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# AETIOLOGICAL FACTORS THAT LEAD TO SUICIDE ATTEMPTS AMONG THE YOUTH OF LUSIKISIKI AREA

**BY**

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**ABSTRACT**

The general aim of this study was to investigate the aetiological factors that lead to suicidal attempts among the youth of Lusikisiki area in the Eastern Cape Province. A sample of hundred and fifty participants with an average age of 24 years old was selected using convenient sampling. Data was collected using self-administered questionnaires. After the data were collected, it was then analysed through descriptive and inferential statistics. Findings show that various factors lead to suicide ideation and suicide attempts among youth of Lusikisiki. Economic hardship, depression and substance abuse to name few, were found to be among factors that lead to suicide attempt.

Based on the research findings, the researcher recommends that various stakeholders such as the Department of Social development should work in corroboration. Departments such as Department of Education and Sports, Recreation and Culture should make awareness campaigns that will psycho-educate youth in rural areas, possibly alleviating drug and substance abuse. Those awarenesses may also tap into strengthening psychosocial well-being of youth. Furthermore, Department of Social Development should come up with community outreach programs aimed at alleviating poverty as the contributory factor towards suicide attempt.

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***Key words:*** Suicide attempt, Aetiological factors, Youth

## DECLARATION

*Declaration on Previous Submission:*

I, Mzamile Benute Zweni, declare that this research project titled: *Aetiological factors that lead to suicide attempts among the youth of Lusikisiki area* submitted for the award of degree in the faculty Social Science and Humanities at the university of Fort hare, is my own unaided work and has never been submitted for any other degree at this university or any other university.

Signature: Date:

*Declaration on Plagiarism:*

I, Mzamile Benute Zweni, hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations. This document has been submitted through a similarity detection software and the report was reviewed by my supervisor. I declare there is no plagiarism in this research project.

Signature: Date:

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# CHAPTER ONE: INTRODUCTION AND BACKGROUND

## 1.1. INTRODUCTION

This chapter serves as an introduction and a background to the study. Suicidal ideations and suicidal attempts are more prevalent among black South Africans due to various contributory and perpetuating factors. Among others, fractured psychosocial well-being, poor support system and cultural related issues. Hence this study seeks to identify the etiological factors that lead youth to suicidal ideations and attempts. Various hypotheses are formulated to be approved or nullified based on the participants' responses. The findings will thus give a comprehensive view about the geneses and perpetuating factor-viewpoint towards suicide among the youth. For the purpose of this study, this chapter starts by giving the background to the study, problem statement, the research hypotheses, aim and objectives, significance of the study and provides the chapter outline.

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## 1.2. BACKGROUND TO THE STUDY

The phenomenon of suicide is common across the world. Various reasons leading to suicide and suicidal attempt include lack of emotional, financial and psychosocial support (Nock et al., 2018). In support of that, Owens (2011) argues that people commit or attempt suicide for various reasons emanating from childhood negative experiences. The family constellation, family conflicts, parental divorce or dysfunctional families are also contributors towards high prevalence of suicide and suicide attempts (Nock et al., 2018; Owens, 2011). This implies that, conflict resolution skills among parents is important to avoid adverse effects that would be observed on children such as fractured self-esteem leading to self-doubts and self-worthlessness, subsequently suicidal ideations and attempts (Tasman et al., 2015).

Tasman et al. (2018) cited various family issues such as family structure and socio-economic conditions as factors that lead to suicide among the youth. It is claimed that the more conflict exists between parents, high chances of children to become depressed with minimal attention and support that they deserve. As a result, children become depressed due to ongoing parental conflicts, especially on the adolescence and youth ages, hence they become vulnerable and prone to suicide ideations and suicide attempts.

Studies show that children of separated or divorced parents are more vulnerable to attempting suicide than their counter parts who are living within stable families (Baldessarini et al., 2019; Ohtaki et al., 2019; Zainum & Cohen, 2017). The reasons could be attributed to the lack of support and frustration since parents are no longer in good terms, which leads to psychological effects. For example, Kaplan and Saddock (2013) found that egoistic suicide is determined and more prevalent when there is a lack of meaningful family ties or social interactions. On the other hand, children who get the necessary support and attention from their parents are less likely to commit suicide.

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Drawing from attachment theory pioneered by John Bowlby, postulates that young children need to have relationships with their parents or primary caregiver for the development of their normal social and emotional development (Grady, 2017). Those child-parent bonds have great impact carrying on throughout their lives. In that regard, close attachment between the parent or caregiver and the child improves survival of the child, and thus reduces the possibilities of suicidal attempts (Hong, 2017).

Poor parental supervision and peer relationships may also contribute to the emotional, psychosocial and cognitive consequences that predispose youth to suicidal

attempts (Gibson, 2014). The issue of facing isolation and economic deprivation can also lead to high suicide attempt. A study conducted by National Injury and Mortality Surveillance System (NIMSS) in 2003 indicate that the majority of people who are working in the Eastern Cape are mineworkers and their families solely depend on them as these mineworkers are the only ones who are working. For example, Tasman *et al*. (2015) found that alcoholic parents and drug addicts pay less attention to their children, living them with unattended depressive episodes, and subsequently develop suicidal ideations and resorting to suicide attempts. In the same breath, children living with both attentive and supportive parents are less likely to attempt to commit suicide.

There are gender differences regarding reasons leading to attempted suicide. It has been noted that females do not usually attempt suicide for the same reasons as males, with the former succumbing to peer pressure (Owens, 2011). Kaplan and Saddock (2011) further assert that other factors that are associated with suicide are bereavement and a change of residence. For example, a young boy who went to boarding school may be more vulnerable to suicide due to peer pressure. Culture contributes to suicidal attempts through societal norms and gender role stereotypes (Doreen, 2018). Those categorizes often impart humiliation and shame, lack of support from family members, failure to meet expected norms. For example, perceived South African concept *"Indoda ayikhali"* (*man does not cry*) deprives men an opportunity to grieve and vent out their internalized painful experiences (Penxa-Matholeni, 2019).

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## 1.3. PROBLEM STATEMENT

The Eastern Cape Province in South Africa has been bedevilled by cases of suicide attempt, especially in the OR Tambo District as confirmed by the high number of attempted suicide cases at St. Elizabeth Hospital in Lusikisiki (Stats SA., 20-September, 2014). Statistics in St Elizabeth hospital show that between 2005 and

2015,146 cases of attempted suicide have been reported and statistics are increasing as compared to Libode, a nearby area in the Eastern Cape Province where they recorded about 97 attempted suicide cases during the same period (Gardener, 2016). These figures only reflect reported attempted suicides, excluding unreported suicide attempts and suicidal ideations. This illustrates the pervasiveness of suicide attempts and suicidal ideations in South African communities.

The issue of attempted suicide in South African communities, in both rural and urban areas has become a significant public health problem especially in the Eastern Cape Province. A survey by South African Medical Research Council showed that one in five youngsters considered committing suicide since 2013 through self-harm, hanging themselves, jumping from high places or self-poisoning (Gareth, 2016). The researcher noted the significant increase in reported cases of attempted suicides, especially in the rural areas of Ngquza Hill, Lusikisiki. It is therefore against this background that the researcher has decided to embark on this study to investigate the etiological factors that lead to attempted suicide among the youth of Lusikisiki area.

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## 1.4. HYPOTHESES

According to Bless and Burger (2017), hypothesis is the tentative statement about the relationship of the variables. Babbie and Mouton (2015) concur and further define hypothesis as a tentative solution to the problem. In this study, the researcher has formulated hypothesis that outline the correlational relationship between the etiological factors and the prevalence of suicide attempts. The study seeks to approve or nullify these hypothesis as follows:

*Hypothesis 1*. Level of education and economic factors, particularly poverty and poor living conditions have an impact on youth to attempt suicide in Lusikisiki.

*Hypothesis 2.* Dysfunctional family, marital disharmony, domestic violence and cultural factors have an impact on youth's attempted suicide in Lusikisiki.

*Hypothesis 3.* The use of substances such as cocaine, alcohol, and marijuana have an impact or effect on youth attempted suicide.

## 1.5. AIM AND OBJECTIVES

The aim and objectives of this progressing study are outlined in the following sub-headings:

### 1.5.1. Research Aim

The main aim of this study is to identify and explore the etiological factors that predispose youth to attempt suicide in rural areas of Ngquza Hill, Lusikisiki.

### 1.5.2. Research objectives

- To identify socio-economic factors and their role in driving youth to attempt suicide in Lusikisiki.
- To outline familial factors that lead youth to attempt suicide in Lusikisiki.
- To investigate and establish the extent to which the use of substances compel youth to commit suicide in Lusikisiki.

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## 1.6. SIGNIFICANCE OF THE STUDY

Determining the etiological factors leading to attempted suicide will add to the body of knowledge on aspects that predispose youth to suicidal attempts, possibly enable various stakeholders to educate and raise awareness. Interested parties such as Department of Social Development, Department of Education and social activists will thus use the findings to educate those who are at risk and mostly affected. The possible recommended strategies are informed by the research findings, to address the prevalence of suicide in rural communities of the Eastern Cape.

## 1.7. CHAPTER OUTLINE

Chapter 1 highlighted the background of the study, describing the rationale for this study. The significance has been stated, following the aim, objectives and the hypothesis of the study. Chapter 2 reviewed relevant literature on suicidality among the youth. This is followed by the research methodology used in this study as explicated in chapter 3. The results of the statistical analysis and associated research findings are presented and discussed in chapter 4. Chapter 5 constitutes recommendations and conclusion.

## 1.8. CONCLUSION

This chapter provided the back ground of the study explaining suicidality that informs the problem statement of the study. The three hypotheses have been explained, with variables ranging from economic factors particular living conditions, dysfunctional family, substance use and other factors that predispose youth to suicide. The aim and objectives of this study were outlined to illustrate the significance and research rationale of this study. The following chapter, chapter 2 focuses on literature review and theoretical framework that underpinned this study on suicide ideation and suicide attempts.

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# CHAPTER TWO: LITERATURE REVIEW

## 2.1. INTRODUCTION

The previous chapter provided the introduction and background information on the on contributory factor for suicide attempt. This chapter gives a brief history on the aetiological factors that contribute on suicide attempt amongst the youth in rural areas of the Eastern Cape. Furthermore, this chapter looks at the effects of suicide attempt among the youth in order to get a broader understanding of the phenomenon. The international prevalence of youth suicides and South African reports will also be highlighted. The theory of Bronfenbrenner ecological systems theory (1977-1979) serves as a guiding theoretical model and underpins this study and will be explained by applying relevant contributing factors and resources to the model. Definition of terms is presented below to foster a contextual understanding of the key terms used and their contextual meaning.

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## 2.2. DEFINITION OF KEY CONCEPTS

The following are the operational terms central to the study:

### 2.2.1. Suicidal behaviour

Brendel et al. (2012) explain that suicidal behaviour which includes suicidal ideation is referred to as a frequent thought of ending one's life. Suicide attempts referred to incidents where an individual tries to commit suicide but not successful, in the actual event of trying to end one's life). Completed suicide is when the individual commits suicide successfully and death occurs. Brendel *et al.* (2012) believe that suicidal behaviour most of the time is accompanied by sensitive feelings of hopelessness, depression, or self-destructive behaviours. This gives the impression that suicidal behaviour is a very broad term which involves a variety of factors, each of these factors play a big role in the causes of suicidal behaviour.

### 2.2.2. Suicidal ideation

Suicidal ideation is regarded as the most popular example of suicidal behaviour. Suicidal ideation refers to a person who wants to take her or his own life or is thinking about suicide (Krug *et al.,* 2013). However, there are also two kinds of suicidal ideation, namely passive and active. Passive suicidal ideation occurs when an individual wishes that he or she could die, but the individual does not have any plans to commit suicide. Active suicidal ideation, on the other hand, is not only individual thinking about suicide, but the individual in this case is having the purpose to commit suicide, including planning how to do it. According to (Krug *et al*, 2013) Suicidal ideation is viewed as one of the symptoms of major depression and bipolar disorder. Suicidal ideation is viewed as the beginning of self-destructive behaviour to an individual, whereas the majority of people who think about committing suicide do not proceed to suicide attempts or completed suicides (Simons & Murphy, 2013). McAuliffe (2016) indicates that all suicide attempters and those individuals who commit suicide successfully have experienced suicidal ideation at some point, however, not necessarily everyone who has ideation proceeds to attempt suicide or complete suicide successfully.

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### 2.2.3. Attempted Suicide/Para-suicide

Suicide researchers are not in agreement with the meaning of para-suicide and attempted suicide as to whether they are synonyms or not. Pretorius and Roos (2014) express the view that there is a difference between the words ‘para-suicide’ and ‘attempted suicide’. Shilubane *et al.* (2012) further explains that the term Para-suicide was used in a working environment or in a practice environment to explain cases of attempted suicide where there is no purpose present. The term ‘attempted suicide’, on the other hand, is utilized when the individual or person attempts suicide with the purpose to die (Bridge *et al.,* 2013).

## 2.3. THEORETICAL FRAMEWORK

The theoretical underpinnings of this study is based on the following theory:

### 2.3.1. Bronfenbrenner's theory

This study is based on Bronfenbrenner's ecological theoretical suppositions as one of the most accepted theories in terms of the explanations regarding with the influence of the social environments on human development or on the up bring of a person. According to this theory the environment you grow up in as a human being can affect individual's life. The social factors can determine the way individuals think, the emotions that the person feel, and also the individuals likes or dislikes. Bronfenbrenner's theory has advanced four systems which these systems consist of microsystem, meso systems, exo system and macro systems. All these systems put a person or individual at the centre of many series.

#### 2.3.1.1. Micro systems

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According to Bronfenbrenner, micro system refers to the immediate environment of the child; that is where the child lives, which also includes the family of the child, caregivers that are in the life of the children, people at school and also people at a daycare centres. Bronfenbrenner emphasizes the fact that any person who can make decisions regarding the welfare of the child in a form of relationship would be included. Bronfenbrenner's theory under micro system believes that if all individuals create or make the environment that is nurturing and encouraging the child then the growth and the development of the child will be encouraged, but if the environment is isolating and lonely, the growth and development of the child would be discouraged. Some of the examples which are contained in the micro system include friends, religious, and neighbourhood. These examples are regarded as influential on the youth's behaviours.

#### 2.3.1.2. Meso system

Meso system is where a person's individual micro systems does not function independently but there is interconnection which influence one another, for example if the child's parents communicate with the child's teachers, this interaction can influence the child's development. According to this ecological systems theory if the child's parents and teachers are in good terms then it can have a positive effect on the development of a child while if they were not in good terms it can have a negative effect on the development of a child.

#### 2.3.1.3. The Exosystem

Exosystem is one of the ecological systems theories which was developed or established by Urie Bronfenbrenner in 1970s. This system contains or constitutes other formal and informal social structures, which indirectly influence the child and also affect one of the micro systems. Exosystem has the following examples such as neighborhood, parent's workplace, parent's friends and mass media. These environments do not involve the child directly because they are external but, affect the child indirectly.

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In the case of exosystem where it can affect the child's development, it is when one of the parents had a conflict or dispute with the boss at work, then the parent comes home and have a temper with the child because of something which happened at workplace and have a negative attitudes towards the child development.

#### 2.3.1.4. Macro system

Macro system is contained in the Bronfenbrenner's ecological system theory. Macro system focuses on how the cultural elements affect the child's development, for example wealth, socio-economic status, poverty and ethnicity. The culture that the individuals may be involved within may influence their beliefs and perceptions about

events that may develop in future. Another example of macro system is when a child who is living in a developing country or in a third world country would experience a different development than a child who is living in a wealthier country. The living conditions determined by economic conditions and psycho-social support have an impact on how one perceives their life situations. Hence, support system is believed to be a protective factor towards suicidality.

The final components of Bronfenbrenner's ecological system theory is known as the Chronosystem. This system includes all the environmental changes which occur over the lifetime which influence the child's development. For example, historical events and major life transitions, which may include normal life transitions like a child's start at school and non- normal life transitions where the parents are getting divorce or move to a new house.

There is significantly contributing factors which are associated with youth suicidal behaviour, such factors include depression, substance abuse, family dysfunctional and also hopelessness Pettit *et al.* (2011). According to Baugher et al, (1993) substance abuse and depression have been constantly identified as correlates of attempted suicide in youth who show the signs of suicide. Some research studies indicate that youth who attempt suicide usually suffers from depression (Garlow et al., 2008; Miller & Seligman, 1975). Lewinsohn et al. also mentioned that youth who had suicidal ideation show the signs or symptoms of depression. Kelley (1993) believes that the relationship between suicide and depression is not simple as we think or as it seems. While Cole (1998) has a different view that not all the youth who show or possess suicidal behaviours are depressed. According to Lamis *et al*., (2016), hopelessness is the negative attitude that is developed by the individual because of certain events, that is when someone goes through some difficulty times or painful

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process such as loss of dignity, unemployment, family conflicts, financial constraints, and these have been identified as serious in this study as corroborated by many researchers (Hawton, 2011; Cliford & Juliet, 2020; Hawkins et al., 2017). In this research substance abuse, hopelessness, family dysfunction and suicidal ideation has been identified that they have an association in youth (Krietman, 2006). Although hopelessness is associated with youth suicide (Lyon et al., 2000) there is more research needed to be conducted to look or explore whether the negative attitude to a future event, that is hopelessness or depression experience the association of substance abuse and drugs. According to the psychological autopsy studies, people who completed suicide have a history of using substance abuse in their life. In support of the above Hawton *et al.* (2011) found that more than 38% of the youth suicide attempters consumed alcohol in 6 hours before they attempt suicide.

### 2.3.2. The significance of the Microsystem level

This level, microsystem and interact with other factors, therefore that interaction can put youth in a higher risk of attempting suicide. As we know that the immediate influences of youth suicidal behaviour are observed in a microsystem which involve those the youth have immediate contact with, including the family, the school and the peers, youth can be predisposed to suicidality more like socialization. This implies that youth can be prone to suicidality after various factors enacted during socialization. In the present study, five variables were viewed such as family history, family dysfunctionality, marital disharmony, peer influence or schooling, and other agencies of socialization. Thus, various factors were found to be contributing of suicidality among youth.

According to Berk (2000) microsystem is a very close environment to the child which involved structures where the child has a constant direct contact.

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Bronfenbrenner's ideas were interpreted by Paquette and Ryan (2001) in which they maintain that in this level the relations which happen between the two individuals or persons happen in two ways that is from the child and towards the child. In this case is where you find that a child's parents have an influence on his or her beliefs and behaviour whereas at the same time the child as well has an influence on the parents' belief and behaviour. This method is called by Bronfenbrenner as bi-directional influence, and he pointed out that this relationship happens in all the levels of the environment. Bronfenbrenner emphasize that in a microsystem the so-called bi-directional interaction is got a powerful influence on the child development.

Family relationship has been confirmed to be the most intermediate source of support for the youth (Zelda Holtman et al., 2011) which occurs within the micro system and in which the child's immediate interactions take place for example in the child's neighbourhood and in the family. However, youth who experienced dysfunctional family are more at risk of committing suicide or attempting suicide because they are more vulnerable (Lamis *et al.,* 2016). Feigelman et al. (2016) argue that impulsiveness, emotional instability and the lack of reasoning in the family contribute to suicide attempt. In a study conducted by Muthen (2016) found that peer pressure contributes to suicide attempt among the youth. Lamis et al. (2016) discovered that when parents' divorce or get separated or when parents loses his or her job youth can feel guilty about the incident and attempt suicide or commit suicide. In a study conducted by Pompili et al. (2012) found that substance abuse is the contributing factor to the youth suicide, Shaffer et al., 2017) argue that youth engage in such behaviour because they need attention.

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## 2.4. HISTORICAL BACKGROUND OF SUICIDE

The issue of suicide and attempted suicide is a worldwide or international social issue, and its statistics are growing in number. In spite of the great concern raised by these increasing trends, it is clear that very little research has been done or conducted on suicide and attempted suicide, especially in economically developing nations (Schlebush & Millerton, 2012). It is estimated that the high rate of death by suicide or attempted suicide will be increased by 2020, as it is estimated that one in every twenty people are likely to commit suicide. One concerning aspect of this problem is the high level of youth who are committing suicide (Wassermann et al., 2015). The amount of attempted suicide, however, is not easy to calculate or to count because some of the individuals who are affected by this issue are not admitted to or treated in hospitals. Some of the people cannot put or place anything in writing to record a self-inflicted wound (Cutler et al., 2011). Attempted suicide is more commonly among the youth who always face many challenges in their lives that are beyond their control. These challenges include loss of social cohesion, when the family of the individual is dysfunctional and there is a breakdown of a family structure at home, economic instability, marital disharmony at home, increasing unemployment and an increase in depressive disorders (Wassermann et al., 2015).

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There are other factors which are related to attempted suicide including domestic violence, poverty, and substance abuse (Lewinsohn et al., 2013). The official statistics paint a very grim picture of the problem posed by suicide internationally. The World Health Organization (WHO, 2015), indicates that, every year 804,000 people die by taking their own lives – one every 40 seconds - implying a crude suicide rate of 100,000 deaths per 11,4 million people. In some countries suicide is among the three leading causes of death of people between the ages of 16 and 44, and it is the second

leading cause of death for people between the ages of 10 and 24. Attempted suicide is a multi-factorial phenomenon whose complexity includes, but is not limited to, psychological, social, economic, biological, psychiatric, cultural, and environmental factors (Lewinsohn et al., 2013).

## 2.5. PREVALENCE OF SUICIDAL ATTEMPTS AMONG YOUTH

Annually, it is estimated that more than one million people die because of suicide, a global mortality rate of 16 per 100000, or one death every 40 seconds Mcloughlin & Gould (2015). The study conducted by Suominen (2004) at the University of Kwa-Zulu Natal shows that in the last 45 years, attempted suicide rates increased by 60% worldwide. The issue of suicide in some countries is highest among the age group of 15-44 years old, followed by ages of 10-20 years. These figures do not include suicide attempts which are mostly dominant 20 times more, thus occurring most frequently than successful suicide (Mcloughlin & Gould, 2015). In countries which were formally known as socialist states, the issue of suicide is expected to increase by 2.4% by 2020. The reason for such increase is attributed to a lot of alcohol consumption and forced labour (Kolves & Milner, 2010). It is known that, generally, suicide rates are growing among the youth as a result they are regarded as the highest risk both in developed and developing countries (McLaughlin & Gould, 2015). According to WHO (2019) close to 800 000 people die due to suicide every year.

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A prior suicide attempt is the single most important risk factor for suicide in the general population. Suicide is the third leading cause of death in 15-19-year-olds. WHO (2019) shows that 79% of global suicides occur in low- and middle-income countries. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. Suicide is a global phenomenon

which occurs throughout the lifespan and was the second leading cause of death among 15–29-year-olds globally in 2016 (Schlebush & Millerton, 2012).

Although suicide is a serious public health problem; it is preventable with timely, evidence-based, and often low-cost interventions (Wasserman et al., 2015). For national responses to be effective, a comprehensive multi-sectorial suicide prevention strategy is needed (WHO, 2019). While the link between suicide and mental disorders (in particular, depression and substance related disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness (WHO, 2019).

Suicide is one of the priority conditions in the WHO Mental Health Gap Action Programme (mhGAP) launched in 2008, which provides evidence-based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. In the WHO Mental Health Action Plan 2013–2020, WHO Member States have committed themselves to working towards the global target of reducing the suicide rate in countries by 10% by 2020 (WHO, 2017).

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### 2.5.1. United States of America (USA)

During the 20th century in the United States of America, it was observed that the significant fluctuating rates of suicide differ from various areas. For example, WHO (2018) shows that there was a decline in suicide rates amongst the youth in some areas of USA in the early. In a study conducted by Schinka et al. (2012) it was found that suicide among different cultural groups is growing, especially among American Indians. In 2017 it is estimated that about 1, 4 million Americans attempted suicide (American Foundation for Suicide Prevention) as cited from Garlow (2008).

### 2.5.2. United Kingdom (UK)

The rate of adolescent suicide in the United Kingdom has risen throughout the last century (Brent et al., 2015), whereas in England and Wales youth suicides ever since the 1900s are reported to have decreased in terms of the statistics (Brent et al., 2015). In countries such as Ireland, Northern Ireland and in Scotland it is reported that the rate of suicide is increasing (De Leo, 2015). Ireland is one of the countries that is experiencing a high rate of youth suicide, with a simultaneous increase in crime rates, alcohol dependency, and divorce rates. Statistics show that in United Kingdom suicide rates have decreased in 2016 from 10.9 per 100 000 in 2015 to 10.4 persons per 100 000 dying from suicide in 2016 (www.ons.gov.uk-bulletins).

### 2.5.3. Australia

The World Health Organization (WHO, 2019) has observed varying suicidal attempt in various regions across the globe. Various reasons and factors perpetuating suicidality differs from one geographic location to the next. This also applies to African communities. New Zealand has reported a decrease in the suicide rate during the twentieth century (Muthen, 2016). However, Muthen (2016) observed a constant rise of suicide rates among Australian adolescent males in the beginning of the 21st century. Australia is believed to have an average of 8.3% deaths caused by suicide in each day (mind frame, 2019). This signifies a great upshot of suicidality on the overall mortality rate.

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### 2.5.4. Europe

The male youth suicide rates were observed across the world including the European countries (Reeves *et al*., 2012). In the early 1960s and early 1990s, countries such as Greece, Italy, Portugal, and Spain had low suicide rates among the youth as compared to other countries. For example, they tend to have less than ten suicidal

attempts per 100 000; whereas countries like Belgium, France, Germany, Austria and Switzerland all have high youth suicide rates ranging from 20 to 43 suicide per 100 000 of their population. Countries such as Denmark, Sweden and Norway also indicate a high rate of youth suicide (De Leo & Evans, 2004).

According to European Union in 2015, 56200 (amounting to 1.1 %) most deaths amongst youth were due to intentional self-harm. According to WHO (2020) suicide rate is also high in developed countries, with stable economy. For example, in July 2018 about 30 people per 100 000 committed suicides in Australia and Germany. This shows that the suicidal trend is exponentially increasing. This could be apparent in communities ravaged by poverty, where social ties are broken, where there is no social support and mental health, or mental well-being is disregarded.

### 2.5.5. South Africa

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According to the World Health Organization (WHO, 2019) the rate of suicide in South Africa surpassed the world average (Schlebush, 2012). It was discovered that suicide is the third highest cause of death in South Africa. The research which was conducted at the Nelson Mandela School of Medicine in Durban in 2012, shows that attempted or para-suicide is increasing in the country and the youth is identified as the most vulnerable group. According to Charlene (2018) South Africa is number six in Africa in terms of suicide rate. WHO (2018) support this with evidence that about 12 of every 100 000 individuals in South Africa attempt suicide. It is commonly accepted that most of the suicide and suicide attempt occur among youth who suffer from depression. In South Africa factors such as unemployment and economic hardship lead to 30% of all attempted suicide (Akanle, 2021; Matandare, 2018).

Feigelman *et al*. (2016) discovered that a third of the total suicide attempts in South Africans were youths. Regarding the issue of suicide behaviour in South Africa, it is noticeable that it is more common to the youth than in older people, and the rate is

rising from the age of 15 and also between the ages of 20 and 34. From the year 2000 the highest suicide rate was between 25-39 years and between 20-34 in 2004, while the 15 -19 age group also exhibited a significant rise during that time (Schlebusch *et al.* (2017). Schlebusch *et al*. (2017) discovered that 9.5% of deaths which are not natural among the youth in South Africa arise from people who commit suicide. Unlike other countries where the high rate of death is due to natural causes, the incidence of suicide in adolescents is widespread in South Africa, although it is receiving very little attention (Pillay & Wassernaar, 2017).

During the apartheid era Indians, Coloureds and Blacks were given very little attention by the apartheid government (Brent et al., 2015) and this explains why there is a lack of collected information regarding their cultural suicide rates. In their study, Madu and Matla (2003) reported that 37% of the people were experiencing suicidal ideation, whereas 17% of the people committed suicide. 16% of the participants had plans to take their lives, and 21% of them attempted suicide but were not successful. Discrepancies in suicide statistics are to be expected, given the absence of a structure which is reliable to have a database of all clients who attempted suicide or committed suicide. One of the reasons for this problem is that there is no accessibility of information since some of the cases are not recorded in their respective institutions (Krug *et al.,* 2013). Because there is no record keeping on the issue of suicidal behaviour and the fact that research on suicide is limited, there is little knowledge on suicide rates in Africa, especially in South Africa (Lamis et al., 2016). Studies conducted in 1994 indicate that between 8% and 10% of deaths were due to unnatural causes and it was exposed that suicide is the leading cause of death in South Africa (Muthen, 2016).

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After the apartheid regime finally gave over to a democratic nation, South Africa experienced some serious social and political changes in 1994. Although the transformation was done peacefully, the level of stress was increased because other things were not fulfilled and the expectations of the people who were previously disadvantaged were not met. Furthermore, the white people had fear of losing their positions therefore it caused them to have a negative attitude about democratic South Africa, more than other races (Norris et al., 2008). Since 2003 the rate of suicide in urban areas has ranged from 11 per 100 000 in the Western Cape Province to 15 per 100 000 in the Province of Gauteng (Muthen, 2016).

According to the National Injury Surveillance System (NIMSS) (2019) 21.8% of unnatural deaths are caused by suicide. The study focused on youth suicide whereas the most prevalent rates of suicide are widespread among the ages. Most countries now have a current report about the high rate of suicide which is more among the youth than older people (Lamis et al., 2016). In the current years many international studies on youth suicidal behaviour are emerging on getting new information about this epidemic across many countries (Lamis et al., 2016). South Africa's estimated suicide rate of 13.4 people per 100 000 is approximately four times the global rate of 3.6 per 100 000 in 2017. In South Africa risk of self-harm kills an estimated 18 people every day. South Africa's estimated suicide rate of 13.4 people per 100,000 is approximately four times the global rate of 3.6 per 100 000 (Stats SA, 2020)

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## 2.6. CONTRIBUTORY FACTORS TO SUICIDE AND SUICIDE ATTEMPT

The following are the contributory factors towards suicide and suicide attempt, some of those factors predisposes youth to suicidal ideations.

### 2.6.1. Cultural Factors related to suicide

South Africa is a multi-culturally diverse country, meaning that it respects all languages and both genders, and South Africans believe in cultural diversity. Despite what has just been said, westernization, especially in urban areas, is causing people to leave their cultures and focus on western culture (Brigde et al., 2020). This refers to the individual absorbing the western culture at the expense of his or her own traditional culture; therefore, a person in this case is clearly using western practices instead of the original culture. Bridge et al. (2020) explain that these changes of cultures may cause persons to feel isolated or estranged, because they are no more practicing their own culture, and therefore this may play a contributing role in the youth suicide rate.

### 2.6.2. Abduction or Forced Marriage in South Africa

In South Africa, *ukuthwala* is the practice of abducting young girls and forcing them into a marriage without the consent of their parents (www.justice.gov.za). This practice mainly occurs in rural parts of South Africa, in the Eastern Cape Province and Kwa Zulu Natal. This problem of abduction is dominated in Lusikisiki where young girls are abducted most of the time, especially within poor families in the remote areas (Mail & Guardian by Davidson, 29 November 2017). Before the new dispensation, *ukuthwala* (that is abduction or forced marriage) among the Xhosa and Zulu people, was once accepted for a mature girl to be married with an old male, with the permission of the girl and the suitor. However, *ukuthwala* has been abused to victimize isolated rural woman and enrich male relatives (Maphalala, 2017). The practice received negative publicity, with media reporting on 17 June 2009 that more than 20 Eastern Cape girls are forced to drop out of school every month because of *ukuthwala*. *Ukuthwala* is regarded as the sex trafficking and is devastating rural South Africa (Mail and Guardian

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by Steven, 29 November 2017) and is commonly practiced in the Eastern parts of the Eastern Cape.

According to Rice (2014) while marriage rates in South Africa are exceptionally low, *ukuthwala* (abduction marriage) appears to be increasing in some rural communities despite decline of the overall rates of marriage. It is argued that situating *ukuthwala* within a broader social, economic, and political context, can offer a richer appreciation of moral values that scaffold it and it can contribute to broader conversations about violence, social change, gendered and generational struggles in South Africa today (Rice, 2014).

SABC NEWS on 13 January 2019 reported that Eastern Cape Social Development has warned parents who arranged marriages between their children and older men under the custom of *ukuthwala* that they will face a full might of the law. That came after police in the province opened a case of abduction against the 26 year old man from Baziya outside Mthatha for allegedly taking a 15 year old to Limpopo to become his wife.

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This was after the girls' family negotiated *lobola* with her husband family for her to marry the man (www.sabc news.com.) The incidents of the abduction of young girls who are forced into marriage by older men under the pretext of the *ukuthwala* cultural practice have been on the rise in recent years (Maphalala, 2017). A study by Maphalala (2017) investigated the impact of *ukuthwala* cultural practice on the schooling and livelihood of a girl child. The findings of this study show that teenagers who are victims are more vulnerable to suicide and attempted suicide.

### 2.6.3. Body parts harvesting

According to Meel (2013) albinism is common in most African states like Kenya, Malawi and South Africa. People, particularly traditional healers and Sangomas, have certain beliefs that some body parts of Albinos may be used for traditional medicine purposes. As a result of this Albinos become depressed once they become aware of this as a result they can commit or attempt suicide (Meel, 2013). These people end up living in anxiety in the community, as such, taking one's life through suicide may easily occur (Meel, 2013).

It is argued that people with albinism in Africa live in ambiguity. It is also asserted that the double meaning is happening because albinism is linked to water spirits and ascribed/notional celibacy (Meel, 2013). It is also maintained that the biggest obstacle preventing people with albinism from taking full part in Zimbabwean society derives from African traditional religious myths and beliefs, which make them to live in ambiguity (Meel, 2013). These persist today and stigmatize people with albinism. Some rituals have certain beliefs about albinism causing impaired self-esteem, subsequently leading to sense of suicidality. However, a significant support, proper guidance and education could instil more sense of resilience, subsequently lower suicidal rates. It is believed that albinos bring good luck as such albinos are more vulnerable to murder. Things like financial stability and luck is associated with albinos. However, in some culture's albinism is associated with curse like droughts and floods and they become discriminated against so they can attempt suicide. Due to this situation people with albinism become more vulnerable to suicide and attempted suicide. The cultural turn in critical suicidology questions dominant biomedical and psychiatric understandings of suicidal behaviour. As a result, people only believe what is believed in the communities.

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### 2.6.4. Witchcraft and sorcery

According to Meel (2013) witchcraft is likely to lead to suicide especially in the suspected or accused person. Once a person is accused of being involved in witchcraft, such a person can commit suicide because of ill-treatment received from the society. If focus is put on the importance of considering the influence of culture on suicide then the models that construct suicide as a symptom of mental illness may be challenged (Douglas, 2015; White et al., 2016). White et al. (2016) claim that witchcraft is one of the causes of attempted suicide. It is claimed that if a family member is accused of witchcraft, it may result in the teenager or school going child being stigmatized by other learners at school. Once the adolescent is subjected to these conditions then the learner may end up committing suicide (White et al., 2016).

### 2.6.5. Traditional male initiation

According to Douglas (2015) male initiation as a ritual is practiced in most African states. In South Africa initiation is usually regarded as AmaXhosa ritual through which every male is supposed to go before one can be regarded as a true man. During initiation initiates are subjected to a lot of bulling in initiation schools. During such process death of initiates have risen, some reported to be due to dehydration (Douglas, 2015). Reports from the office of traditional leaders in the Eastern Cape accused the society of being irresponsible concerning protection of initiates (Douglas, 2015).

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As a result of high death rates in initiation schools' boys become anxious of going to initiation schools. Once boys become anxious, they are more likely to be depressed if they are forced to go there. During that depression period boys can end up attempting suicide (Douglas, 2015). On the other hand, boys are subjected to a lot of pressure at school if they have not yet gone to initiation school. As a result of this pressure they may resort to attempting suicide (Douglas, 2015). According to Fihlani

of BBC news (20 November 2019) there are a number of factors that lead to high death rate in our initiation schools. Among such factors is the manner in which initiates are treated in the bushes. It is argued that as a result of bad treatment initiates receive in the bushes then they are more vulnerable to stress and depression. This view concurs Douglas (2015) argument that initiates then become depressed and can easily think of suicide. Feni and Fuzile (2015) argue that deaths of initiates in the Eastern Cape are due to eating of more starch which is difficult to chew (Daily Dispatch, 2015, 21 July 2015). Feni and Fuzile (2015) also argue that some boys go to initiation schools without the permission of parents.

During such illegal initiation there is a lot that is happening to the initiates. Some initiates are likely to lose their manhood due to the lack of experience from the side of the surgeon doing initiation (Douglas, 2015). Once initiates lose their manhood, they become a laughing stalk of their friends and then they think of taking their lives as they view life as meaningless (Douglas, 2015). According to Feigelman et al. (2016) during initiation season some initiates got injured as a result they are taken to hospitals. In Xhosa culture, once one goes to hospital for initiation such an initiate is not regarded as a complete man (Feigelman et al., 2016). It is then that an initiate becomes depressed due to frustration as he will be subjected to discrimination in the communities. Attempted suicide or suicide will then be regarded as the only available option.

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### 2.6.6. Psychosocial Problems leading to Suicide

Psychosocial problems represent the potential to act as causes of stress and precede mental disorders such as depression and anxiety (Hawton, 2011). As a result of such psychosocial problems individuals are at risk of self-harm. For Barlow and Durand (2020) for stressful incident to be considered as a cause of suicide it must have

happened to the person who has attempted suicide. These include the abuse of drugs and alcohol, a history of childhood abuse which might be sexual, as well as loneliness emanating from different forms of social isolation. These factors of suicidal behaviour, for example, include individuals who are living in poverty because of unemployment, or when individuals lose their loved ones, relationship breakdown, problems which are work related, financial problems, family conflict and problems with friends (Hawton, 2011). Clifford and Juliet (2020) found that stressful life events are consistently linked to the increased suicide vulnerability. Stressful life events can precipitate many psycho-social difficulties which in turn can lead to suicide related behaviour. Nolen (2008) found that financial stresses in a family can negatively impact on or affect all members of the family. According to Clifford and Juliet (2020) when an individual, for example, loses a job, this is persistently linked to increased suicide vulnerability. Economic hardships often contribute to destructive behaviour. It can result in the inability to deal with psycho-social difficulties, and this in turn may lead to suicide-related behaviour.

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Financial problems or lack of money can also limit or reduce a person's social interactions and lead to withdrawal from family and friends (Clifford & Juliet, 2020). Financial crisis can lead to stress in youths. Once the youth become stressed, they are likely to commit suicide. The research conducted indicates that attempted suicide is the biggest problem in rural communities and is also associated with poverty which leads them to commit suicide. The former Transkei is one of the regions in South Africa which is dominated by poverty (NIMSS, 2019). The issue of poverty is increasing in the Eastern Cape Province as shown by the fact that seventy-five percent of the people who are living in this province live below the poverty line of R800 or less per month.

### 2.6.7. Dysfunctional family structure and dynamics

Family relationships have been confirmed as the central or most intermediate source of support for the youth Zelda Holtman *et al*. (2011). Zelda Holtman et al. (2011) also continue discovered that family can act as a buffer to those individuals who have experienced serious vulnerability. However, with the family structures changing because of the high rate of divorce and parents who are single, most of the youth are lacking the necessary supportive relationships when they need them the most. Emotional circumstances including death, divorce, separation of parents and family disputes have been quoted as common events or incidences in the lives of youth who have committed or attempted suicide (Hawton & Van Herring, 2011). Disturbances in a family system can be regarded as the main contributing factor to youth suicidal behaviour. When parents' divorces or when one parent leaves the other, or when a parent loses his/her job, youth can feel guilty about the incident and devise self-destructive ways of behaviour in a form of self-punishment (Lamis et al., 2016).

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It is believed that the youth who have difficulties, or who come from dysfunctional family backgrounds are more at risk of committing suicide because they are more vulnerable (Lamis et al., 2016). This issue is associated with poor problem solving within their families; families are lacking the skills of tackling their problems constructively. There are other factors which contribute to this issue, including impulsiveness, emotional instability and also the lack of reasoning in the family, as well as poor decision-making skills (Feigelman et al., 2016). Muthen (2016) found that peer pressure can lead to suicide and attempted suicides among the youth in different forms. Some families fail to discuss significant issues which affect the youth. Families do not take young members at home seriously when they experience certain problems which

involve them. They are taken for granted at home and others don't even pay attention to them when they are reaching out for help (Feigelman et al., 2016).

## 2.7. SUBSTANCE ABUSE

Pompili et al. (2012) discovered that individuals who attempt suicide could possibly be involved in substance abuse. Youth that is involved in substance abuse usually need more help as they are always involved in reckless behaviours. It is further argued that youth engage in such behaviour because they need attention, affection and care (Shaffer et al., 2017). It is also possible that they may be suffering from other mental issues perpetuated by substance abuse, and subsequently leading to suicidal thoughts. Suicidal ideations and attempts could be more apparent to youth that has used substances to conceal their life challenges. This indicates that the use of substances could lead these individuals from suicide ideation, to attempted suicide. Shaffer et al. (2017) continue explained that all those people who had suicidal thoughts were abusing substances such as cigarettes, marijuana, and alcohol.

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The youth who have a background of using drugs consistently tend to experience problems such as poor academic performance, health related problems (e.g. mental health issues), poor relationships with friends, and conduct problems (Shaffer et al., 2017). There are also consequences with their family members, with their communities, and also with society at large (Hawkins et al., 2017). In addition, there are problems that are associated with the abuse of substances which include absenteeism from school, dropping out of school, and other antisocial activities. All these problems could result in attempting suicide or committing suicide when the young person is not achieving academically, and sees suicide as the only way out of the problems he or she is experiencing (Meel, 2011).

When the youth start abusing alcohol and drugs, this may lead to a family crises or problems and compromise many aspects of the family life. At the same time, it may result in a family becoming dysfunctional. Both the siblings and the parents are implicated in the abuse of alcohol and drugs by youth (Hawkins et al., 2017). The abuse of substances within the family can drain the family of their financial and emotional resources. Hawkins et al. (2017) shows that cognitive and behavioural problems experienced by youth who are using narcotic drugs can have an impact on their academic performance and can also disturb the performance of other students.

Physical disabilities and diseases are among the health related problems which are contributing factors of youth to use substances, which may lead them to commit suicide, when they are not improving their lives. A big number of youth who use alcohol and other drugs face an increasing risk of death through committing suicide or attempting suicide (Pillay & Wassener, 2017). The study that was conducted by the Drug Abuse Warning Network (Pillay & Wassener, 2017) which contains a representative sample of hospitals in the United States of America, reports that there is a rise in the number of people who are looking for emergency treatment in the hospitals related to unlawful drug use.

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The reports which have been assembled since 1994 show that drug-related emergence of youth between the ages of 12 to 17 grew by 18 percent between 1993 and 1994 (Hawkins et al., 2017). Statistics show that at least 15% of South Africans are said to have drug problem according to the countries Central Drug Authority. According to article published on parent 24 drug abuse treatment has admitted 8787 people in 2016 and 10 047 in 2017 (Davidson, 2017).

## 2.8. THE RELATIONSHIP WITH PEERS

According to Pillay and Wassernaar (2017), peer pressure plays a vital role in youth suicidal behaviour. Pillay and Wassernaar (2017), also found that the conflict between siblings, peers, relatives, and teachers increase the suicidal behaviour of the youth. The study which was conducted in New Zealand focusing on youth who are suicide attempters, found that more than half of the participants reported that they have problems of break down in relationships with family and friends (Pillay & Wassernnar, 2017). According to Rebecca et al. (2015), they explained that the presence of peer group relationships affects the quality of youth's life and when they try to build relationships with their groups, they are likely to attempt suicide. However, when they are faced with the competitiveness within the peer group setting and there is a strong possibility of failure or recurring failure, some of them see suicide as a solution for their perceived failure.

According to the study conducted in 2005 by Suominen (2004) at the University of Kwa-Zulu Natal by the Department of Psychology, inability to deal with the peer pressure can lead to suicide and attempted suicide. Youth who commit suicide also often have close friends who have committed suicide. The youth who attempt suicide but are not successful often share their intention before they do it, but they are often not taken seriously. In other societies, there is this idea that people who threaten to attempt suicide should not be taken seriously, but after all these incidences of suicide, when youth joke or talk about this phenomenon, it must be taken seriously (Pillay & Wassener, 2017).

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## 2.9. PSYCHIATRIC AND BIOLOGICAL PROBLEMS

As per Pandey (2013) neurobiology of self-destruction has been read for many years. The study reveals that youth are more likely to have bipolar disorder. Once

people have such disorder suicide can be easily committed. There are abnormalities in neurotrophins and serotonin, as a result young people are more vulnerable to attempted suicide (Pandey, 2013). Pandey (2013) argue that there is a genetic component of suicide. Some studies showed that if a particular generation has a history of suicide, it is therefore more likely that members of such family are at risk of attempted suicide (Pandey, 2013).

Psychiatric problems, including but not limited to depression, also contribute largely to suicide attempts. Illnesses, especially those of a painful and disabling nature, are also significant factors (Barlow & Durand, 2018). Barlow and Durand (2018) found that old people who suffer from serious illness that can make them experience pain are at a high risk of attempting suicide. Chronic illnesses such as high blood pressure, diabetes and a stroke are also contributory factors. Some illnesses that commonly increase the risk of suicide are HIV/AIDS, cancer of the brain and some neurological disorders or conditions, while social isolation can also be a cause of attempted suicide, as well as chronic disability. Barlow and Durand (2018) argue that depression is the major cause of suicide among youth.

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## 2.10. DEPRESSIVE SYMPTOMS

Pettit *et al.* (2011) explained that hopelessness is when a person is demotivated or loses hope in life in a particular way. This lack of hope is an indication of symptoms of depression and is linked to adolescent suicidal behaviour (Pettit et al., 2011). Pettit et al they also found that the symptoms of depression in the youth are totally different from symptoms of depression found in adults. For example, when adults experience depression they become sad whereas the youth show depression through anger and outbursts and they present with irritability. The youth do not want to accept criticism for their behaviour, and they can complain that they are not adding any value to their lives

when they are frustrated. The youth who are depressed tend to withdraw themselves from their family members or their friends (Pettit et al., 2011).

## 2.11. GENDER DIFFERENCE IN YOUTH SUICIDE

Lee and Wong (2020) found that women are the ones who have high levels of suicidal ideation, and as a result, they also make more suicide attempts as compared to men. Men, however, commit suicide more often than women. This trend can be seen in the youth as well. In most of the countries where the information was collected, except China, the male youths show a higher rate of suicide than females, whereas the females experience a higher prevalence of suicidal ideation and suicide attempts (Bridge et al., 2013).

Marcenko et al. (2017) found that gender plays a significant role in the ideation of females rather than males. This view is supported by Simons and Murphy (2013) who also discovered that, females have significant higher suicidal ideation than males, whereas there is a big difference in terms of the prevalence of female and males in terms of suicidal behaviour. Beautrais (2018) questions whether research on suicidal ideation and suicide attempts focuses on the risk factors which contribute to the females experiencing this phenomenon. Schlebush et al. (2015) found that males are the ones who commit or attempt suicide more than females, and further explain that anger and aggression are the contributing factors to attempting suicide.

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## 2.12. TYPES OF SUICIDE

Durkheim (2008) argued that when people receive uncontrollable pressure from society, they might resort to negative behavioural thoughts or even suicidal thoughts. According to Durkheim (2008) social pressure and the influence of society can play a big role in an individual's suicidal thoughts, and the issue of suicide is determined

through social integration and the experiences of the individual. Durkheim (2008) proposed four types of suicide to address this issue. These types are as follows:

### 2.12.1. Egoistic suicide

Durkheim (2008) explained that when individuals struggle to be involved in societal activities and find it not easy to connect with the community, they may resort to egoistic suicide. This nature of suicide can be particularly relevant to South African adolescents who are placed in previously Model C schools (Stillion et al., 2015). Cultural differences may lead to feeling isolated. Lack of belonging is a well-known risk factor for suicidal behaviour among adolescents.

### 2.12.2. Altruistic suicide

Altruistic suicide is the sacrifice of one's life for the benefit of others (Steven, 2011).This type of suicide takes place when a person is involved in many groups and does not feel isolated. A clear example of this altruistic suicide is found in the occurrence of suicide bombing. This suicide bombing has dominated countries such as Russia, Israel and Palestine since the 1980s and is also growing fast in countries such as Pakistan and Iraq after the endorsement of the war against terrorism in the United States of America in 2001 (Steven, 2011).

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### 2.12.3. Anomic suicide

This type of suicide occurs when an individual is struggling to deal with the problems they face in a reasonable manner, and these problems create more stress in the relationship between themselves and society at large. They will be unable to find solutions to their growing problems and, therefore, resort to suicide to escape the problems (Steven, 2011). This type of suicide is more relevant to this study. When the youth and adolescents are facing incidents of suicide in their family members or friends, they may channel their feelings negatively to cope with the anger they have.

### 2.12.4. Fatalistic suicide

This one is caused by the regulation from society, which restricts the individual's freedom for example a society may only accept a person if he or she does what is prescribed in society. This is what Carl Rogers called conditions of worth. Therefore, victims feel that they do not have a future and they lose hope. Fatalistic suicide is more common in countries like India and South Africa especially among youth (Lester & Gunn, 2016).

## 2.13. EFFECTS OF SUICIDAL ATTEMPTS

According to Jang et al. (2016) discover that when individual engaged on suicide attempt family caregivers and the person who acted will likely face a myriad of consequences and feelings. Jang et al. (2016) further explain that an individual can suffer a serious injury from the brain or other organs or become paralyzed. After the injury, family and friends can often involve in physical care of the person, visits to the hospital and consulting the doctor, in some countries where suicide is still seen as a crime, a person can be charged by the police. Jang et al. (2016) explained that the issue of stigma can affect the individual's well-being and the individual can be avoid by friends and also by the society at large and can also affect the family psychological.

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## 2.14. LEGISLATION ON SUICIDE

According to the criminal law consolidation act 1935(SA) (S13 at (1) it is not an offence to commit suicide or attempt suicide in South Africa, therefore there is no legislation that deals with suicide at the moment, assisted suicide has no legal ground to stand as codified legislation and it is not protected by the constitution of South Africa, therefore it is illegal for a doctor to assist a patient on ending his or her life (Lamis et al., 2016).

Discussing the issue of suicide legislation is a tricky subject because suicide is a very polarizing topic. In this case there are people who believe that it is wrong to commit suicide because the act shows selfishness and it also leaves survivors to deal with the stress. There are individuals who believe that everyone should have freedom to commit suicide and take their own life if they are living in a constant state of pain and suffering (Section 108 of 1996). In many places throughout the world, attempting suicide or even following through with the act is considered a crime. From 1886 to 1968 it was illegal, but this legislation no longer stands. Assisted suicide is still illegal in South Africa, but there is some thought that it may eventually be legalized (Section 108 of 1996).

## 2.15. SUICIDE PREVENTION AND SUPPORT FOR THE YOUTH

The youth need psychological education so that they can understand the issues of life they also need the necessary support from their parents to survive after they have grown up in a bad environment, or where they were raised in a dysfunctional family or without their parents or family structures (Brigde et al., 2020). The youth need necessary skills in order to cope with their anger and also not to be violent in society. There are organisations or institutions that are offering necessary programmes to support the youth, such institutions include churches, schools, and NGOs. Suicide among the youth is not decreasing, which indicates that there is a need to put more emphasis on the youth in order to support them and provide them with the necessary coping skills (Brigde *et al*., 2020).

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## 2.16. SUICIDE PREVENTION STRATEGIES AMONG YOUTH

Douglas (2015) explains that the efforts to prevent youth suicidal behaviour require public health model strategies in school settings. This public education may encourage youth to seek help if they recognize symptoms of suicidal risk. It was

discovered that the new approaches or new way for school-based suicide prevention programs are needed because evaluations of prior school programs concluded that their fruitfulness was not suitable to prevent suicide, to change adolescents' attitudes about suicide, or magnify help-seeking behaviour (Shaffer *et al.*, 2017).

Morstrom and Rossow (2016) mentioned that suicide prevention efforts should focus on identifying high-risk youth and adolescents, and there is a need of monitoring them when they show early signs of suicidal risk. The significance issue about suicide is to establish community case-finding approaches in a form of screening procedures and referral of those youth and adolescents who are found in a community to be at risk for suicidal behaviour (Morstrom & Rossow, 2016). The issue of educating mental health professionals, medical, and school professionals, clergy, and others who are in contact with the youth and adolescents to identify youth and adolescents who are at risk for suicidal behaviour is an important suicide prevention strategy.

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Some other reports recommended that youth who had a history of suicidal behaviour were especially upset and had negative feelings about suicide prevention. It was found that comprehensive screening may be a more effective method to identify youth who are at risk for suicide and to promote their referral, and compliance with treatment. The recent research indicates that there are no unfortunate effects of using the direct screening of adolescents for suicidal behaviour (Mostrom & Rossow, 2016).

There are guidelines that has been established for media coverage and it can be useful in lessening the risks for suicide after media presentations. This may be important to reduce the potential for suicide that is documented to occur within 2 weeks after media presentations of actual suicide. Morstrom and Rossow (2016) indicate that there are guidelines that have been proposed for community response on suicidal youth. The main function of these guidelines is to focus on organising community

networks which include school professionals, mental health professionals, police, religious leaders, and parents to respond to the needs of peers and family of a youth suicide victim (Morstrom & Rossow, 2016). The very good approaches in the media are necessary to promote helpful media coverage of the event and to prevent confusion, fear, and risk for other youth suicidal acts stimulated by the presence of news reports and presentation of the story of a youth suicide.

Morstrom and Rossow (2016) indicate that other studies suggest that suicidal behaviour may be low among friends and acquaintances of an adolescent suicide victim within 6 months of the suicidal death, but the risk for major depressive episode and posttraumatic stress disorder is high among such friends and acquaintances. Community support is necessary to identify youth who are most exposed to peer suicide and to offer acute interventions to assist them with their responses to the loss of their friend (Douglas, 2015). Finally, there is a strong belief that the availability of firearms and guns is significantly associated with youth suicide risk. It was said that the efforts to prevent youth suicide require a national intervention or focus to advocate for better restrictions on the availability of guns and firearms and other lethal methods, clinical assessments of youth suicide risk should determine whether there are available lethal means for suicide in the home (Shaffer *et al*., 2017).

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## 2.17. TREATMENT OF SUICIDE

According to Morstrom and Rossow (2016) the most important treatment that can be utilized to reduce the number of people who are committing suicide, is the availability of psychiatric services that involve outpatient and emergency services as well as inpatient facilities. Community programs are important in reducing suicidal risk.

According to Douglas (2016) indicate that hospitalization is a way of removing the youth from the environment which can make them feel much stressed or

disorganized. Douglas (2016) further indicates that suicidal youth should not be discharged from the emergency service without thoroughly discussing their clinical condition. The compliance of the family with a planned treatment will be enhanced by positive family experience with the emergency service staff.

Douglas (2015) mentioned that Psychotherapeutic interventions which involve the development of trust and empathic atmosphere for truthful communication is used to reduce or lower the suicidal behaviour. Steven (2017) believes that delineation of the motivation for a suicidal act is an important feature of treatment. Steven (2017) mentioned that there are certain contributing factors that increase suicide risk a special when individual loss a special person such as the separation of parents or break up with a boyfriend. There are two motives which lead to youth plan to commit suicide as a solution to the problem they face. Frustration and deprivations are amongst motives where the people they do whatever they want to do as well as the feelings of being demoralized (Shaffer *et al.,* 2017).

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Shaffer *et al.* (2017) explain that the treatment of suicidal youth and adolescents is broader to the point it requires the simultaneous use of multiple modalities. There are few systematic controlled studies of treatment efficacy for suicidal youths. Shaffer *et al*. (2017) mentioned that there are various treatments that has been utilized or used which includes dynamic, supportive, cognitive-behavioural therapy (CBT), and Psychopharmacologic modalities. Controlled treatment studies exist for risk factors of suicide, such as the treatment of major depressive disorder, however these studies exclude the youth who are at high risk of suicide.

Cognitive –behavioural therapy for depressed youth has been identified as more effective than family or supportive therapy for reducing depressive symptoms. Shaffer *et al.* (2017) found that Interpersonal psychotherapy, which address the issue of

interpersonal conflicts which involve conflicts, loss, interpersonal role disputes and role transitions, has been found to be more effective in reducing or lowering depressive symptoms among youth than a controlled treatment. Dialectical-behavioural controlled therapy is the only psychotherapy that has been effective in reducing suicidal behaviour in adults and youth, and it has been producing very good results in the treatment of suicidal youths (Shaffer *et al*., 2017). Family therapy can decrease family discord and enhance effective family problem-solving and conflict resolution.

A time-limited, home-based family intervention had only limited efficacy in reducing suicide attempts, especially among the youths without major depressive disorder (Douglas, 2015). Douglas (2015) indicates that Lithium has been found to decrease recurrence of suicide attempts in youths with major depression or bipolar disorder by almost nine-fold. Psychopharmacological treatment which is used to reduce the risk of underlying conditions that are associated with the suicidal behaviour, involve the use of medications specific to the diagnosis of the underlying conditions.

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## 2.18. CONCLUSION

This chapter reviewed the relevant literature to aetiological factors to suicidal ideations and suicide attempts. The historical overview of suicide has been given and discussed the concepts associated and central to the topic of suicide. Among such concepts includes suicidal behaviour, suicidal ideation, attempted suicide, and those concepts were briefly discussed. Moreover, the chapter showed the relationship between gender and suicidality among youth. Various types of suicide have been discussed guided by Durkheim (2008). Among such types egoistic, altruistic, anomic, and fatalistic suicide have been put forward. Furthermore, prevalence of suicide was discussed starting from global prevalence up to prevalence in South Africa.

The chapter also looked at various factors that contribute to suicide. Cultural factors have been identified as one of the causes of suicide. Cultural factors like forced marriage is likely to lead to suicide especially among the Nguni tribes in South Africa. Family dysfunctions, substance abuse, peer pressure is linked to causes of suicide. Various strategies of suicide prevention among youth like media awareness campaigns and direct screening can be utilized to minimise the risk of suicide. Finally, treatment for suicide have been put forward. Psychotherapy especially cognitive behavioural therapy was deliberated. The following explicate the research methods and techniques use in this study.

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# CHAPTER THREE: RESEARCH METHODOLOGY

## 3.1. INTRODUCTION

This chapter serves to present the research methods used in this research study. A research methodology is like the blueprint of a research study to be conducted. It gives guidance to the researcher on how to conduct the research. It provides the researcher with a straightforward and precise research procedures to follow. In this chapter, the explanation of the research design, sampling technique, data instrument and data collection process and ethical implications are explained. The ethical issues that were considered in this study were also explained thoroughly in this chapter, and the area in which the study took place was explained by the researcher in this chapter. The following sub-heading explains the components of research methodology pertinent to this study.

## 3.2. RESEARCH DESIGN

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This study used a quantitative research design. According to Babbie (2005), a quantitative study is an inquiry into a social or human problem, based on testing theory composed of variables, measured with numbers. Statistical procedures are used to determine whether the predicted generalizations of the theory hold true. This research employed positivism research philosophy. Positivism adheres to the view that only factual knowledge gained through observation, including measurement, is trustworthy (Babbie, 2005). In this study, the role of the researcher was limited to data collection and interpretation through objective approach and the research findings are observable and quantifiable. Hence this study was independent of the observer.

Positivist paradigm has the following assumptions and beliefs as they relate to this study: the realistic ontology which assumes that there are real world objects apart from the human (Babbie, 2005). In other words, there is an objective reality. At the

same time, there is representational epistemology which assumes that people can know this reality and use symbols to accurately describe and explain this objective reality (Babbie & Mouton, 2015). In this study, the researcher can compare his claims and ascertain the truth. Through positivism there can be prediction and control. The assumption is that the general patterns of cause and effect can be used as a basis for predicting and controlling natural phenomenon. The positivist approach generally involves generating of hypothesis and hypothesis testing.

### 3.3. AREA OF THE STUDY

Data was collected at St. Elizabeth Hospital and the Department of Social Development in the Eastern Cape Province in Lusikisiki area, Eastern Cape Province, South Africa. This town is under Ingquza Hill Local Municipality under the umbrella body of O.R. Tambo District. St. Elizabeth hospital serves large communities in the North-East of Lusikisiki. The communities are made up of diverse households, such as single parent headed households, child-headed households, as well as nuclear and extended family households (Stats'SA, 2018). Most dwelling structures are rondavels and they tend to be extremely overcrowded. The families themselves have limited resources due to their big family sizes and scarce job opportunities (Stats SA, 2018).

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There is a high rate of unemployment in these communities largely because of low levels of education, which make it difficult to secure formal employment. The majority of people earn below the poverty line, that is, less than R50 per day (Stats' SA, 2018). There is also emotional fatigue in these communities due to escalating rate of death from HIV/AIDS and other death cause, including Covid-19 pandemic (Social workers report, home circumstances, St Elizabeth hospital, 2015). The high rate of unemployment causes parents to allow other people who have means, to abuse their children so that the parents themselves can benefit in order to survive. For example,

having multiple sexual partners, engaging into transactional sex, forced marriages or abduction. Some communities which are served by the hospital are more developed than others in terms of access to resources such as water, electricity, clinics and road accessibility (Stats SA, 2018). However, despite those differences, youth face social issues that compromise their mental well-being, subsequently leading them to suicidal ideations or suicidal attempts.

## 3.4. POPULATION AND RESPONDENTS

Population refers to a group of people to be studied (Bless, 2017). The target population for this research were the patients who were previously admitted at St. Elizabeth Hospital for suicide attempts and individuals who have attended Social Development counselling sessions between January 2016 and January 2020. The population included both males and females, employed and unemployed individuals between the ages of 18 and 35. The researcher purposively targeted participants who were in the after-care programme and only attending follow-up sessions with their respective social workers. The participants were asked to voluntarily complete a questionnaire in the presence of the researcher.

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## 3.5. SAMPLING TECHNIQUE

According to Saunders, Lewis and Thornhill (2012), sampling technique is a process of grouping elements or unit of analysis from a defined population. Non-probability sampling was used in this study. Non-probability sampling is a type of sampling where the first available primary data source was used for the research without additional requirements (Saunders, 2012). Under this exercise, convenient sampling was used since the researcher was using participants who are experiencing the common problem which was suicidal attempts, or battled with suicidal ideations in St. Elizabeth Hospital and the Department of Social Development and the researcher

get the access through the permission from the department of social development and from the department of health at St Elizabeth Hospital. The researcher sampled 150 participants both males and females. A sum of 90 females, which is 60% of sampled participants, and 60 males constituting 40% of the sampled participants. Participants were homogeneously black isiXhosa speaking youth from rural setting.

A marked increase of attempted suicide amongst the youth of Lusikisiki area was noticed through the social workers statistics at St Elizabeth Hospital, where they record all their patients. This research study forms part of the initiation to identify possible etiological factors that may lead to attempted suicide amongst the youth of Lusikisiki area, as well as to plan and implement interventions aimed at redressing these contributing factors to youth suicidality.

## 3.6. INSTRUMENT OF DATA COLLECTION

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The researcher used a self-constructed questionnaire for data collection. The questionnaire was made available in English since it was administered in the presence of the researcher in order to make clarifications where necessary for the participants who may not understand the questions from the questionnaire. The administration of the questionnaires occurred during working hours, determined by the St Elizabeth Hospital and the Department of Social Development. The participants were asked to voluntarily complete questionnaires in the presence of the researcher, where they did not understand the questions, they were guided by the researcher. The questionnaire had two sections, A and B. Section A contained demographic details of the participants and Section B addressed the fundamentals of this study such as economic hardship, poverty, financial instability, dysfunctional family or family disharmony, drug consumption such as substance abuse which include alcohol, cultural factors, suicidal ideation, and types of attempted suicide. The section B of the questionnaire was

developed based on the objectives of the study in order to address the hypothesis of the study that the researcher want to embark on. The reason for that is because the researcher wants to test the validity of the hypothesis.

## 3.7. RELIABILITY AND VALIDITY OF INSTRUMENT

According to Babbie and Mouton (2015) reliability means an ability of an instrument to come up with more or less the same results when administered more than once to the same participants. Validity of an instrument means that an instrument measures what it is supposed to measure (Bless et al., 2006). It is therefore important that a research instrument be valid and reliable. The instrument was taken for pilot study to test for reliability and validity. In pilot study the researcher used five participants with the same characteristics as those of the population of research. Test retest reliability were done to ascertain reliability.

### 3.7.1. Reliability and Validity Analysis

Cronbach's alpha is a measure of internal consistency, that is, how closely related a set of items (questions in a questionnaire) are as a group. It is considered to be a measure of scale reliability. A "high" value of alpha (greater than 0.70) implies a good reliability of the instrument/research tool. Exploratory factor analysis is one method of checking dimensionality. Cronbach's alpha can be written as a function of the number of test items and the average inter-correlation among the items. Below, for conceptual purposes, is the formula for the Cronbach's alpha:

$$\propto = \frac{N\bar{c}}{\bar{v} + (N-1)\bar{c}}$$

Where:

*N* is the number of observations included in the calculation;

The average inter-item covariance among the items is $\bar{C}$ and V-bar is the observed average variance. Considering the instrument of the data for this research, the observed Cronbach alpha was 0.882. By any known research standards, this level of Cronbach's alpha satisfies the minimum level of internal consistency. For an observed alpha of 0.882, the data collection instrument is consistent (See the following SPSS tables)

**Table 1: Case Processing Summary**

| | | N | % |
|---|---|---|---|
| **Cases** | **Valid** | **25** | **83.3** |
| | **Excluded** | **1** | **16.7** |
| | **Total** | **30** | **100.0** |

**Table2: Reliability Statistics**

| Cronbach's Alpha | N of Items |
|---|---|
| **0.882** | **61** |

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## 3.8. ETHICAL CONSIDERATIONS

The following ethical issues were considered during the process of data collection of this study. The researcher first got ethical clearance from the university's higher degrees committee at Fort hare University after the proposal was approved. The ethical clearance number for this study is MAK011SZWE01 as attached on the appendices (*See appendix A*).

### 3.8.1. Institutional Permission

A letter requesting permission was sent to the manager of St Elizabeth Hospital and permission was granted in a form of responding letter. The second letter was

written to the District manager of Social development (*See Appendix B*) and permission was granted in a form of responding letter (*See Appendix C*)**.**

### 3.8.2. Informed consent

Informed consent means the consent given by participants that they are willing to participate in a study and they have not been forced to do so (Babbie & Mouton, 2015). The researcher explained the purpose of the study to the participants and requested them to participate voluntarily. Those who were willing to participate were given consent forms to sign (*see Appendix D*).

### 3.8.3. Confidentiality and Anonymity

According to Babbie and Mouton (2013), confidentiality entails the manner in which the information obtained from the participants is kept secret in a safe place. Anonymity is the way of protecting participants' identity so that it cannot be known where and/or from whom the information was obtained. In such a manner, no one can be associated with such information as it constitutes personal lived experiences. Those who agreed to voluntarily participate were assured that the information they provided will be kept in a safe place. Participants were also assured that their identity will be kept anonymous. Where possible, pseudo names would have been used in the process of tabulating data and reporting findings. However, in this quantitative study no names were used, but figures.

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### 3.8.4. Beneficence

Beneficence is the action that is done to benefit others as explained by Babbie and Mouton (2013). Beneficent actions were taken to help prevent or remove harm or to simply improve the situation of participants. Beneficence also include protecting and defending the rights of others, rescuing persons who are in danger, and helping individuals. In this study beneficence occurred through talking to participants about

their lived experience in line with suicidality. The researcher will report back the findings to the St Elizabeth Hospital and Social development. The researcher will thus conduct workshops after the study so as to capacitate the community members on intervention strategies aimed at minimizing the risks, predisposing and perpetuating factors to suicide among Lusikisiki youth.

### 3.8.5. Non-maleficence and deception

This is one of the pertinent ethical issues in research since it entails an act of not harming respondents of the study (Babbie & Mouton, 2013). However, one of the most common ethical dilemmas arises in the balancing of beneficence and non-maleficence. The researcher ensured that he acted in a manner that benefited the respondents whilst mindful not to cause any harm to the respondents. In other words, the researcher did not cause any harm that is psychological and physical to the respondents. Furthermore, owing to the principle of voluntary participation, the researcher informed participants their right to withdraw at any moment should they feel uncomfortable, and they will not be penalized for that. The researcher also tried not to deceive participants in order to let them participate in the study.

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### 3.8.6. Dissemination of research results

The researcher will give feedback to the respondents about the results of the study through workshops, for example the researcher will organize a community workshop for the benefit of the society at large. The researcher will talk on radio programs to discuss the findings of the study as an awareness campaign aimed at educating youth about suicide and suicide attempt. Copies of the thesis will be lodged at the resource center of St. Elizabeth Hospital for interested party to peruse. Also, the research document will be available in online resources. Possibly, the researcher will also present the findings of the study through accredited peer-reviewed journal articles.

## 3.9. CONCLUSION

This chapter explored the research design, population and sampling technique, the data gathering process, and the measuring instruments of the study. Sampling method used were, data collection methods, instruments used to collect data and t procedures were discussed. Lastly, ethical considerations of the study were explained and its application to the progressing study. The following chapter will encompass the results obtained in the study and a discussion of those results.

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# CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

## 4.1. INTRODUCTION

This chapter presents the data that come out of the study t., the analysis and the interpretation thereof. The chapter contains introduction, the descriptive analysis considering the response percentage distribution and the inferential analysis performed to look for the relationship among variables. Performed analysis lay down the frequencies and corresponding percentages. Cumulative percentages are presented in various tables, enabling the researcher to attain descriptive analysis and make comparison of responses based on given percentages. The study considered factors such as respondent's age group, respondent's gender, marital status among others as key variables. Research themes in this study were: reason(s) for use of drugs, forms of drugs, frequent use of drugs and other sub-themes pertinent to the study. The interpretation thus based on the proportional comparison of the responses in percentages. Data was analysed using a statistical package for social sciences (SPSS), and this is a software package which is used to perform statistical operations. Results obtained from these statistical operations are displayed using frequency tables and bar charts in this chapter.

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## 4.2. CODING OF THE COLLECTED DATA FOR ANALYSIS

The process of data-coding is part of a data cleaning and organisation practice, and data was coded before being analysed. The coding in this case depends on the variable of interest at the specific time. As a matter of necessity, all variables whose responses can be classified or numbered must be coded for the sake of organisation of the data for organized analysis and for a well-defined output. Data coding is a process of replacing responses with dummy numbers for mere identification. However, the final output will always be in the original names (labels) for a clear understanding by the researcher. Furthermore, the interpretation will always reflect the original

response labels as stated by the researcher. Coding can be either in letters (lower case or upper case) or digits. It is commonly understood that data is the lifeblood of any research, and thus it requires good treatment. The following are some of the variables in the research tool whose responses were given dummy coding for ease data capturing and as part of data organisation. The original labels are stated on the left with corresponding codes on the immediate right.

## 4.3. STATISTICAL ANALYSIS

According to Dodge (2003) a descriptive analysis or statistics is a summary statistic that quantitatively describes and summarizes features of a collection of information. Hence this study used descriptive and inferential statistical analysis to get significant relationship among variables. Drawing from the work of Freedman (2008) statistical inferences are the processes of using data analysis to deduce properties underlying probability distributions. For that reason, inferential statistical analysis infers properties of a population. For example, by testing hypothesis and deriving estimates. Since inferential statistics can be contrasted with descriptive statistics, descriptive analysis is solely concerned with properties of the observed data and it does not rest on the assumption that the data come from a larger population. Thus, inferential analysis was appropriate for this study because the researcher intended to establish whether there is a relationship between various variables such as attempted suicide, economic hardships, and other variables as independent and dependent variable.

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### PART A: DESCRIPTIVE ANALYSIS

This section serves to provide descriptive analysis for the ongoing study. Various variables such as age, gender marital status, culture, education will be analysed in the following sub-headings using tables and graphs. Analysed data showed that all respondents were Black isiXhosa speaking South Africans, residing in Lusikisiki in the Eastern Cape.

***TABLE 3: Respondent's age***

| Age in years | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 17 – 20 | 25 | 16.7 | 16.7 | 16.7 |
| | 21 – 24 | 35 | 23.3 | 23.3 | 40.0 |
| | 25 -28 | 60 | 40.0 | 40.0 | 80.0 |
| | 29 -32 | 25 | 16.7 | 16.7 | 96.7 |
| | 33 -36 | 5 | 3.3 | 3.3 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The respondent's age group show that majority of participants (about 40%) were respondents aged between 25 and 28 years. Followed by 23, 3% of young adults aged between 21 and 24 years. Approximate 16, 7% shared by respondents aged between 17 and 20, and by those aged between 29 and 32. The least among response percentages was 3, 3% shared by respondents aged between 33 and 36 years.

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***TABLE 4: Respondent's gender***

| **Gender** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Male | 55 | 36.7 | 36.7 | 36.7 |
| | Female | 95 | 63.3 | 63.3 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The respondent's gender, distribution was shown on the above table. Data on the respondent's gender group showed that the majority of respondents (approximately 63, 3%) were females, almost outnumbered male respondents who constituted almost 36, 7%. This implies that more females participated in the study, suggesting that many females battle with suicide ideations and suicide attempts. These findings are

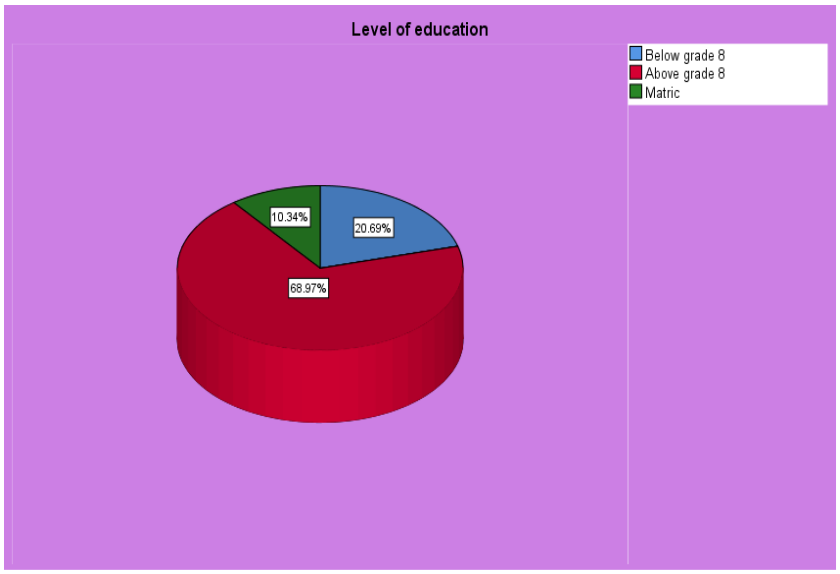
confirmed by Lee and Wong (2020) who also found that women are the ones who have high levels of suicide ideations and suicide attempts as compared to men. In line to that, Simons and Murphy (2013) further supports that suicidality is most common among females compared to males. However, females mostly use less severe things during their suicidal attempts. Things like medication overdose, cutting or drug-overdose to name a few. On the other hand, males tend to be more aggressive during their suicide attempts, mostly hanging themselves, jumping on high bridges or buildings.

***TABLE 5: Marital status***

| **Marital status** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | SINGLE | 130 | 86.7 | 89.7 | 89.7 |
| | WIDOWED | 15 | 10.0 | 10.3 | 100.0 |
| | Total | 145 | 96.7 | 100.0 | |
| Missing | System | 5 | 3.3 | | |
| Total | | 150 | 100.0 | | |

Most of the respondent's marital status shows that 89, 7% of them were single, and 10, 34% were widowed. These findings exclude those who are separated or divorced.

***GRAPH 1: Level of education***




The pie chart above shows the respondent's level of education, depicting that 69% of respondents were somewhat literate since they had grade eight or higher grades. Followed by a magnitude of 20.7% of respondents who had literacy level below grade 8. The respondents who have passed matric constituted 10, 3% of sampled respondents.

***TABLE 6: Occupation***

| **Occupational status** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | UNEMPLOYED | 120 | 80.0 | 80.0 | 80.0 |
| | EMPLOYED | 5 | 3.3 | 3.3 | 83.3 |
| | SELF- EMPLOYED | 25 | 16.7 | 16.7 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The table above shows that majority of respondents (80%) were unemployed, 16, 7% respondents were self-employed. Significantly, only 3, 3% of respondents were employed. This gives a significant connection between employment and the state of metal well-being as it relates to suicidality of the youth, especially in rural areas of the

Eastern Cape. From these findings, the unemployed youth rampaged by poverty, with heightened frustration and stress level are likely to be overwhelmed by suicidal ideations and subsequently attempt suicide. These exasperating feelings are more prevalent in families that have no one employed (Chen *et al*., 2012). This is in support of hypothesis one: *Economic factors, particularly poverty or poor conditions, give rise to youth attempted suicide in Lusikisiki.*

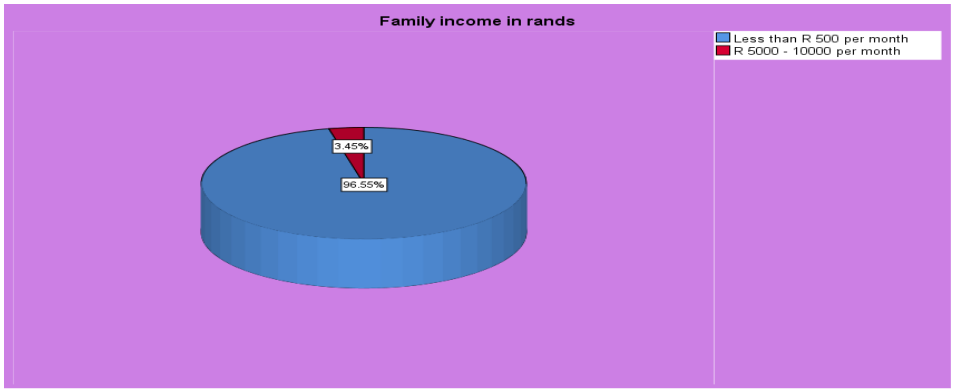
*TABLE 7: Person employed from respondent's home*

| **Person employed from respondent's home** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | MOTHER | 5 | 3.3 | 3.3 | 3.3 |
| | FATHER | 25 | 16.7 | 16.7 | 20.0 |
| | BROTHER/SISTER | 55 | 36.7 | 36.7 | 56.7 |
| | UNCLE | 5 | 3.3 | 3.3 | 60.0 |
| | NONE | 60 | 40.0 | 40.0 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The table above showed that a great proportion of respondents sum up to 40% respondents whose family members are not working. This was followed by 36, 7% which was followed by those respondents who had only brothers or sisters working. 16, 7% were respondents who were provided for by their extended elderlies who may be regarded as the father, since he possesses the father figure roles. The least proportion of 3.3% were respondents who rely on their maternal financial support, it could be from mother's sister or uncles who are working.

*GRAPH 2: Family income in Rands*

**Family income in Rands**




The respondent's family income shows that majority of respondents amounting to 96, 6% were respondents who their family income is less than R500.00 per month. This less than R500 income could be child support grant or social relief grant for the unemployed youth. Round about 3.5% families who gets between R5000 to R10000. This indicates that vast majority of youth, especially in rural areas still leaves below the poverty lines.

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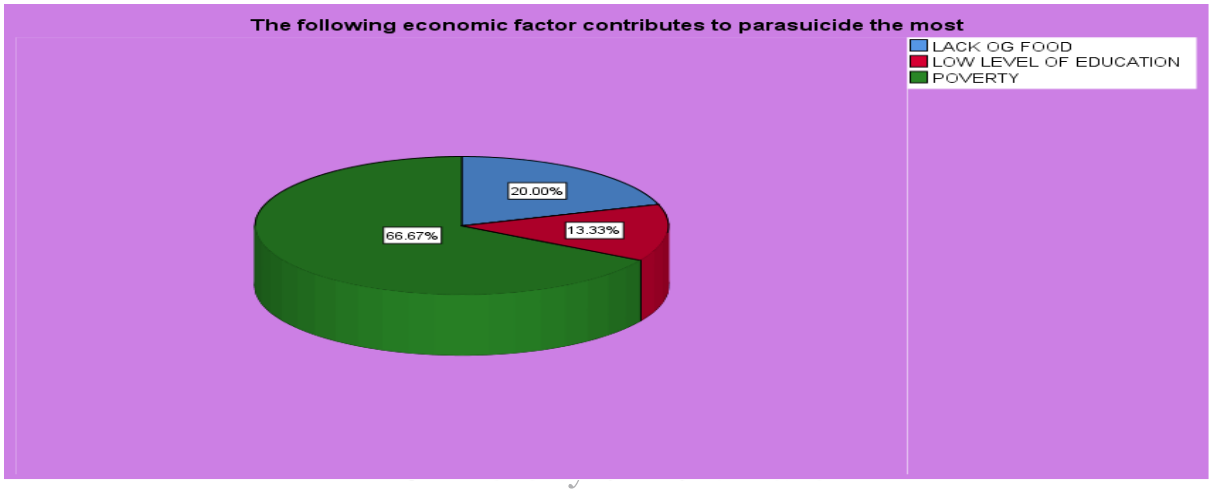
*TABLE 8: Who provides for the family upkeep?*

| **Who provides for the family upkeep** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | GOVERNMENT GRANTS | 90 | 60.0 | 64.3 | 64.3 |
| | EXTERNAL FAMILY | 50 | 33.3 | 35.7 | 100.0 |
| | Total | 140 | 93.3 | 100.0 | |
| Missing | System | 10 | 6.7 | | |
| Total | | 150 | 100.0 | | |

The respondents who provides for the family upkeep as illustrated by the table

above, show that approximately 64, 3% respondents depend on their family government grants. While on the other hand, 35, 7% of respondent reported that they solely rely on their external family members. Table 4, 5 and 6, and graph 2 show that financial factor direct or indirectly compel the youth to adverse poverty state. Hence poverty fuelled by socio-economic conditions is believed to subject and predisposes youth into suicidal thoughts, and subsequently suicide attempts.

*GRAPH 3: The following economic factor contributes to attempted suicide*.

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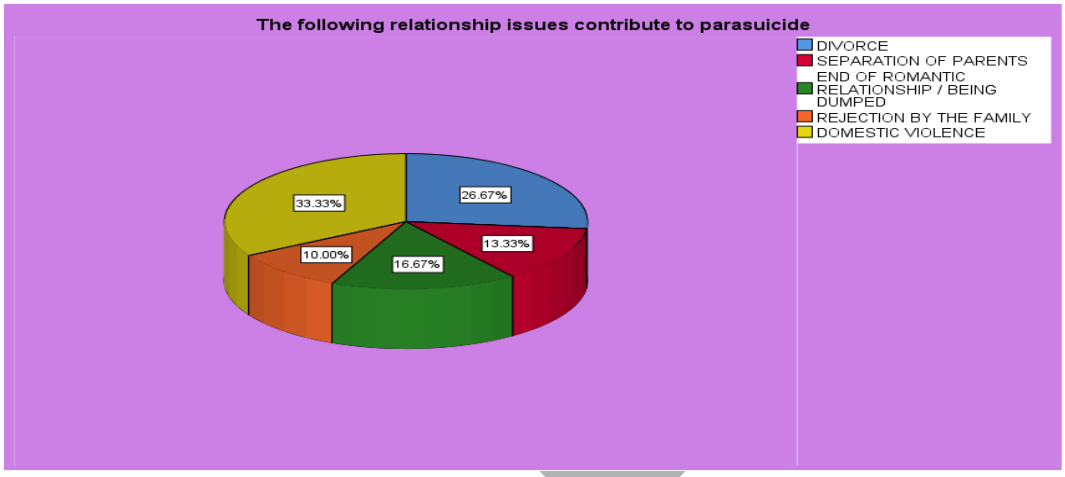
The graph above indicates that the majority which is (66, 67%) was formed by those was formed by those respondents who are living in poverty. This was followed in magnitude by (20, 00%) respondents who lack food, then followed by (13, 33%) respondents who have low level of education. These findings could be in line with the economic factors which contribute to attempted suicide as outlined by Clifford and Juliet (2020).

Clifford and Juliet (2020) found that economic hardships often contribute to destructive behaviours and also explained that individuals are unable to deal with psycho-social difficulties which predispose them to suicide related behaviours. It is also argued that financial problems or the lack of money can limit a person's social interactions and lead

to the withdrawal symptoms, depriving an individual an opportunity of engaging with family members and friends. Drawing from the research conducted by NIMSS (2019), poverty is increasing in the Eastern Cape Province, predisposing youth into suicidality.

*HYPOTHESIS 2: Dysfunctional family, marital disharmony, domestic violence and cultural factors give rise to youth attempted suicide in Lusikisiki.*

*GRAPH 4*: Relationship issues contributing to attempted suicide




The graph above indicates that the majority (33, 33%) was formed by those respondents who are experiencing domestic violence in their homes, this was followed by (26, 67%) which was formed by those respondents whose parents are divorced, followed by those respondents who are being dumped or end of romantic relationship which is allocated (16, 67%) and respondents who are experiencing separation of their parents constitute (13, 33%). The least response percentage which is (10.00%) is allocated to those respondents who are rejected by their families.

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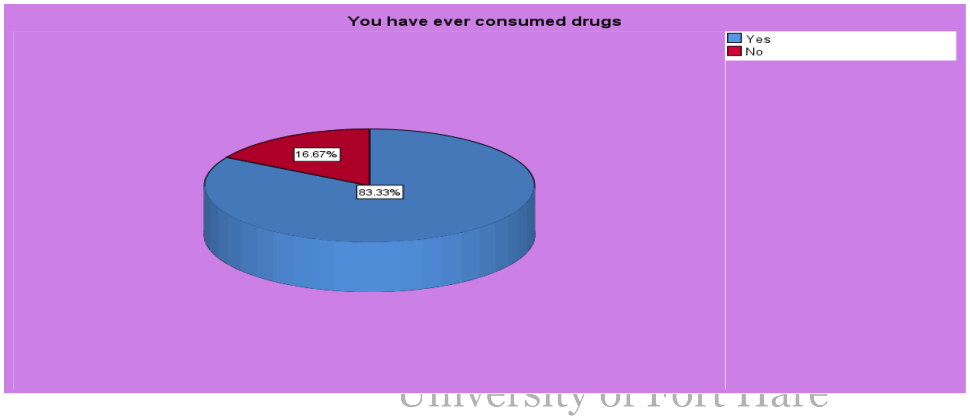
This research finding agrees with the study of Zelda Holtman *et al*. (2011) who found that emotional circumstances including death, divorce, separation of parents, domestic violence and family disputes are the common events in the lives of youth who have attempted suicide. They also found that disturbances in a family system is regarded as the main contributing factor to youth suicide behaviour. Lamis *et al*. (2016)

found that youth who have difficulties or who come from dysfunctional family backgrounds are likely to commit suicide because they are vulnerable. They also found that peer pressure can lead to attempted suicide among the youth in different forms because some families fail to discuss significant issues which affect the youth, families do not take youths serious when they are experiencing certain problems.

*Hypothesis 3: The use of substances such as cocaine, glue, alcohol, and marijuana contribute to youth attempted suicide.*

*GRAPH 5: Drug use and consumption*

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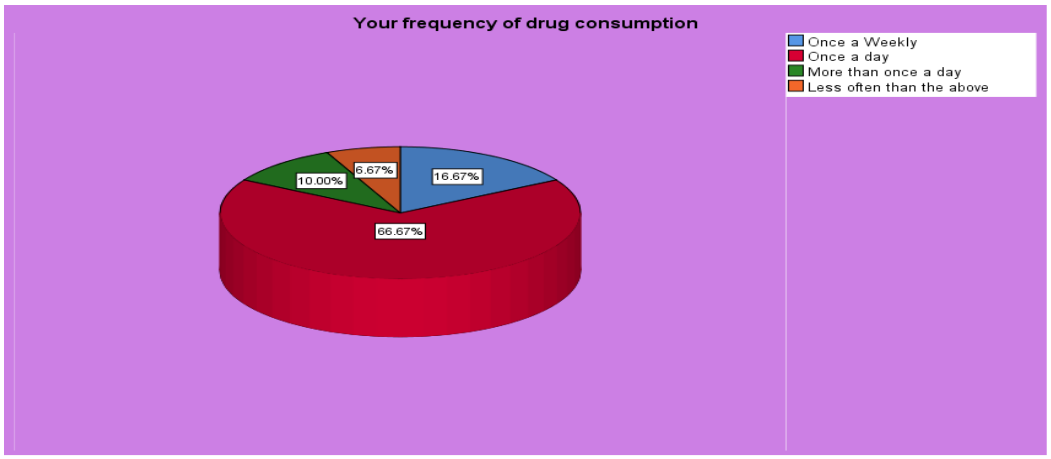
The graph above indicates that most of the respondents (83, 33%) consumed drugs, and followed by those respondents who have not consumed (16, 7%). Drawing from the above *Graph 5* which indicates that most of the respondents consume drugs (N=125) amounting to 83,3%, these findings are confirmed by Pompili *et al*. (2012) arguing that individuals who attempt suicide could possibly be involved in substance abuse. Shaffer *et al*. (2017) further concur that people who had suicidal thoughts were abusing or tend to use substances such as cigarettes, marijuana, alcohol and other substances aiming to getting rid of their intrusive thoughts, prompting to suicide.

*GRAPH 6: Frequency of drug consumption*




The graph above showed that most of the respondents (66, 7%) use drugs once a day, followed by those respondents who use drugs once a weekly by 16, 7% and respondents who use drugs more than once a day by amount to 10%, while those who use drugs less often than the above constitute 6,7% of the participants.

*TABLE 9: Drug usage and drug consumption*

| **State the drug/drugs you use** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Marijuana | 45 | 30.0 | 30.0 | 30.0 |
| | Sniffed glue | 15 | 10.0 | 10.0 | 40.0 |
| | Alcohol | 90 | 60.0 | 60.0 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The e respondent's used different type of drugs uses on as the table above shows, two-thirds majority N=90 (60%) of respondents mostly consume alcohol, while 30% use marijuana and 10% sniff glue. These findings could be in line with the use of alcohol in relation to suicide as explained by Clifford and Juliet (2020). Drawing from the alcohol myopia model which posits that alcohol produces an intolerant effect causing users to pay more attention to striking environmental cues and pay less

attention to less other cues, causing them to temporarily forget about their intrusive thoughts (Innamorati *et al*., 2015). For example, based on the findings, unemployed youth, with economic hardships tend to binge alcohol to shake off their unwanted thoughts engraved by their psychosocial difficulties, thus increasing suicide susceptibility. Once intoxicated, individuals tend to engage into risky behaviours, possibly suicide (Crossland, Kneller & Wilcock, 2016). For example, this (Crossland *et al.*, 2016) found that more than 63% youth once they got overwhelmed by stress, they opt for suicide. Also, more than 37 % have been found to be suicidal once faced by excruciating family issues.

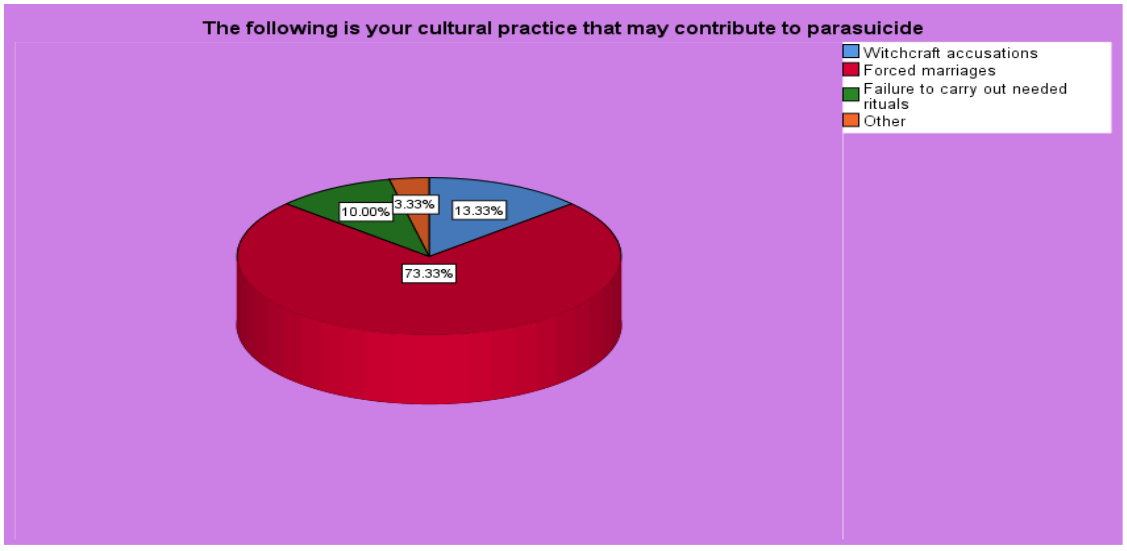
*TABLE 8: Drug abuse and overdose*

| **Respondent has intentionally overdosed him/herself on drugs** | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 95 | 63.3 | 63.3 | 63.3 |
| | No | 55 | 36.7 | 36.7 | 100.0 |
| | Total | 150 | 100.0 | 100.0 | |

The table above shows that most of the respondents (63, 3%) were found to be overdosing medication or drugs as compared to 36, 7% who were not overdosing substances or drugs. On the other hand, findings show that 3, 3% of respondents have burned themselves purposefully. The findings also indicate that 70% of respondents avoided painful experiences during their suicidal attempts, experiences such as hanging themselves or electrocuting. It could be deduced that, respondents for this study were survivors of suicide attempts and those who had extreme suicidal ideations. This assumption is informed by the findings revealing that participants did not use extreme painful methods of ending their lives. Presumably, those who have used

drastic methods in committing suicide have died. Hence all respondents reported not having attempted to jump on high bridges, not shooting themselves or drown themselves because they could have led to complete death. The findings also reveal that peer influence plays a slight role in compelling youth to commit suicide. All participants reported not having been convinced or persuaded by friends to commit suicide. For example, despite having a friend or relative who has committed suicide, it does not mean that such youth will commit suicide.

*GRAPH 12: Cultural practices contributing to suicide attempts.*




The respondent's cultural practice t may contribute to suicide, the pie graph above showed that the majority of the respondents (73, 3%) were respondents who experienced forced marriages in their homes and in their families. With 10% respondents having experienced witchcraft accusations in their families believed to be the cause for their suicidality. On the other hand, 3.3% reported that their suicidal tendencies were influenced by rituals that they need to perform. These findings agreed with the study by Maphalala (2017) that found teenagers who are victims of force marriage or abduction, referred to as *ukuthwala* are more vulnerable to attempted suicide. The frustration they endure during this process and the traumatic experience

they went through put more psychosocial impact in their lives, leaving them hopeless. It is that sense of hopelessness that predisposes youth into suicidal thoughts and subsequently, suicidal attempts. Evident to high prevalence of abduction, on the 17 June 2009 the media reported that more than 20 Eastern Cape girls were forced to drop out of school every month because of *ukuthwala* practice. These cultural dogmas seem to be inconsiderate of the youth's psychosocial well-being. Hence youth is mostly at risk of suicidality.

**PART B: INFERENTIAL ANALYSIS**

This section of data analysis and interpretation is concerned with determination of the existence of an association between any two selected variables. In very simple language, this section deals with bivariate data analysis. One of the variables will be a dependent variable while the other will be the independent variable. The main research objective of this section is to establish the degree of association between the dependent and the independent variables, inline to the main research objectives of this research. Two constructed hypotheses are the null and alternative hypotheses. The rejection of the null hypothesis depends on the result of the analysis for a given pair of variables. The basis of interpretations will be through the observed Chi-square statistic or the observed p-value. The observed p-value will be compared to the level of significance (whose value has been fixed across this analysis to be 0.10) and the null hypothesis will be rejected if the observed p-value turn to be smaller than the level of significance.

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Rejection of the null hypothesis is a demonstration of the existence of association between the two variables. The null hypothesis will state a negation of the existence of association. The analysis will thus be as simple and to the point as possible, bearing in mind the research objectives. The analysis will be carried in the subsections to follow. For every pair of variables, four items must be stated: the

hypotheses, the level of significance, the observation, the interpretation and the conclusion from the research perspective. This analysis conforms to the Statistical Chi-Square Statistics whose formula is given as follows:

$\chi^2_{n-1} = \sum_{i=1}^{R}\sum_{j=1}^{C}(\frac{o-E}{E})^2$ Which follows the Chi-Square Distribution with (r-1) x(c-1) degrees of freedom.

Where: ***O*** are observed frequencies; ***E*** are expected frequencies; ***R*** denotes the number of rows; ***C*** denotes the number of columns and $\chi^2_{n-1}$is the Chi-Square Test-Statistic. The level of significance has been stated to be 0.05.

**Respondent's age and culture as contributory factors to para-suicide.**

*Null hypothesis $H_0$*: There is no association between respondent's age and culture as contributing factors towards para-suicide. *Alternative hypothesis $H_1$*: There is a significant relationship between respondent's age and cultural factors contributing towards para-suicide. The Level of significance: 0.05 and the observed p-value is: 0.000.

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The observations show that the observed p-value is far smaller than the level of significance. The decision, therefore, is that, since the p-value was smaller than the level of significance, the null hypothesis was rejected in favour of the alternative hypothesis. Thus, concluding that respondent's age and culture has a very strong influence on attempted suicide.

**Table 9:** ***Gender and cultural factors to para suicide***

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 43.670[a] | 12 | .000 |
| Likelihood Ratio | 57.618 | 12 | .000 |
| Linear-by-Linear Association | 1.336 | 1 | .248 |
| N of Valid Cases | 145 | | |

*Null hypothesis $H_0$:* There is no association between respondent's gender and culture as contributing factors towards para suicide. *Alternative hypothesis $H_1$:* There is a significant relationship between respondent's gender and cultural factors contributing towards para-suicide. The level of significance: 0.05 and the observed p-value is: 0.000. From the observations, the observed p-value is far smaller than the level of significance. Resolution, since the p-value was smaller than the level of significance, the null hypothesis was rejected in favour of the alternative hypothesis. Leading to assumption that respondent's gender has a very strong influence on some parts of respondent's cultural factors that may contribute to para-suicide. This is in line with the literature findings showing that some cultural practices such as abduction, a form of forced marriage predisposes youth into suicidal ideations.

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**Table 10:** *Drugs and substances as a contributory factor to para-suicide.*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 39.857[a] | 3 | .000 |
| Likelihood Ratio | 45.588 | 3 | .000 |
| Linear-by-Linear Association | 1.106 | 1 | .293 |
| N of Valid Cases | 145 | | |

*Null hypothesis $H_0$:* There is no association between frequency use of drugs or substances amongst the youth to para-suicide. *Alternative hypothesis $H_1$:* There is a significant association between frequency use of drugs or substances amongst youth to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.000. It has been observed that p-value is far smaller than the level of significance. Leading to the decision that, since the p-value was smaller than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. Hence it is concluded that frequency use of drugs or substances has significant influence amongst the youth on attempting suicide.

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**Table 11:** *Dysfunctional family and marital disharmony*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 152.614[a] | 9 | .000 |
| Likelihood Ratio | 135.873 | 9 | .000 |
| Linear-by-Linear Association | 40.978 | 1 | .000 |
| N of Valid Cases | 145 | | |

*Null hypothesis $H_0$:* There is no association between dysfunctional family and marital disharmony to para-suicide. *Alternative hypothesis $H_1$:* There is an association between dysfunctional family and marital disharmony to para-suicide. The level of significance has been found to be: 0.05 and the observed p-value is: 0.000. From the observations, the observed p-value is far smaller than the level of significance. Leading to the decision that, since the p-value was smaller than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. Thus, concluding that dysfunctional family and marital disharmony has a strong significant influence among the youth on suicide attempt or para-suicide. This is in line with the findings from the study by Lamis *et al*. (2016) outlining that disturbances in a family system can insinuate suicidal ideations and reckless behaviours among youth. For example, when parents go through divorce, youth tend to feel guilty and devise self-destructive ways to get rid of their ordeal, possibly opting for suicide.

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**Table 12:** *Domestic violence and cultural factors*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 57.815[a] | 3 | .000 |
| Likelihood Ratio | 58.306 | 3 | .000 |
| Linear-by-Linear Association | 48.633 | 1 | .000 |
| N of Valid Cases | 145 | | |

*Null hypothesis $H_0$:* There is no association between domestic violence and cultural factors to para-suicide. *Alternative hypothesis $H_1$:* There is an association between domestic violence and cultural factors to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.000. The observed p-value is far smaller than the level of significance. The decision is that, since the p-value was smaller than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. Leading to the conclusion that, domestic violence and cultural factors has a very strong influence on suicide attempt or on para-suicide.

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**Table 13:** *Lack of family or social support*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 83.037[a] | 9 | .000 |
| Likelihood Ratio | 74.012 | 9 | .000 |
| Linear-by-Linear Association | .004 | 1 | |
| N of Valid Cases | 135 | | |

*Null hypothesis $H_0$*: There is no association between social support and lack of family to para-suicide. *Alternative hypothesis $H_1$*: there is an association between social support and lack of family to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.000. The observed p-value is far smaller than the level of significance. Pointing to the decision that, since the p-value is smaller than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. This implies that social support and lack of family has a strong significant influence on para-suicide. This could be true since social support restores sense of belong, love and rejuvenates confidence.

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**Table 14: Marital status and economic factors**

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 172.037[a] | 6 | .000 |
| Likelihood Ratio | 171.960 | 6 | .000 |
| Linear-by-Linear Association | 69.028 | 1 | |
| N of Valid Cases | 150 | | |

*Null hypothesis $H_0$:* There is no association between marital status and economic factors that may contribute towards para-suicide. *Alternative hypothesis $H_1$:* There is a significant association between marital status and economic factors that may contribute towards para-suicide. The level of significance: 0.05 and the observed p-value is: 0.535. The observation show that the observed p-value is greater than the level of significance. The decision is that, since the p-value is far greater than the level of significance, the null hypothesis could not be rejected in favour of the alternative hypothesis. This brings to conclusion that; marital status does not have any influence on any part of the respondent's economic factors that may contribute to para-suicide at the 0.05% level of significance.

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**Table15: Marital status versus Reason for using drugs**

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 2.186[a] | 3 | .535 |
| Likelihood Ratio | 3.594 | 3 | .309 |
| Linear-by-Linear Association | 2.044 | 1 | .153 |
| N of Valid Cases | 135 | | |

*Null hypothesis $H_0$:* There was no association between marital status and part of respondent's culture that may contribute to para-suicide. *Alternative hypothesis $H_1$*: There is an association between marital statuses versus reason for using drugs contributing to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.075. It is observed that p-value is greater than the level of significance. Since the p-value is greater than the level of significance, the decision is that the null hypothesis should not be rejected in favour of the alternative hypothesis. Hence the researcher concluded that marital status versus reason for using drugs does not have a significant influence on some parts of respondent's cultural factors that may contribute to para-suicide. Para-suicide does not depend on one's marital status.

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**Table 16: Level of education and economic factors**

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 5.172[a] | 2 | .075 |
| Likelihood Ratio | 7.104 | 2 | .029 |
| Linear-by-Linear Association | 3.226 | 1 | .072 |
| N of Valid Cases | 150 | | |

*Null hypothesis $H_0$:* There is no association between level of education and economic factors contributing to para-suicide. *Alternative hypothesis $H_1$:* There is a significant association between level of education and economic factors contributing to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.014. The observations show that the observed p-value is far smaller than the level of significance. Informing the decision that, since the p-value was less than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. The researcher thus conclude that the level of education has a very strong influence on economic factors that may contribute to para-suicide.

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**Table 17:** *Level of education versus reason for using drugs*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 16.015[a] | 6 | .014 |
| Likelihood Ratio | 21.618 | 6 | .001 |
| Linear-by-Linear Association | 2.991 | 1 | .084 |
| N of Valid Cases | 135 | | |

*Null hypothesis $H_0$:* There is no association between level of education and Reason for using drugs contribute to para-suicide. *Alternative hypothesis $H_1$:* There is an association between level of education and reason for using drugs contribute to para-suicide. The level of significance is: 0.05 and the observed p-value is: 0.000. Observation show that the observed p-value is far smaller than the level of significance. Hence the decision is that the p-value was smaller than the level of significance, the null hypothesis was rejected in favour of the alternative hypothesis. Leading to conclusion that, the level of education has a very strong influence on some reason for using drugs and contributing to para-suicide.

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**Table 18: D***rug consumption and economic factors contributing to para-suicide*

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 30.714[a] | 4 | .000 |
| Likelihood Ratio | 27.564 | 4 | .000 |
| Linear-by-Linear Association | 2.623 | 1 | .105 |
| N of Valid Cases | 150 | | |

*Null hypothesis $H_0$:* There is no association between whether respondent had ever consumed drugs or not versus economic factors contributing to para-suicide. *Alternative hypothesis $H_1$:* There is a significant association between whether respondent had ever consumed drugs or not versus economic factors contribute to para-suicide. The level of significance: 0.05 and the observed p-value is: 0.000.

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From the observations, the p-value is far smaller than the level of significance. The researcher decided that, since the p-value is smaller than the level of significance, the null hypothesis had to be rejected in favour of the alternative hypothesis. Hence it was concluded that, whether respondent has ever consumed drugs or not versus economic factors has a very strong influence on contributing to para-suicide.

***Table 19: Drug usage***

| **Chi-Square Tests** | Value | Df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 39.079[a] | 3 | .000 |
| Likelihood Ratio | 45.012 | 3 | .000 |
| Linear-by-Linear Association | 2.015 | 1 | .156 |
| N of Valid Cases | 135 | | |

*Null hypothesis $H_0$:* There was no association between whether respondent had ever consumed drugs or not and reason for using drugs. *Alternative hypothesis $H_1$:* There is a significant association between whether respondent had ever consumed drugs or not and reason for using drugs. The level of significance: 0.05 and the observed p-value is: 0.000. *Observation:* The observed p-value is far smaller than the level of significance. *Decision:* Since the p-value was smaller than the level of significance, the null Hypothesis was rejected in favour of the alternative hypothesis. *Conclusion:* Whether respondent had ever consumed drugs or not has a very strong influence on reason for using drugs contribute to para-suicide.

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## 4.4. CONCLUSION

This chapter provided data presentation, data analysis and data interpretations. Part-A provided descriptive analysis and part-B provided inferential analysis. In both parts tables and graphs were used to present data and possible suppositions emanating from the tabulated and graph presented data. Null and alternative hypothesis were tested, and derived conclusions were also presented. Reviewed literature and the study's findings were merged to get a broader understanding of the phenomena. This

helped the researcher to be able to support or nullify the research hypothesis. Based on those data presentations and analysis, the following chapter provides discussion, recommendations, and conclusion for the study.

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# CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

## 5.1. INTRODUCTION

This chapter provides a brief overview and summary of the study through highlighting pertinent contributions of reviewed literature and the research findings. The chapter also provides a linkage of its theoretical underpinnings of ecological theory as pioneered by Bronfenbrenner in relation to the research findings. Various perspectives and factors predisposing youth into suicidality in relation to study's findings will be outlined. Statistical findings, both descriptive and inferential will be presented concomitant to factors found to predispose youth to suicidal ideations and suicide attempts. This chapter will also conclude by presenting the limitations and possible recommendations pertinent to the study.

## 5.2. PERSPECTIVES FROM THE LITERATURE

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Figures show a significant increase in number of people attempting to commit suicide or who engage in risky behaviours, subjecting youth into premeditated acts of killing themselves (statistics: St Elizabeth Hospital, 2015). Hence the researcher investigated the etiological factors leading to suicidality among the youth in rural areas of Lusikisiki. The theoretical underpinning of this study is ecological systems theory as pioneered by Bronfenbrenner (1977). This theory served as a guiding theoretical model to investigate contributory factors of suicidal ideations and suicide attempt amongst the youth. Ecological theory indicates how personal, interpersonal and sociocultural factors may lead to impulsive behaviours including suicidal attempts. This is in line with findings of the study that multiple factors lead to attempted suicide among youth, especially in a pathological society where youth tend to be drug abusers. Based on the theory's suppositions, it can be deduced that social pressures and the influence of society play a significant role in an individual's social thoughts and reckless decision making. Those irrational thoughts and hasty decision pave grounds for suicidal

ideations and suicidal attempts among youth, especially in rural areas where social services are rarely provided. Literature significantly indicates overwhelming pressure from the society may compel youth into suicidal attempts, especially when there is no social support. Hence the combination of etiological, perpetuating and predisposing factors such as substance abuse, economic hardship and dysfunctional family were found to lead youth to suicidal ideation and suicide attempts.

## 5.3. FINDINGS OF THIS STUDY

The findings for this study are given in the following sub-headings:

### 5.3.1. Level of education and socio-economic factors

This study found that level of education and socio-economic factors have strong influence on suicide attempt in Lusikisiki youth. This is because level of literacy and availability of necessary needs shape the level of thinking and informs decision making. The findings show that 66, 7% of participants were living in poverty. This is also confirmed by the level of significance, where P-value was found to be 0,014, necessitating reliance on alternative hypothesis over null hypothesis. In support of that, Hawton (2011) asserts that level of education and economic hardships are linked to increased suicide vulnerability. For example, the descriptive analyses of the study indicate that most families' income are less R5000 per month. From these findings, it is clear that youths are mostly stressed due to socio-economic reasons worsened by level of literacy. Hence these factors were found predisposing youth to suicide ideation and suicidal attempts. For example, level of education versus reason for using drugs, 13, 3 % reported having low level of education and more into drugs. This was confirmed by the level of significance where P-value was found to be 0.000, smaller than the level of significance, null hypothesis is rejected in favour of alternative hypothesis. Hence it is deduced that the level of education has a very strong influence on the reasons for using drugs, subsequently contributing to para-suicide.

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### 5.3.2. Social support and family ties

Lack of family or social support is found to be amongst factors that are closely linked to suicide attempt among youth of Lusikisiki. This is supported by the findings showing that more than 36, 7% of participants have poor social support and fractured family ties. This is also confirmed by the level of significance where P-value was found to be 0,000, necessitating reliance on alternative hypothesis over null hypothesis. Hence lack of social support or lack of family ties amongst the youth has a strong influence and may contribute towards para-suicide. In support of that, Hawton and Van Herring (2011) argue that majority of youth are lacking the necessary supportive relationships when they need them the most in their families, worsened by instabilities in a family systems and such volatilities pave grounds for contributory and perpetuating factors to predispose youth into suicidal behaviours.

### 5.3.3. Domestic violence and cultural factors

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Domestic violence in families has been identified as the main cause of suicidal behaviour in families. This study found that 33, 3% of participants cite domestic violence as a leading family factor that subject youth to suicide behaviours. This is also confirmed by the level of significance where the observed P-value was found to be 0,000. In support of that, Lamis *et al*. (2016) found that youth who have difficulties or come from dysfunctional family backgrounds are more at risk of committing suicide because the vulnerability they are subjected to by family violence cultural doctrines.

### 5.3.4. Dysfunctional family and marital disharmony

Dysfunctional family and marital disharmony have been identified as contributing factors to para-suicide amongst the youth in rural areas of the Eastern Cape. The study found that 33, 3% of the participant refer to dysfunctional family and marital disharmony as leading factors to para-suicide. This is confirmed by the level of

significance where observed P-value is 0.000. In line to that, Bridge *et al.* (2020) views dysfunctional family, marital disharmony and domestic violence as the leading family related factors to suicide attempt. These observations are in par with the findings of the current study. On the other hand, approximately 89, 7% indicated that they were single and about 10% were widowed. The level of significance determined by the P-value was found to be 0,535. Since the P-value is larger than the level of significance, alternative hypothesis was rejected in favour of null hypothesis. However, it has been concluded that marital status and economic factors do not directly influence the youth into para-suicide, but may indirectly predispose them to suicidal ideations and suicidal attempts, depending on the family and other forms of support systems.

### 5.3.5. Drugs and substances

Substance abuse has been found to lead to suicidal ideations and suicide attempt. Majority of participants (60%) cited that abusing substances and drugs have predisposed them to suicidal ideations and suicide attempts. This is confirmed by the level of significance where the observed P-value is 0,000, meaning that drugs and substances has an influence and a tendency of predisposing youth towards suicidality. The findings from the research conducted by Pompili *et al.* (2012) reveals that individuals who attempt suicide could possibly be involved in substance and drug abuse. These findings concur with the current study's results. The findings show that 63, 3% of participants have attempted committing suicide due to stress that has lured youth into substance and drug abuse, however, the P-value in that regard is 0,075. Thus, alternative hypothesis was rejected in favour of null hypothesis.

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Among commonly abused substances there is alcohol, dagga and other easily available substance such as Nyaope are believed to predispose youth to suicidality. These findings are also supported by Schlebush (2017) who argue that in South Africa

the age range of people who mostly attempt suicide ranges from age 15 and 34 since year 2000. However, in year 2004 the age range was found to be between 25-34 years, closely correlates with the findings of this study. For example, Hawkins *et al*. (2017) argue that people involved in abusing substances are more vulnerable to suicide attempt. This could be attributed to the fact that intoxication reduces the level of reasoning and lead to impulsive behaviours. In alignment and agreement, this study found that more than 60% of participants use alcohol and 30% reported intensive use of drugs. Hence sometimes they find themselves having intrusive thoughts and subsequently suicidal attempts.

## 5.4. LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

The limitations and recommendations of the study are presented in the following sub-headings:

### 5.4.1. Limitations of the study

The study is limited to Lusikisiki youth and yet suicide is a national crisis. The number of participants does not permit findings to be broadly generalized. On the other hand, this study focused on the youth, yet all age groups do commit or attempt suicide.

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### 5.4.2. Recommendations of the study

The researcher recommends that similar studies aimed at exploring etiological factors of suicidality should be conducted across the province or throughout the country. Concurrent studies across the country can be of assistance in describing suicide as the serious social issue among South African youth. The findings from such studies could facilitate needs analysis and may inform various stakeholders to get a workable approach towards providing psycho-educational programs and other amicable solutions to the phenomenon. Mental health and psychosocial education

provided by professionals could edify youth on how best they can deal with their intrusive thoughts or irrational behaviours that may lead to suicide. Government and nongovernmental agencies should have a clear and feasible suicide prevention strategies. For example, authorities such as medical, clergy and other relevant stakeholders that work closely with adolescents and youth can identify risks or potentials of suicidality prior its manifestation, subsequently implementing preventative measures. Indorsed psychiatric referrals or hospitalization should be made subsequent to justifying therapeutic interventions and unpredictable conditions. Social agencies should strive towards providing the necessary services and basic needs to rural communities where they are needed the most. Psychosocial well-being of youth should be looked at, and provided for, in rural communities characterized by dysfunctional families, societies strongly subscribing to patriarchal dogmas, communities rampaged by poverty and socio-economic hardships.

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## 5.5. CONCLUSION

This chapter discussed the research findings complimented by the available literature and subsequently provided recommendations pertinent to the study. In the previous chapters, the use of descriptive analysis and inferential statistics was necessary for correlating various variables such as social support, family disharmony, cultural factors, substance and drug abuse and other biographic factors such as age, sex or race in relation to suicidality amongst youth.

Suicide ideations and suicidal attempts among youth in rural areas of South Africa has become a weighty challenge that calls for drastic measures across various stakeholders. Reviewed literature and the findings of this study indicate a relationship between various factors such as depression as the component of impaired mental health and suicidality among youth. Also, cultural practices such as forced marriages

or abduction, mysterious beliefs such "*women must have a child*", "*indoda ayikhali*" meaning men do not cry… subject youth to unbearable psychological effects that results to suicidality. For example, drawing from the findings by Bridge *et al*. (2017), such cultural beliefs may cause youth to feel isolated and alienated. That sense of loneliness subject youth into suicide ideations and suicidal attempts. It is for those reasons that this study suggested multiple and inter-disciplinary proactive preventative approaches amongst stakeholders. Such approaches may include psycho-educational interventions aimed at strengthening psychosocial well-being of youth, especially in rural communities.

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**Appendices**

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ETHICAL CLEARANCE CERTIFICATEREC-270710-028-RA Level 01

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Certificate Reference Number: MAK011SZWE0i

Project title: Etiological factors that lead to parasuicideamong the youth of Lusikisiki Area.

Nature of Project Masters in Psychology

Principal Researcher: Mzamile Zwenl

Supervisor: Mrs M. Makupula

Co-supervisor: N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above. This certificate is valid for a year from the date of approval; thereafter, the Principal investigator/swill be expected to apply for renewal.

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Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in thedocument;
- Any material breaches of ethical undertakings or events that impact upon the

Ethical conduct of the research.

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

*Special conditions: Research that includes children* as *per the official*

*regulations of the act must take the following into account:*

*Note: The UREC* is *aware of the provisions of Department of Health Charter of Ethics in Health Research Principles,* Processes *and Structures; DOH 2015, signed by the Minister of Health in March 2015. This certificate* is *granted in terms of the provisions of the above-mentioned document.*

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected;
  - Relevant information has been withheld or misrepresented;
  - Regulatory changes of whatsoever nature so require;
  - The conditions contained in the Certificate have not been adhered to.

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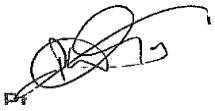
- Request access to any information or data at any time during the course orafter completion of the project.

- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such areport must be sent to the Dean of Research's office.

The Ethics Committee wished you well in your research.

Yours sincerely



Professor Pumla Dineo Gqola

Dean of Research

12 November 2018

University of Fort Hare
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University of Fort
Hare Private Bag X9083
East London 5201

Date: 25/06/2018

The Hospital
Manager St Elizabeth
Hospital Private Bag
x 1007 Lusikisiki
4820

University of Fort Hare
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Dear Sir/Madam

REQUEST TO DO THE RESEARCH PROJECT

I hereby request a permission to do the research project in your institution as a requirement for the fulfilment of my master's degree in psychology.

The research is about the contributing factors of para-suicide amongst the youth of Lusikisiki area who are admitted in the hospital. This study will also help the institution in order to address the problem and also help them in formulating action plans to the problems. The results of the study will be available on request after the study is completed.

Yours faithfully

Mr. M.B. Zweni

Prov
EAS
HEALTH

St. Elizabeth Hospital
Private Bag X1007
LUSIKISIKI
4820

Tel no : 039 2S3 S000 EXT
S047 Fax No : 039 2S3 1116

Enquiries: Ms A. Masangwana
Email add: amandamasangwana@gmail.com

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| | |
|---|---|
| **To:** | Ethics Committee: Fort Hare University |
| **From:** | MISS MASANGWANA |
| **Date:** | 28/06/2018 |

| |
|---|
| **SURNAME, NAME: ZWENI M.B.** |
| This serves to inform you that I, the Social Work Supervisor at St Elizabeth Hospital do not object that Mr Zweni M.B. can undertake a research study on the topic, Para- suicide impact among the youth of Lusikisiki. |

**SOCIAL WORKER**

I ;rH HOSPITAL

P/BAGX10C7 LIJSIK!S11<I4820

TEL: 039 253 505'1/5046 / FAX: 039

2531116,

University of Fort Hare
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APPENDIX i

Copy of Letter to Participants

102 First Avenue, Ncambedlana, Mthatha Date:

Dear Participant

Re: Invitation to take part in research titled, 'Etiological factors that Lead to parasuicide among the youth of Lusikisiki Area'

I, Mzamile Zweni invite you to participate in a research project entitled 'Etiological factors that lead to parasuicide among the youth of Lusikisiki Area', for a Master's degree in Psychology. The study will be done under the supervision and guidance of Ms M. Makupula of the Department of Psychology, University of Fort Hare.

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The main aim of this study is to identify etiological factors that lead to youth parasuicide in Lusikisiki. This aim is broken down into the following objectives.

- To identify economic factors that contribute to youth parasuicide in Lusikisiki.
- To single out familial factors that lead to youth parasuicide in Lusikisiki
- To investigate and establish how, and the extent to which the use of intoxicating substances contributes to youth parasuicide in Lusikisiki. The objective of this research study are twofold:

I wish to invite you to participate in this research project.

After obtaining your consent, a questionnaire in the language of your choice will be administered. To complete the questionnaire will take between 20 and 35 minutes. You are kindly asked to respond to all questions. The questionnaires will be collected once completed by you at a time and place convenient for you.

Research results will be made available to you on request. Participation in this study is voluntary and even during the course of an interview you can withdraw at any time without penalty. You will not be paid for participation in this study.

In order to protect your name, I will undertake the following:

- To insist that no names be written on questionnaires;
- To keep all raw data securely when not in use;
- To ensure that no one except my supervisor, coder and I will have access to the raw data, and
- To leave you with my contact address in case you need to see me in connection with any matter arising from the study.

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Your participation in this study has the potential of benefiting all parties working in the area of suicide and parasuicide, as well as lessening incidents of the same. The direct benefit to you is that you will have the opportunity to reflect on your experiences.

Signed at……..on this……day of2018

APPENDIX ii

Copy of Consent Form

**Title of research**

**Purpose of the**

**studyProcedure**

**Potential risks and**

**discomfortsAnticipated**

**benefits**

**Payment for**

**participation**

**Confidentiality**

**Participation and withdrawal**

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**Identification of investigators**

Name of

investigator

Physical address

Telephone number

Email address

**Ethical approval**

This study has been reviewed and approved by the University Research Ethics

Committee (UREC) for studies involving human subjects. For research problems or questions regarding this study UREC may be contacted through Prof Gideon De Wet at the Govan Mbeki Research and Development Centre (GMRDC) at the University of Fort Hare.

**Consent**

I the undersigned understand the procedures described above. My questions have been answered to my satisfaction, and I agree to XYZ for purposes of this study. My consent is purely voluntarily, and I knowingly give informed consent to use this data for the purposes of this research.

Participants name: _____

- ☐ I consent to XYZ for the purposes of this study

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- ☐ I do not consent to XYZ for purposes of this study

Participant's signature:_____

**APPENDIX A**

**QUESTIONNAIRE**

---

ETIOLOGICAL FACTORS THAT LEAD TO PARASUICIDE AMONG THE YOUTH OFLUSIKISIKI AREA

SECTION 1: BIOGRAPHICAL INFORMATION

Instructions: please indicate you answer with an XHOW OLD ARE YOU? :----------

1. AGE (YEARS)

| | | |
|---|---|---|
| 17-20 | | |
| 21-24 | | |
| 25-28 | | |
| 29-32 | | |
| 33-36 | | |

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2. GENDER/SEX

| | |
|---|---|
| MALE | |
| FEMALE | |

3. WHAT IS YOUR RACE?

| | |
|---|---|
| AFRICAN | |
| WHITE | |
| COLOURED | |
| ASIAN | |

4. WHAT IS YOUR MARITAL STATUS?

| | | |
|---|---|---|
| SINGLE | | |
| MARRIED | | |
| DIVORCED | | |
| WIDOWED | | |
| OTHER; Specify | | |

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| | | |
|---|---|---|
| | | |

5. LEVEL OF EDUCATION

| | |
|---|---|
| NEVER BEEN TO SCHOOL | |
| BELOW GRADE 8 | |
| ABOVE GRADE 8 | |
| MATRIC | |
| ABOVE MATRIC | |

6. OCCUPATION STATUS

| | | |
|---|---|---|
| UNEMPLOYED | | |
| EMPLOYED | | |
| SELF-EMPLOYED | | |

7. WHAT IS YOUR HOME LANGUAGE?

| | | |
|---|---|---|
| ISIXHOSA | | |
| ISIZULU | | |
| ENGLISH | | |
| OTHER | | |

8. WHO IS WORKING AT HOME? ----------

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| | |
|---|---|
| A MOTHER | |
| B FATHER | |
| C BROTHER/SISTER | |
| D UNCLE | |
| E NONE | |

2.1.2 IF NO ONE WORKS WHO PROVIDE THE FAMILY BASIC NEEDS?

A. GOVERNMENT GRANTS

B. EXTERNAL FAMILY

2.1.3 HOW MUCH IS YOUR FAMILY INCOME?

| | |
|---|---|
| LESS THAN R5000 PER MONTH | |
| R5000-R10000 PER MONTH | |
| MORE THAN R10000 PER MONTH | |
| | |

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SECTION 2 2.1 ECONOMIC FACTORS THAT MAY CONTRIBUTE TO PARASUICIDE

| | | |
|---|---|---|
| | Which one of the following economic factors contribute to parasuicide? | |
| INSTRUCTIONS | **Please circle the appropriate number** | |
| A | 1. LACK OF FOOD<br>2. LACK OF CLOTHES | |
| | 3. LOW LEVEL OF EDUCATION | |
| | 4. NOT RECEIVING HOUSES | |
| | 5. POVERTY | |
| | 6. UNEMPLOYMENT | |
| B | ALL OF THE ABOVE | |

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| | |
|---|---|
| SECTION 3 | Relationship difficulties that may contribute to parasuicide |

| | |
|---|---|
| 3.1 | Which of the following relationship issues do you think contribute to Parasuicide? |
| INSTRUCTIONS | Please circle only one appropriate number |

| | | |
|---|---|---|
| A | DIVORCE | 1 |
| B | DEATH OF PARENTS | 2 |
| C | SEPARATION OF PARENTS | 3 |
| D | END OF ROMANTIC RELATIONSHIP/BEIN GDUMPED | 4 |
| E | REJECTION BY THE FAMILY | 5 |
| F | OTHER. PLEASE SPECIFY …… …… …… | 6 |

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| | |
|---|---|
| SECTION 4 | CONTRIBUTION OF SUBSTANCE USE AND ABUSE TOPARASUICIDE |

| | | | |
|---|---|---|---|
| 4.1 | Have you ever | Yes | No |

| | | | |
|---|---|---|---|
| | consumeddrugs | 1 | 2 |
| | | | |

| | |
|---|---|
| 4.2 | How often do you used drugs? IF YES |

| | | |
|---|---|---|
| ISTRUCTION | Please circle the appropriate number | |
| A | Once a week | 1 |
| B | Once a day | 2 |
| C | More than once a day | 3 |
| D | Less often than the above | 4 |
| E | Other: Please SPECUFY | 5 |

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4.3 IF YOU USE DRUGS WHICH ONE/S DO YOU USE?

| | | | | | | |
|---|---|---|---|---|---|---|
| INSTRUCTIONS | Please tick all that apply | | | | | |
| A | Dagga | | | | | |
| B | Ectasy | | | | | |
| C | Cocaine | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| D | ~~Brown Sugar~~ Nyaope | | | | | |
| E | Heroin | | | | | |
| F | Cough Syrup | | | | | |
| G | Sniff glue/petro l | | | | | |
| H | Alcohol | | | | | |

I OTHER. PLEASE SPECIFY

……

……

……

……

……

……...

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WHY DO YOU USE DRUGS?

| | |
|---|---|
| A Due to Stress | |
| B My Family Issues | |
| C My Friends use drugs | |
| D Financial Problems | |
| E Other, Please specify.<br>……<br>……..<br>……<br>……<br>……<br>…….... | |

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SECTION 5

| | | Yes | No |
|---|---|---|---|
| 5.1 | Have you ever harmed yourself intentionally? | 1 | 2 |

| | | |
|---|---|---|
| 5.2 | Which of the following have you ever done to yourself? | |
| INSTRUCTIONS | Please circle all that apply | |
| A | Cut yourself on purpose in order to bleedout | 1 |
| B | Intentionally overdose on drugs | 2 |
| C | Burned yourself on purpose | 3 |
| D | Attempted to strangle or hang yourself | 4 |
| E | Swallowed poisons on caustic substances | 5 |
| F | Stabbed or punched yourself on purpose. | 6 |
| G | Attempted to jump from height | 7 |
| H | Attempted to shoot yourself with afirearm | 8 |

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| | | |
|---|---|---|
| I | Attempted to drown yourself | 9 |
| J | Other. Please specify …… …. | 10 |
| | | |
| | | |

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| | | | | |
|---|---|---|---|---|
| 5.3 | Have any of your friends, siblingsor family members attempted or committed suicide? | Yes | No | Don't know/NotSure |
| | | 1 | 2 | 3 |

| | | | |
|---|---|---|---|
| 5.4 | Did you ever make detailed planbefore harming or attempting suicide? | Yes | No |
| | | 1 | 2 |

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| | | |
|---|---|---|
| 5.5 | Which of the following in your culture may contribute to parasuicide? | |
| INSTRUCTIONS | Please circle only one appropriate number | |
| A | Witchcraft accusation | 1 |
| B | Forced Marriages | 2 |
| C | Complications from ulwaluko | |
| D | Failure to carry out needed rituals | |
| E | Other, please specify<br>……<br>…..…… | 3 |

| | | |
|---|---|---|
| | …….. | |

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

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