. No discussion! I was grounded. My phone



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They said the pain would go away
That I would awake one day
And walk in the breeze
They said my mind would be free

That day never came

Now I sit here
As the days go by
Watching the sun
Slowly fade and die

I often think
About when I shall be gone
When the day of my death
Shall inevitably dawn

There was a time
When it had brought me to tears
When my very salvation

Had been so near

And while I may say
Those days are long gone
One can never truly say
When the matters of the mind
Are called upon…

Dear diary

I realised that I needed help. Enter psychologist. I don't know what it was but seeing a psychologist really helped me. Things are easier to deal with and not everything is so intense. When I have problems I know that I'm strong enough to deal with them. I have hope and I am satisfied with the person that I am. Now all that remains is for me to achieve my goals and fulfil my potential.

K was experiencing severe depression. When K was informed of the results of the assessment she responded by saying that she suspected she was depressed. She had read an article on depression and she had been experiencing a few of the symptoms. Her doctor prescribed antidepressants.

K's visit to the psychologist was a cry for help – a desperate cry for help. No one appeared over the last four years or more to have realised that she was crying out for assistance. Her mother noticed the mood swings and put it down to adolescent behaviour. The mother reported that K has experienced mood swings for over a year. She, the mother, has had to walk very cautiously around K, not wanted to offend her or spark off an outburst. The mother has since been very supportive of K. Her father … remains her father.