SUICIDE PREVENTION AMONG LEARNERS IN THE NORTHERN FREE STATE SCHOOLS: THE VIEWS OF YOUTH AT RISK

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DECLARATION

I, the undersigned, hereby declare that the work contained in this study is my own original work and that all the resources used or quoted have been indicated and acknowledged by means of complete references

Ivonne Makue

December 2015

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DEDICATION

I dedicate this thesis to my beloved, belated mother who passed away, in January 2010. She was behind my success every step of the way. She was the one who encouraged me to pursue and complete my studies. Her one wish while she was alive, was to accompany me to the graduation ceremony and I hope wherever she is, she is proud. “Your word is the lamp to my feet”

.

ABSTRACT

Key words: Suicide, suicide behaviour, suicide ideation, suicide intervention, suicide among youth, youth at risk of suicide, suicide, mental health in learners, mental health in schools.

The main aim of this study was to investigate strategies for suicide prevention as perceived by youth at schools in the Northern Free State. This was an explorative qualitative research which employed to data collection strategies: draw and write technique and structured interviews.

A literature conducted revealed key aspects: that suicide can be prevented especially if symptoms are detected early; the school is strategically positioned to implement universal and selected intervention programmes, 1. an alliance and synergy with the parents, community members and external stakeholders, 2. mental health policy and 3. Gatekeeper training underpin mental health promotion and reduction of suicide incidences in schools, and that there are currently no suicide- specific curriculum-based programmes to educate learners about suicide in South Africa.

Selection of sites was purposefully done as all five participating schools were in an area where .youth were at risk first because of socio-economic conditions they lived under and secondly, due to the fact that some had attempted suicide and some considered killing themselves. The study revealed that participants were aware of the causes and means of committing suicide. They had personal experiences of suicide behaviour, some had family history of completed and attempted suicides. They proposed several strategies to deal with suicide in schools comprising those of: enhancing social support and faith- based strategies reducing stress, early identification of learners at risk and education awareness programmes. A framework was developed to integrate all the interventions recommended by participants into a single ecosystemic model. It recommends methods of prevention and medication at various ecosystemic levels

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DECLARATION

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I herewith declare that I was responsible for the language editing of the thesis:

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CHAPTER 1

ORIENTATION TO THE STUDY

1. 1. INTRODUCTION AND RATIONALE

Suicide is regarded as a worldwide public health issue that accounts for many deaths among people of South Africa on a yearly basis (Joe, Stein, Seedat, Herman & Williams, 2008:454; Masango, Rataemane & Motojesi, 2008:25). This shows that more and more at-risk youth in South Africa are in danger of resorting to suicide when they are faced with adversity. The term suicide is understood differently, however, there is agreement among researchers that suicide refers to self-inflicted death (Masango *et al.*, 2008:255; Palmer, 2003:289) that often occurs when one's coping resources are blighted.

The effects of suicidal behaviour or a completed suicide on the mental health system of the victims, friends and family members of the person who committed suicide are catastrophic. The notion of victims in this research is anyone caught up in an asymmetric situation. Asymmetry means destructive, alienating, or having inherent suffering. The concept "victim" includes any person who experiences injury, loss or hardship due to any cause (Wild, Flisher & Lombard, 2004:612). Individuals who lose a loved one to suicide are more at risk of becoming preoccupied with the reason for the suicide, wishing that they had prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one, and stigmatised by others (Neimeyer, Prigerson & Davies, 2002).

Furthermore, individuals who experience suicidality of a loved one tend to have conflicting reactions to that behaviour. Symptoms of grief that may be experienced by suicide survivors include intense emotion and longings for the deceased, severely intrusive thoughts about the lost loved one, extreme feelings of isolation and emptiness, avoiding doing things that bring back memories of the departed, new or worsened sleeping problems, and having no interest in activities that the

sufferer used to enjoy (Frieson, Melikian & Wadman, 2002:114). These feelings may lead to suicide ideations, attempts and completed suicide if not dealt with at an early stage.

Several causes and risk factors can be implicated in suicide. A study conducted by Hirst (2010:46) discovered that suicide occurred in the context of severe and chronic stress and pain and that impulsivity accounted for most successful suicides. This shows that when youth feel overwhelmed, lack support and ways of coping with adverse circumstances in their lives, they develop suicide ideation and may even attempt to commit suicide. According to Gould, Greenberg, Velting and Shaffer (2013:58), more than 90% of youth suicide victims have at least one major psychiatric disorder, although younger adolescent suicide victims have lower rates of psychopathology.

According to the stress diathesis model (*cf.* 2.4.1.4) discussed in Chapter 2, a suicide act is caused by underlying risk factors, accompanied by proximal risk factors in an individual (Roy, Sarchiapone & Carli, 2007:265). The aforementioned distal factors could on one hand be developmental, biological or genetic, including a traumatic childhood, family history of suicide and personality traits. Proximal risk factors on the other hand could include life events, stress, and acute episodes of mental illness or acute substance or alcohol abuse.

Suicide ideation and behaviour are high among adolescents as this is often a period of important developmental changes (Evarall, Bostik & Paulson, 2005:693). According to Schlebusch, Vawda and Bosch (2003), the youngest suicide fatality in 2001 was 10 years old, but more often suicides which are fatal occur in the age group between 15 and 19 years. The Daily Maverick (2015), citing the South African Depression and Anxiety Group, indicates that suicide rates among teens aged 10–14 have nearly doubled in the last 15 years. These statistics are shocking as it means that children start to have suicidal thoughts and attempts at an early age.

If basic human adaptation systems (Masten, 2001:227) such as a stable personality, loving family and wider community are disrupted the child may feel overwhelmed. Feeling overwhelmed, vulnerable and without hope, support and access to mental health services, exacerbate the situation, with some children resorting to suicide as a way of getting out of problem situations (Masango *et al*., 2008:25). This challenges parents, teachers and care-givers to come up with specific interventions that are culturally relevant. The need to prevent suicide by mobilising personal strengths or assets of youth and those that their ecologies can provide is the focus of this study. The term –youth throughout this research will include children and adolescents as, according to Apter, Bursztein, Bertolote, Fleischman and Wasserman, (2009), most South African studies tend to group them together. Youth is referred to in this research as persons aged 13 to 35.

Numerous studies on adolescent suicide have been conducted worldwide. In South Africa in particular, George (2005) researched the influence of psychosocial factors and resources on suicide ideation of adolescents and Du Plessis, Marna, Hlaise, Keven and Khazamula (2012:262) investigated the psychosocial factors as predictors of suicide ideation amongst adolescents in the Free State province. The gap identified in these studies is that the authors did not pay attention to suicide interventions. With this study, the intention is to consider the perceptions of youth at risk regarding suicide interventions by engaging them by means of symbolic drawings.

Youth in the Northern Free State can be classified as “-at risk” and vulnerable. They are affected by manifold risks, including violence, abuse, adverse socio- economic services (Kelly as cited in Eloff, Ebersöhn & Viljoen, 2007:105) and deprivation of family-based upbringing (UNICEF, 2009). The section below provides information about such factors that put youth in the Northern Free State at risk.

1.2 BACKGROUND TO THE STUDY

The Fezile Dabi District Municipality in the Northern Free State is made up of four municipalities, namely Ngwathe, Metsimaholo, Moqhaka and Mafube. The Mafube local municipality is situated in the north-eastern part of the Fezile Dabi region and consists of four towns Frankfort/Namahadi, Villiers/ Qalabotjha, Cornelia/Ntswanatsatsi and Tweeling/Mafahlaneng. These towns can be considered rural, bearing in mind their small population density and the fact that they focus mainly on commercial agriculture. Villiers, Tweeling and Cornelia are located in an area of agriculture significance and mainly provide restricted services to the surrounding rural communities and primarily accommodate farm workers migrating to these towns. The main agricultural activities include stock farming, maize and sunflower seed production. Tweeling is located approximately 150km east of Sasolburg and 350km north-east of Bloemfontein and is situated adjacent to the Frankfort/Reitz primary road. The total estimated residents in Mafube is 57 876 (Statistics South Africa, 2011).

Frankfort is situated 55 km east of Heilbron and approximately 120km south-east of Sasolburg. Frankfort remains the growth point in Mafube and plays a major role as a regional service provider and in terms of industrial and commercial development. It is a small town typically developed and serving the predominantly agricultural community. The R54 provincial road from Kroonstad to KwaZulu-Natal runs adjacent to the town. Frankfort, although mainly an agricultural town, does provide certain industrial growth potential which is mainly agricultural orientated (Statistics South Africa, 2013).

Two sets of data were used in this section to indicate the socio-economic conditions in Mafube and Metsimaholo. Data was collected from the three censuses that were conducted in South Africa since 1994, including the latest which was conducted in 2011, and Statistics South Africa.

The table below depicts employment factors in Mafube:

Table 1.1: Employment factors in Mafube

	Male	Female
Employed	63.52 %	36.46%
Unemployed	42.16%	57.84%
Discouraged work seekers	34.07%	65.93%
Population that is not economically active	40.88%	59.12%

Source: Municipal Finance Management Act (2012/2013:55).

According to the table above, the unemployment rate is high in Mafube, especially for females and many of them are discouraged and economically inactive. The number of people not economically active is high in both genders. These statistics could include the aged, children and youth at school. It can be concluded that unemployment contributes to poverty in this region. The number of discouraged work seekers is extremely high; these statistics reflect the situation in South Africa as a whole.

The educational level is also very low in this municipality. The table below presents data on the education level according to gender.

Table 1.2: Education level by gender at Mafube

Gender	Grade 12	Higher Diploma	B. Degree and Post-Graduate	Higher Degree Masters/PhD	No school
Male	4 232	152	45	34	2 146
Female	4 407	181	54	16	3 091
Total	8 639	332	99	49	5 237

Source: Municipal Finance Management Act (2012/2013:55).

The table above shows that there are more females with matric, diplomas, degrees and post-graduate degrees than males. However, the place of women in South Africa is still in the kitchen. Although there has been improvement over the years regarding their level of education, the multiple roles they play makes it difficult for them to study and achieve the highest degrees. This means only 15.8% of the population of Mafube is learned if those who have matric are included. Statistics South Africa (2013) however caution that education does not cushion individuals from the impact of economics, as in 2009 during the global recession, 1 in 10 people with some form of higher education was living in poverty.

The Metsimaholo local municipality is situated in the northern part of Fezile Dabi. The former Sasolburg, Deneysville and Orangeville transitional local councils and a section of the Vaal Dam transitional rural council are included in the Metsimaholo region. The area is largely urbanised (91% urban and 9% rural) (Municipal Finance Management Act, IDP, 2014-2015).

As indicated in the foregoing paragraphs, the demographic profile according to Statistics South Africa (2001), community survey and Statistics South Africa (2013) was used to provide an overview of the Metsimaholo municipality‘s demographic and socio-economic profile. According to this data there was a population increase of 33 154 or 28.6% from 2001 to 2011. Households also increased by 13495 or 41.8% over the same period. The population during the 2011 census was at 149 108. There was also an increase of 6.5% in the number of people that were unemployed between 2001 and 2011. The population in Metsimaholo is more than double that of Mafube. This could be attributed to the fact that this area is urban and houses significant industries. People prefer to stay nearer such towns with the hope of getting employment. The data for education in Metsimaholo is depicted in the table below.

Table 1.3 Education level at Metsimaholo

	1996	2001	2011
Higher Education	9%	8%	12%
GR 12	18%	21%	30%
No Schooling	11%	10%	6%

Source: Statistics South Africa (2013).

The statistics depicted in the table above do not reflect persons who only have partial primary or secondary schooling. The graphic therefore does not add up to 100% (Municipal Finance Management Act, IDP, 2014-2015). Although there was an increase in the number of people with matric and higher education in 2011, the educational levels in these communities are still low. This could mean that most of the people employed (*cf*. table 1.4) are not in high paying jobs and that most of them are unskilled labourers. The positive data in this table pertains to a decrease in the number of people without education. There has been a focus in adult literacy to reduce and curb the rate of illiteracy in the country. The table below shows employment data in Metsimaholo.

Table 1.4: Employment data in Metsimaholo

	Census 2001	Census 2011
% Employed	63%	68%
% Unemployed	27%	32.1%
Economically active population as % percentage of the total population	43.1%	43.7%

Source: Municipal Finance Management Act (IDP, 2014-2015)

The table above shows that employment is high in Metsimaholo. This may be attributed to the fact that the area is urban with industries as indicated earlier. The unemployment rate, although significantly high, is far lower than that of

Mafube. There are more people who are not economically active; this might create social problems in the area and dependency on the government. People would prefer to stay in these areas even if they are not working as the services would be better than in rural and farm areas.

Poverty among the African and Coloured population at Metsimaholo is very high compared to other races, as indicated in the table below.

Table 1.5: Poverty statistics at Metsimaholo

	African	White	Coloured	Indian	Total
Metsimaholo	38.0%	0.5%	38.5%	23.2%	31.1%

Municipal Finance Management Act (IDP, 2014-2015).

Table 1.5 shows that poverty is high among Coloureds and Africans and very low among Whites. The data shows gross inequality in terms of poverty, with one group of people very rich and the other very poor. Absolute poverty in the area would mean that most of the African and Coloured populations do not have access to services and live below the poverty line. The number of people living in poverty is lower compared to that of the whole country, as over half of South Africans live below the national poverty line, according to Shisana, Rice, Zungu and Zuma (2010).The table below shows HIV/AIDS statics.

Table 1.6 HIV/AIDS statistics in Metsimaholo

Global insight	Metsimaholo HIV Estimates	Metsimaholo AIDS Estimates
2010	16201	807
2011	16326	852
2012	16391	887
2013	16431	912
2014	16450	923
2015	16446	934

Source: Municipal Finance Management Act (IDP, 2014-2015)

The table above indicates that the rate of HIV and AIDS has increased dramatically over the years. HIV is not stabilising and the data shows new infections. Statistics South Africa (2014:8) indicates that HIV and AIDS have increased since 2002 from 4 million people being infected to 5.5 mid-year 2014. The HIV/AIDS prevalence in Metsimaholo resembles that of South Africa as a whole. HIV and AIDS put a tremendous burden on families and the community members, as indicated in Chapter 2 (*cf*. 2.6).

This gloomy catalogue of the social problems facing the two municipalities, Mafube and Metsimaholo, indicates that not only the youth but also entire communities are at risk. -At risk is defined by McWhirter, McWhirter, McWhiter and McWhiter (2012) as a set of presumed causes – effect dynamics that place an individual youth in danger of future negative outcomes. In that case a specific behaviour such as suicide ideation or deficiency (lack of support) can provide an initial marker for suicidal behaviour later. Suicidal behaviour is a situation that can be anticipated in the absence of intervention. There are different levels of risk: where youth is exposed to few stressors the risk is low; remote risk with some stressors and negative demographics; high risk with numerous stressors; and imminent risk where there is development of gateway behaviours and activities. The foregoing paragraphs led to the formulation of the problem statement discussed below.

1.3 PROBLEM STATEMENT

Not all suicides are preventable but a methodical approach to suicide interventions can enable schools to assist youth at risk of committing suicide and avert suicide incidents (Reinecke, Curry & March, 2009:2).

Researchers indicate that young people are often reluctant to seek professional help (Rickwood, Deane & Wilson, 2007:S35). This renders schools as obvious

and accepted environments for implementing suicide prevention initiatives for youth displaying suicide risks (Robinson, Titov & Andrews, 2010).

Due to the growing risk of suicide with increasing age, youth can be regarded as the main target for suicide prevention. As indicated earlier, completed suicides become increasingly frequent with age (WHO, 2001). The prevalence of suicide attempts (Lewinsohn, Rohde & Seeley, 2001: 427) as well as those to mental disorders (Tuisku, Pelkonen, Kiviruusu, Karlsson, Ruuttu & Marttunen, 2009:1128) is higher in adolescence than in childhood.

Moreover, it would be interesting to understand what young people themselves think could be done to prevent suicide incidents among them. This is the focus of this study, namely what at-risk youth believe can be done to strengthen them to avoid suicide behaviour. This will give indications of how strength-focused as well as community-based suicide prevention programmes can be constructed in culture-congenial ways to prevent deaths by suicide (Ackerman, 1993:183).

1.4 GUIDING RESEARCH QUESTIONS

What are learners' views on how suicide can be prevented among youth at risk in Northern Free State schools?

Secondary questions formulated from the central question were:

- What is the essence of suicide?
- What factors put youth at risk of suicide?
- What national strategies are in place in South Africa regarding mental health among youth?
- What prevention suicide programmes are in place in schools?
- What are the experiences of youth regarding suicide behaviour?
- What are the views of youths at risk regarding suicide prevention?
- What framework can be developed to enhance suicide prevention at schools?

1.5 AIM AND OBJECTIVES OF THE STUDY

A qualitative study was conducted in order to explore the views of at-risk youth on how incidents of suicide can be prevented in Northern Free State schools. In order to achieve this aim, the research was guided by the following objectives:

- To determine the essence of suicide
- To examine factors that put youth at risk of suicide
- To understand the national strategies in place in South Africa regarding mental health among youth
- To understand prevention programmes that are in place in schools
- To determine the experiences of youth regarding suicide behaviour
- To explore the views of youth at risk regarding suicide prevention
- To develop a framework to enhance suicide prevention at schools

I became interested in this topic because of my experiences with the risk of suicide in youth at schools, as a teacher, a principal of a primary school and as a member of my family. The factors that led to the decision to embark in this type of research are indicated below.

1.6 MY PERSPECTIVE

I am a single mother of two children. I was raised by a single mother who passed on in January 2010. At home I was the last born of five children, four girls and one boy. I lost my eldest brother who was murdered and my sister who was two years older than me, leaving me with two elder sisters. Life was not easy when we were growing up in a shebeen as my mother was a "shebeen queen". The older sister was actually a mother to us as younger siblings. She had to take a bigger responsibility at a young age: that of being a parent. Sometimes my sister would help with brewing and selling African beer to earn living. She would wake up as early as she could to sweep outside. This helped as she would be lucky sometimes to pick up money lost by people who had been drinking in our house the previous night. She

would keep this money to buy bread for us. She never got time to play like any other child as she was channeled to carry out routines for survival. This life was exceptionally difficult for her as she had to repeat almost all the lower grades because of the burden she was carrying and above all her school work was never supervised because my mother was illiterate. This life was so frustrating because some peers used to ridicule us that we are not from the same father. We lived on handouts for school and casual clothing. In high school things improved for my sister as after completing Grade 10 she went to a boarding school. She completed her higher education and obtained a teacher's diploma. In later years I realised that these hardships led to the following behaviour:

Dismissive and defense mechanism - She decided to take early retirement because of job-related stressors. She mentioned not being able to cope with accelerating technology and the changing curriculum. She started being an excessive gambler and became suicidal.

Compulsive behaviour – She became a pathological liar. She started shouting and talking loudly when confronted or advised and became aggressive. She would fidget with her hands or shuffle her feet, and cover her stomach with her hands.

She would be tearful most of the time, but was unable to get help in order to address her fearfulness.

Medication - She started to using analgesia for headaches, sleeping tablets for insomnia which she abused. Instead of a pill or two she would take four to five,

Compulsive buying - She bought new expensive clothes, even if she couldn't afford to.

Compulsive gambling – With this habit she ended up hurting herself, her family and her loved ones, because she continued gambling no matter how hard-up or

broke she was. She would devise means to get hold of money; she became secretive and was in denial.

This behaviour contributed to several attempts to committing suicide. She ended up being diagnosed with bipolar mood disorder and was hospitalised.

As I was watching all this unfolding, I would feel confused, frustrated, stressed and angry. The reason for all these emotions was that I did not know what to do. I felt helpless. If only I could understand how she felt.

I started working in 1992 at a combined school under the Department of Education and Training (DET) from sub A to standard 10, now referred to as grades R – 12 at Small Township in Edenville (Free State). I was employed as a post level 1 educator at the secondary school for two years. I was in charge of career guidance which is now part of Life Orientation/Life Skills. My main task was to advise and support children regarding various social challenges they were faced with due to either poverty or broken families. Following are two of the scenarios that aroused my interest in the phenomenon of suicide:-

Dibakiso‘s (name changed) life story

Dibakiso, a girl at the school where I was teaching, had a passion for keeping a diary of her life experiences. She would deliberately write and leave the diary for me to read, but I had no interest in reading her private thoughts. Then one day she specifically asked me to read the diary. I was so shocked and saddened to realise that the child had attempted to commit suicide because she was being sexually and emotionally abused by her uncle and she could not report the matter to the granny and her parents had passed on while she was still young. She and her sibling were staying with her grandmother. I could not ignore her situation as she was an active child and motivated though she had these difficulties in her life. This situation prompted me to carry the burden of raising the child as my own up to this

day. This has helped her as she could motivate others and help them to open up in cases of sexual abuse.

Matriculation (Grade 12) failure

After many years (12 years to be specific) of motivating and supporting learners and hard work, sacrifice and studying for my own development, I found myself having to counsel and support children who were contemplating suicide. I would comfort and assist family members of children who had failed or succeeded in committing the act. As a principal I worked together with the school-based support team to make sure that vulnerable learners were supported. These traumatising experiences also contributed to my interest to pursue such a study. I believe that a school belongs to the community and that it has a primary responsibility of educating youth for the betterment of the community. The school environment has the potential to moderate the occurrence of risk behaviours. I am looking forward to a time when schools will have clinical psychologists, socio-pedagogues and social workers who are school-based.

1.7 RESEARCH METHODOLOGY

In this study a two-phased study methodology was used, consisting of a literature review and an empirical study.

1.7.1 Phase 1: Literature study

The aim of the study was to explore the views of "at-risk" learners on how incidents of suicide can be prevented in schools in the Northern Free State. In order to contextualise my study, I conducted a literature review so as to learn more about suicidal behaviour, factors that put youth at risk and intervention strategies. I therefore consulted the library for relevant sources such as books, journals, journal articles that were peer-reviewed, and completed studies on the phenomenon of suicide. I also searched for sources on Google, Google scholar and EBSCOHOST where I hoped to obtain peer-reviewed articles in journals as primary sources. The

literature review process started with a conceptual model about the nature of two phenomena: suicidal behaviour and suicide interventions. Conceptualisation allowed me to organise the literature in my mind and convince others of the importance of my study.

1.7.1.1 Conceptual framework

I had to identify issues and variables related to my research topic, suicide prevention among learners in Northern Free State schools: the views of youth at risk. Reading the literature helped me to focus on important issues and variables that had a bearing on the research question. In this section I constructed visual pictures of the literature in the form of tables, literature maps and figures that allowed me organise all the facts at my disposal.

The purpose of Chapter 2 was to justify the significance of this research against the backdrop of previous research and to introduce and conceptualise the constructs that were used throughout the study.

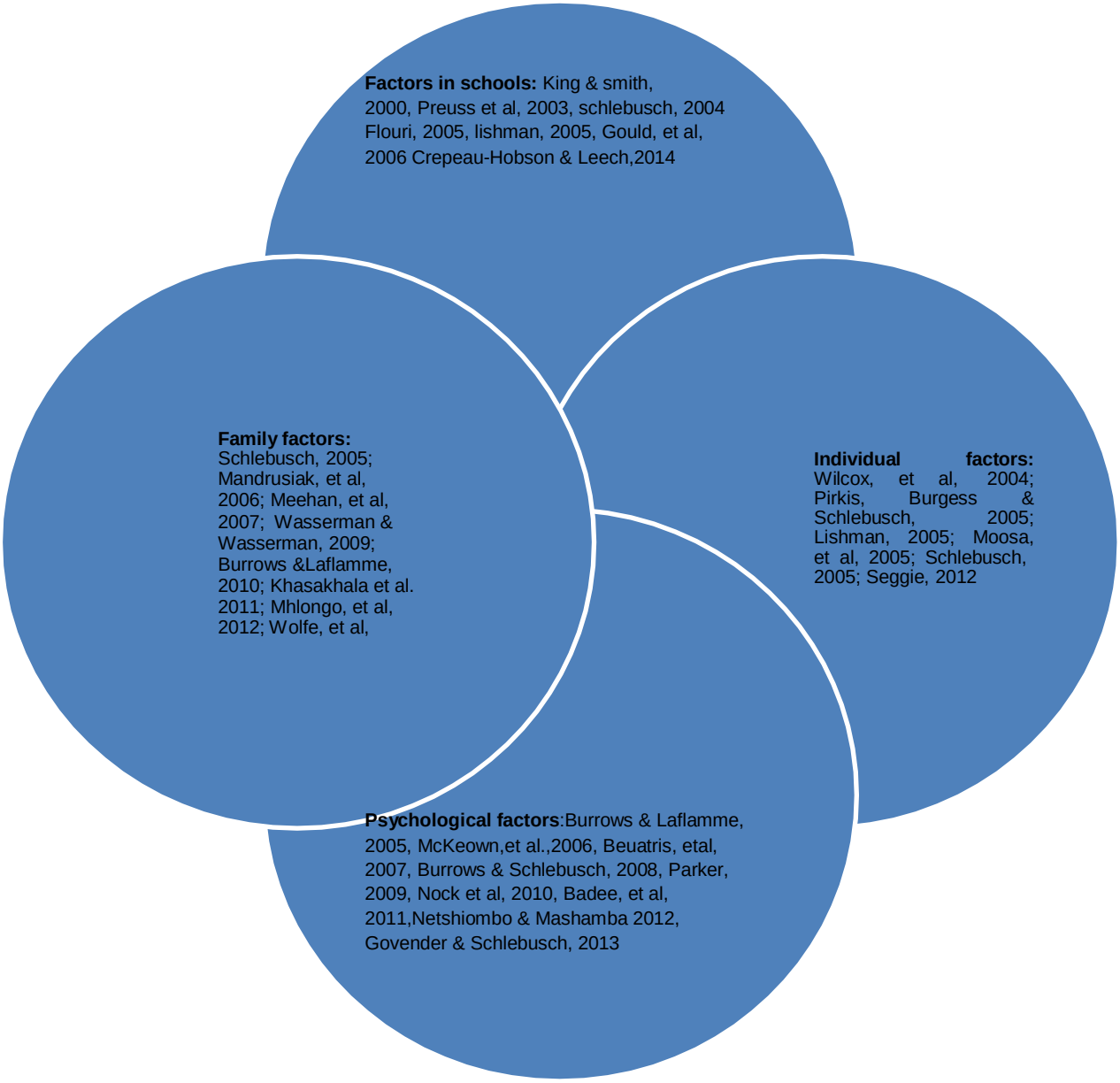
Table 1.7: Sources for suicide behaviour

PREVALENCE
Bradshaw *et al*., 2000; Butchart, 2000; Holden 2001; Pillay *et al*., 2001; Burrows *et al.,* 2003; Flisher *et al*., 2004; Pillay & Bah 2004; Schlebusch, 2004; Schlebush, 2005; Burrows & Laflame, 2006; Joubert & Philane, 2006; Andriessen *et al*., 2007; Donson, 2008; Apter *et al*., 2009; Bertolote *et al*., 2009; Wasserman & Wasserman, 2009; Bertolote, 2010; Schlebusch, 2012; Govender & Schlebusch, 2013
SUICIDE PHENOMENON
Scheidman, 2000; Davidson & Naele, 2001; Stengel, 2002; Madu & Matla, 2003; Holmes & Holmes, 2005; Schlebusch, 2005; Simpson, 2006; Meehanet *et al*., 2007; Bantjies & Van Ommen, 2008; Kaplan, *et al*., 2008; Bech & Awata, 2009; Cash & Bridge, 2009; Miller & Eckert, 2009; Netshiombo & Mashamba, 2012;

Schlebusch, 2012
FATAL AND NON-FATAL SUICIDE BEHAVIOUR
Madu & Matla, 2003; Schebusch, 2005; Pillay & Schlebusch, 2007; Donson, 2008; Schlebusch & Burrows, 2009; Schlebusch, 2012; Netshiombo & Mashamba, 2012; Schlebusch, 2012

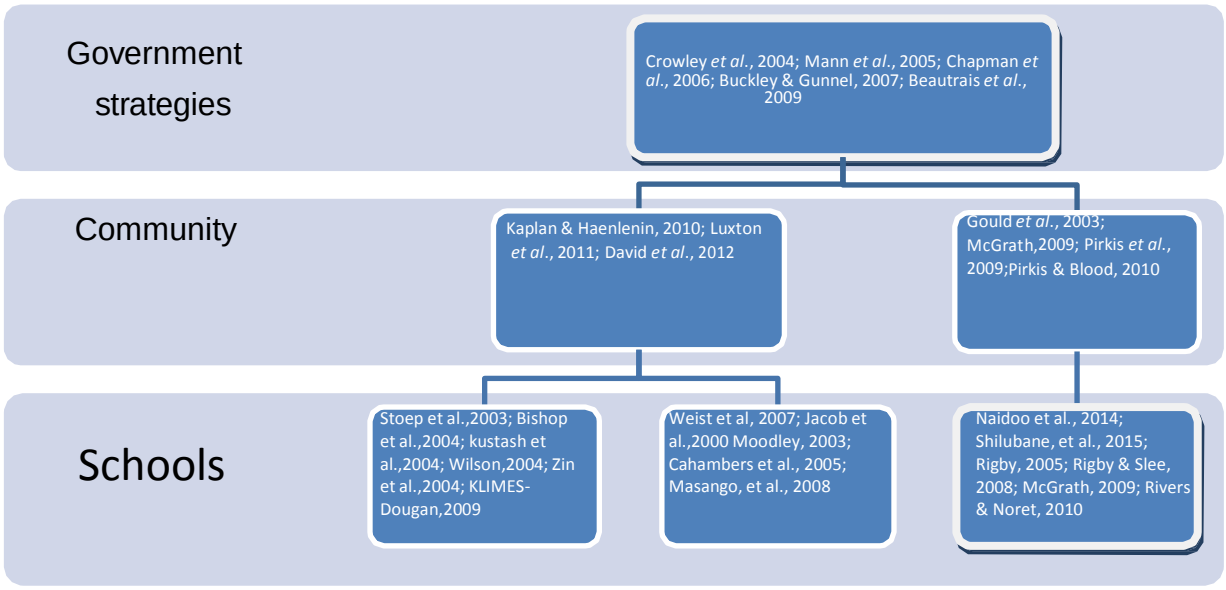
The next figure depicts sources that provided information about suicide risk factors

Figure 1.1: Suicide risk factors


Factors in schools: King & smith, 2000, Preuss et al, 2003, schlebusch, 2004 Flouri, 2005, lishman, 2005, Gould, et al, 2006 Crepeau-Hobson & Leech,2014
Family factors: Schlebusch, 2005; Mandrusiak, et al, 2006; Meehan, et al, 2007; Wasserman & Wasserman, 2009; Burrows &Laflamme, 2010; Khasakhala et al. 2011; Mhlongo, et al, 2012; Wolfe, et al,
Individual factors: Wilcox, et al, 2004; Pirkis, Burgess & Schlebusch, 2005; Lishman, 2005; Moosa, et al, 2005; Schlebusch, 2005; Seggie, 2012
Psychological factors:Burrows & Laflamme, 2005, McKeown,et al.,2006, Beuatris, etal, 2007, Burrows & Schlebusch, 2008, Parker, 2009, Nock et al, 2010, Badee, et al, 2011,Netshiombo & Mashamba 2012, Govender & Schlebusch, 2013

The next figure presents a literature map of sources for suicide intervention

Figure 1.2: Literature map – I ntervention strategies for suicide



1.7.2 Phase 2: Empirical study

The second phase of my study consisted of empirical research. In this regard my study was qualitative and exploratory in nature. This approach is discussed (*cf*. 1.7.2.2) below.

1.7.2.1 Research paradigm

A paradigm is defined as a model or a set of beliefs, assumptions, concepts and propositions accepted and valued (Wiersma 2000:12). This qualitative study used an interpretivist paradigm, which assumes that (Henning, Van Rensburg *&* Smith 2004:20): human life can only be understood from within; social life is a

distinctly human product; the human mind is the purposive source or origin of meaning; human behaviour is affected by knowledge of the social world; and the social world does not exist independently of human knowledge. An interpretivist paradigm emphasises the ability of an individual to construct meaning, with meaning-making process as its basis (McMillan & Schumacher, 2006). The main tenet of this paradigm is that research cannot be observed from the outside but rather from the inside through the direct experience of people. Participants in this research were youth at risk, who were requested to share their experiences of suicide interventions by means of symbolic drawings. The choice of this paradigm clarified my role, which was to understand, explain and demystify suicide interventions through the eyes of youth at risk as suggested by Cohen, Manion and Morrison (2007:19).

One of the limitations of the interpretivist paradigm is that it is subjective rather than objective (McMillan & Schumacher, 2006). I took an objective stance when I collected and analysed data by bracketing my assumptions, as discussed in Chapter 4. Nieuwenhuis (2007) suggest that researchers should be aware of their pre-existing beliefs to make it possible to examine and question their own beliefs in the light of new evidence.

1.7.2.2 Research method

Qualitative research typically studies people or systems by interacting with and observing the participants in their natural environment; it focuses on their meanings and interpretations (Creswell, 2012:16). Qualitative research provides answers to underlying issues (Neelankavil, 2007:104). It was useful in developing a detailed understanding of a suicide phenomenon and its interventions from the perspective of youth at risk in the Northern Free State.

I had two reasons for choosing a qualitative approach; the first one was that I wanted to understand the suicide phenomenon within the specific context, which in this case was suicide prevention among learners. The second reason was to

gain an understanding of the meaning youth at risk assigned to their actions in this context.

An exploratory study is the most preferred choice to unearth the individual and environmental resources that can be mobilised to strengthen the participants in order to buffer the risk of suicide in schools, seen from the perspectives of young people themselves. According to Babbie and Mouton (2001:79), exploratory research is conducted on a particular topic to provide a basic familiarity with that topic, especially a topic of relative newness. This study therefore adopts a qualitative, exploratory research approach so as to delineate the individual and contextual interventions that are in place in schools and communities, in order to prevent suicide among learners. This approach and how it was used in this study is discussed further in Chapter 4 (*cf*. 4.3). A well-chosen strategy of an inquiry was necessary to ensure that learners would be able to talk freely about this sensitive issue.

1.7.2.3 Strategy of inquiry

This research was phenomenological in nature. Despite the fact that I mentioned bracketing earlier (*cf*. 1.7.2.1), which is rejected by some researchers including Creswell (2003) this research fully embraced the description. According to Wertz (2005:175), phenomenology is a ―low hovering; in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known‖. Wiersma (2000) posits that phenomenological methods focus on rich descriptions of lived experiences and meaning. The inductive method used in this research is phenomenological in its concern for individuals' perceptions. Phenomenology also identifies more strongly with hermeneutic traditions which recognise the central role played by the researcher (Smith, 2004).

I think phenomenological research is phenomenological if it involves rich description of the life-world or lived experience (Epstein & Sheldon, 2006) and if

the methods used are justified. There are researchers who focus on narratives emerging from data. Pertaining to the suicide phenomenon and youth‘s perceptions of its interventions, I explored the life-world of youth at risk of suicide in the Northern Free State. My approach has a narrative element as discussed in sections below (*cf*. 1.8.1).

1.7.2.4 Participant selection

The targeted populations for this study were youth who subsist in challenging circumstances in the Northern Free State in South Africa. Based on the information as provided in the background (*cf*. 1.2), youth in Fezile Dabi in the Northern Free State can therefore be regarded as at risk.

A small group, called a sample, was selected for this study. According to Nieuwenhuis (2007:79) sampling is the process used to choose a part of the population for a study. Purposeful sampling is selecting information rich cases for in-depth study (Creswell, 2012:206). The sampling strategy for this study focused on school-going youth aged 16 to 18.

The sample was drawn from five high schools in three circuits in the Fezile Dabi municipal district in the Northern Free State. The three circuits are in Mafube and Metsimaholo. The participants were boys and girls in grades 10-12 who were at risk of suicide. Three high schools were from circuit two, one from circuit one and another from circuit three. I had more males (n=23) than females (n=20) in my research, the reason being that females were reluctant to participate and a number of those who participated did so only by providing symbolic drawings and not participating in structured interviews. The total number of participants in this study was 43 (n=43).

The sample of this research (*cf.* 4.6), recruitment (*cf.* 4.6.2) and the profile of the participants (*cf*. 4.6.2) are presented in chapter 4.

1.8 DATA COLLECTION PROCEDURE

Data for this study was collected in two stages involving symbolic drawings and interviews.

1.8.1 Symbolic drawings

Symbolic drawings were used as the main data collection tool in this research. As Driessnack (2005) posits, traditional methods of research often fail to elicit the socially silenced voices of youth at risk, including those at risk of suicidal behaviour. The choice of this instrument was firstly based on the fact that youth who might be reluctant to talk openly about their experiences of interventions for suicide would use symbolic drawings as their method of communication. Secondly, the concrete data gathered would present youth voices in undistorted ways, as suggested by Ennew (2003).

In this phase, the youth were asked to make symbolic drawings of what or who they thought could help in preventing young people from committing suicide. The youth were asked to write short narratives in which they explained their drawings (Guillemin & Gillam, 2004). The draw and write technique was preferred in this research as it is not intimidating and does not presuppose the participants' answers, thereby increasing trustworthiness (Franck, Sheikh & Oulton, 2007:431). The task involves participants in drawing pictures in response to a question or theme as well as writing down their thoughts about their picture. All participants completed their drawings and wrote narratives explaining what their drawings were about. This process is discussed in detail in Chapter 4 (*cf*. 4.5.1). The next phase of structured interviews followed after all the data from symbolic drawings were captured.

1.8.2 Individual structured interviews

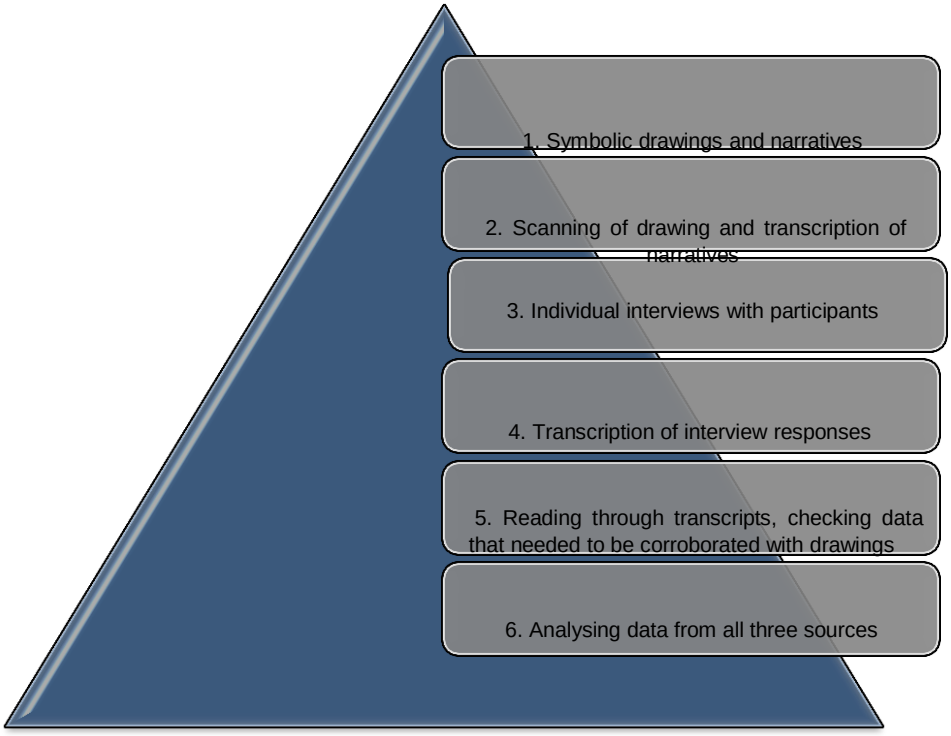
According to Creswell (2012: 217), individual interviews occur when a researcher asks an individual open-ended question to gather data. The aim of a standardised

open-ended interview is to ask participants identical questions, with questions worded so that responses are open-ended (Gall, Gall & Borg, 2003). This data collection tool allowed participants to contribute as much detailed information as they desired and to express their viewpoints and experiences.

Based on the drawings and narratives, interview questions were formulated. Structured interviews were written in the home languages of the participants and in English in order to avoid any misunderstanding. Spaces were provided so that participants could write their responses. Participants were allowed to respond to the questions at home. The written responses were collected after a week on an agreed date.

Responses that were written in Sesotho were then transcribed and translated into English. In order to achieve consistency, I asked a fellow Sesotho-speaking person to back-translate the transcript into Sesotho. Data was collected using a certain process; this was necessary because of the multiple sources of data that were gathered. The process is illustrated in the figure below.

Figure 1.3 Data collection process



The process enabled me to organise the data as I had a clear structure to follow. I was able to analyse the data while I was collecting it.

As indicated in the foregoing paragraphs, the draw and write technique was the main gathering tool. The individual interviews were conducted to supplement information that could not be collected through symbolic drawings. It was useful to corroborate this data with other forms of data mentioned above as it was grounded in the participants' local setting. How this data was collected and the structured interview questions asked are presented in Chapter 4 (*cf*. 4.5.3). How the textual and visual data were analysed is discussed in the section below.

1.9 DATA ANALYSIS

De Vos, Strydom, Fouché and Delport (2010) posits that phenomenologists engage three levels of analysis: by looking at the particular analysis; concerning

themselves with themes common to the phenomenon; and by probing philosophical and universal aspects of being human. This suggestion was followed in this research. I also had to stay closer to the data given to me in all its richness and complexity in order to describe and interpret the participants' life-world.

The drawings accompanied by narratives as well as interviews were subjected to inductive content analysis. According to Babbie and Mouton (2007:273), qualitative researchers adopt an inductive approach to data analysis. Due to the fact that I collected data in the form of written or spoken words and in a visual form the data were analysed by identifying and categorising them according to inductive codes or themes (Terre Blanche, Durrheim & Painter, 2007:47). Specific instances or occurrences are used in order to draw conclusions about the entire classes of objects or events, meaning that a sample is observed and conclusions are subsequently drawn about them (Terre Blanche *et al.,* 2007:47).

I examined qualitative data carefully and developed inductive codes as opposed to priory codes, which are predetermined codes (Nieuwenhuis, 2007:107).

1.10 QUALITY CRITERIA

Lincoln and Guba (1999) suggest criteria for assessing trustworthiness in qualitative research, namely confirmability, credibility, transferability and dependability.

Confirmability - Confirmability in qualitative research was achieved by triangulating data collection methods and theories (Fossey, Harvey, McDermott & Davidson, 2002). Creswell (2005) points out that using different methods to collect data contributes to the trustworthiness of the study.

Credibility - According to De Vos, Strydom, Fouche and Delport (2011), credibility is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was

accurately identified and described. According to Evans and Broido (1999), credibility is partly ensured by a clear description of the procedures involved in conducting the study, analysing the data, and drawing conclusions.

Transferability - Lincoln and Guba (1985) view transferability as the extent to which the study and its findings are applicable to different situations. This is demonstrated by the use of thick and rich descriptions to create a sculpture of the socially constructed meanings (Henning *et al*., 2004). In this study, I ensured that all concepts regarding the topic and objectives were clearly defined to share the same meanings.

Dependability - According to De Vos *et al*. (2011), dependability is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by an increasingly refined understanding of the setting. Terre Blanche, Durrheim and Painter (2006:93) refer to dependability as the degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did.

How quality and trustworthiness was ensured is elaborated on in Chapter 4 (*cf*. 4.9).

1.11 ETHICAL CONSIDERATIONS

According to Macmillan and Schumacher (2001), ethical considerations can be addressed at individual and community levels. The way the participants are affected by the conduct of researchers merits ethical consideration. The risk of harm to participants becomes an essential ethical consideration in deciding what information to disclose and how to disclose it. Revealing the genetic information has ethical considerations for individuals as family members. They are vulnerable to the effects of the information on their self-perception and disclosure of information on familial relationships and sense of privacy. The concern about

how privacy of information revealed by the participants would be protected was a priority in this research (Babbie & Mouton, 2007).

The language in which ethics is expressed includes two distinct types of statements. Ethics contain statements about what is good or bad, what ought not to be done and grounds for those assertions. For example, ethically I ought to seek consent from youth to use their genetic information in my research because doing so respects autonomy and freedom to choose. On the other hand, researchers should be free to use coded genetic information in research because that will enable more information to be used and better research to be conducted**.** As a result, all members of society, including those whose information is used, may benefit (Babbie & Mouton, 2007).

Ethical consideration are generally considered to be honest principles that deal with beliefs about what is wrong and right, moral or immoral. This means that researchers need to act with morality and develop ethical codes in order to govern the way they undertake research (McMillan & Schumacher, 2006:42) Ethical consideration is about the practical implication of the research for both the participants and their sites. De Vos *et al*. (2010:63) state that researchers are responsible for ethical standards to which the study adheres.

The following ethical measures that are prescribed by Cresswell (2009:89-91), Leedy and Ormrod (2005) and De Vos Strydom, Fouché and Delport (2005:58-59) were followed in this research: avoidance of harm; voluntary participation; informed consent; and confidentiality. How these ethical measures were followed is discussed in detail in Chapter 4 (*cf*. 4.10).

I applied to the Ethics Committee of the University to obtain approval to conduct the research, which was granted (FH-SB-2012-0019) (*cf*. Appendix 1). Permission was sought from the Free State Education Department to conduct this study in schools (*cf*. Appendix 2). The principals, parents and learners were approached for permission to conduct research in the Northern Free State. I explained the

purpose of the research to the participants and they were given a choice whether to participate or decline. Participants were guaranteed that the results of the research would be confidential; and that only the study leader and myself would have access to the data. I placed the rights and safety of the participants above anything else.

The participants were alerted to the fact that what they said would be heard by others; however, confidentiality would be adhered to at all times.

1.12 POSSIBLE CONTRIBUTIONS OF THE STUDY

I aimed to document ways in which suicide incidents can be prevented in schools. Since there are no suicide prevention programmes available in schools in the Northern Free State region, this research aimed at making a valuable contribution to the support of youth at risk of suicide. The research is also relevant to the niche area of the focus area teaching-learning organisations, namely, support for barriers to learning.

From the literature that I have reviewed, there is dearth of research regarding suicidal behaviour among youth at schools in South Africa. What is researched quite extensively is inclusion policies which relate to support of learners with barriers to learning. There has been a lack of academic writing on mental health policies guiding programmes that are intended to prevent suicide. This research elaborated on such policies and prevention programmes from an education perspective. This research also proposes a framework based on the views of youth themselves, it therefore, makes use of a bottom up approach employing an ecological theory.

Although this research is important it does not focus specifically to learners who are under immerse pressure due to mental ill health.

1.13 OUTLINE OF CHAPTERS

Chapter 1: Orientation and statement of the problem - This chapter presented the orientation and background of the study. It consists of the introduction and rationale and provides the problem statement and a guiding research question. It also explains the aim and objective of the study and contains a research methodology.

Chapter 2: Essence of suicide – This chapter focused on suicidal behaviour among youth. It defines suicide and emphasises the two types, namely non-fatal and fatal suicide behaviours. It also embarks on factors increasing the risk of suicide, which are psychological, within the individual, interpersonal and those aggravated by family and community factors in the community, including schools.

Chapter 3: Suicide intervention - This chapter focused on suicide intervention including: universal and selective programmes offered by the government, the community and schools. Gate-keeping and training were indicated as important in the implementation of programmes.

Chapter 4: Empirical research design - This chapter comprised of research paradigm and design, the research setting, data gathering methods and procedures, how the sample was chosen and how data were analysed. The chapter ends by explaining how trustworthiness was ensured and ethical measures taken.

Chapter 5: Qualitative data analysis and interpretation - This chapter consisted of the results of the empirical research. Themes identified included: causes of suicide, and four strategies to combat suicide.

Chapter 6: Summaries, Conclusions and recommendations – This chapter presented summaries of chapters, findings from the literature and empirical research and a recommended ecosystemic framework for suicide intervention in schools.

1.14 CONCLUSION

This chapter presented an orientation to the study with the aim of preparing the reader for the subsequent chapters. The problem statement in the form of a background was presented reflecting a context of the study. The chapter also highlighted the research aim, objectives and the research method guiding this research.

The next chapter elaborates on the phenomenon of suicide behaviour.

CHAPTER 2

THE ESSENCE OF SUICIDAL BEHAVIOUR AMONG YOUTH

2.1 INTRODUCTION

Suicidal behaviour in the younger generation in South Africa has become exponential, constituting a major public health concern (Apter, Bursztein, Bertolote, Fleischman & Wasserman, 2009). Children as young as ten years have taken their lives. Trends for young South Africans mirror those in Europe and the United States of America, and attention to trends in these countries may predict future trends in youth suicide in South Africa.

The statistics indicated in this chapter reflect only a part of the problem, and reported prevalence rates are diverse (Bertolote, Fleischmann, De Leo & Wasserman, 2009). The full extent of the burden of suicidal behaviour in South Africa according to Schlebusch (2012:436) has not been well understood due to a lack of dependable data. Under-reporting of suicide incidences is caused by factors ranging from cultural, religious to socio-economic variables. It is also due to families and physicians concealing the true cause of death to avoid stigma. Netshiombo and Mashamba (2012:95) concur with this statement, indicating that there is a dearth of accurate studies investigating suicide trends in South Africa due to the inconsistent and inadequate reporting of suicidal behaviour.

This chapter discusses the statistics on suicide in South Africa and in other countries, the nature of suicidal behaviour, risk factors enhancing suicidal behaviour and suicide ideation and methods used in attempted suicide and suicide completion.

2.2 DEFINING SUICIDAL BEHAVIOUR

There have been many attempts to precisely define suicidal behaviour (Schlebusch, 2005). According to Burrows and Schlebush (2009), it occurs in different forms that involve a degree of severity that can range from a person wishing him- or herself dead to actually killing him- or herself. Schlebusch (2005) argues that in youth it can encompass an unambiguous act of self-demise comprising a heterogeneous spectrum of acts that can range from lethal attempts, with high intent to die (fatal suicidal behaviour) to non-lethal attempts (non-fatal suicidal behaviour), with low or no intent to die. Both these types of suicide are discussed in sections below. According to the Cash and Bridge (2009), suicidal behaviour includes suicide ideation encompassing: thinking about it; engaging in it; writing or talking about it; or planning it (Schlebusch, 2005; Wasserman & Wasserman, 2009). Bantjies and Van Ommen (2008) and Hughes (2008:169) add the following to the definition: having a determination to commit suicide; a need to take one's own life; thoughts about suicide without actually making plans to commit suicide; attempts or completed suicide. Bech and Awata (2009), argue that suicide ideations start at an early age, in children as young as 8 or 9 years old. From these definitions it can be deduced that suicidal behaviour is a process and suicide ideation forms part of its evolution. It signifies a wide range of self-destructive or self-damaging acts in which people engage psychopathology, motive, fatal intent, awareness and expectations of the harmful consequences or outcome of the behaviour.

In this context, suicidal behaviour is not the best method of communication or problem solving technique. It develops when people feel unable to express their anguish in an approved manner or if other efforts to solve their problems have been futile. The feeling of being stuck can lead to a vicious cycle of suicidal behaviour, whether non-fatal or fatal.

2.2.1 Non-fatal suicidal behaviour

Non-fatal suicidal behaviour refers to self-perpetrated suicidal behaviour that does not succeed in ending the victim‘s life. It personifies several indicators such as those seen in attempted suicide and parasuicide (Schlebusch, 2005). Shneidman (2000) refer to non-fatal suicidal behaviour as a complex symptom. It is prominently influenced by socio-cultural factors, stressful life events and poor social adjustment. For example, youth may lack the necessary coping skills to deal with increasing stressors and habitually fail to perceive alternatives for solving difficulties. They may therefore focus intently on non-fatal suicidal behaviour as their only solution or resort to maladaptive coping strategies, including substance abuse as discussed below (*cf*. 2.4.2.2).

In South Africa non-fatal suicidal behaviour in the young is as serious a problem as fatal suicidal behaviour. In a study among secondary high school pupils in Limpopo Province, suicide rates of 17% for boys and 13% for girls were reported, while in another study conducted among African secondary learners by Madu and Matla (2003), 37% of those surveyed thought of taking their lives, 17% had threatened to do so, 16% had made plans to commit suicide, and 21% had actually made suicide attempts. The frequency of non-fatal suicidal behaviour among secondary school pupils was found to be lower among Blacks than among Asians and Whites (Wild, Flisher & Lombard, 2004).

This trend is confirmed by hospital-based research that noted a sharp rise in non-fatal suicidal behaviour in African youth aged 18 year and younger. According to Schlebusch and Burrows (2009), the 10-19 year age group is the second-most at risk age group for non-fatal suicidal behaviour after young adults in the 20-29 year age group. About one third of hospital admissions for non-fatal suicidal behaviour involve children and adolescents (Schlebusch, 2012:437). In non-fatal suicidal behaviours females predominate with an approximate male to female ratio = 3:1 (Schlebusch, 2012:437). Most of the patients in a group of youth (15 – 24 years) referred to a regional hospital for non-fatal suicidal behaviour in a

study conducted by Schlebusch and Burrows (2009) were either learners and/or unemployed. This suicidal behaviour, according to Schlebusch (2004), is usually prompted by acute social conflicts, socio-economic deprivation, AIDS phobia, academic failure, teenage pregnancy and mental illness. Thus, non-fatal suicidal behaviour more often belongs to the social classes associated with social volatility and poverty. In that case non-fatal suicidal behaviour is gradually used as a first-line, crisis management strategy by the youth, particularly the ones that would not always be considered to have obvious mental illness.

One of the strongest risk factors projecting future suicidal behaviour is previous non-fatal suicidal behaviour. According to Dobson (2008), more than 50% of people with non-fatal suicidal behaviour had made more than one attempt, and nearly 20% of the second attempts were within 12 months of the first attempt. Women have much higher rates of non-fatal suicidal behaviour but lower rates of actual suicide than men (Dobson, 2008).

Based on these figures it is therefore not surprising that Rocket (2010) conclude that non-fatal suicidal behaviour is more common in the younger age group.

2.2.2 Fatal suicidal behaviour

Joe *et al*. (2008) and Miller, Eckert and Mazza (2009) argue that suicide does not have one universally accepted definition. It can however be defined, simply, as explicit or inferred self-inflicted death. Scheidman (2000) defines it as – a conscious act of self-induced annihilation, best understood as multidimensional malaise in a needful individual who regards an issue for which the suicide act is perceived as the best solution. Moskowitz, Simpson, McKennab, Skipworth, and Barry-Walsh (2006) attribute suicide to any death which is the direct or indirect result of a positive or negative act accomplished by the victim himself which he

knows will produce this result. O'Carroll *et al.* cited by Cash and Bridge (2009:613) explain suicide as including completing suicide. Schlebusch (2005) defines fatal suicidal behaviour as self-committed, completed suicidal behaviour that personifies the victim's determination or aim to die. In order for the process to be complete the victim manages to achieve a pre-determined goal. These definitions indicate that, firstly, suicide is not a random or a pointless act and secondly, it is a way out of a problem.

Moskowitz *et al*. (2006) state that suicide may be and has been defended in different ways, including that suicide is either called a disease in itself, which is either a special form of insanity or regarded not as a distinct phenomenon. It can be viewed as event involved in one or several varieties of insanity that have not been found in sane persons. Holmes and Holmes (2005) support this argument, indicating that suicide is not only an episodic syndrome, but one of frequent occurrence. The frequency may indicate that suicide is an indication of mental alienation with certainty Gould, Greenberg, Velting and Shaffer (2003). The only methodical procedure, according to Gould, Madelyn, Patrick, Jamieson, Daniel and Romer (2003), consists of classifying the indications of mental alienation according to their essential characteristic. For example, the suicide committed by an insane person forms the principal type of insane suicide. What is not clear is whether all cases of voluntary death can be included under systematically arranged groups. However, suicide may be seen only as a phenomenon resulting from many different causes and appearing under many different forms.

The four essential elements of insanity as indicated by Holmes and Holmes (2005) are as follows:

- **Maniacal suicide** - which is due to hallucinations or delirious conception.

  The person kills him/herself to escape from an imaginary danger or disgrace, or to obey a mysterious order from on high.

- **Melancholy suicide** - which is connected with a general state of extreme depression and exaggerated sadness, causing the person not to realise sanely the bonds which connect him with people and things about him. Hallucinations and delirious thoughts often associate themselves with this general despair and lead directly to suicide. However, these thoughts are not mobile like those observed among maniacs. The fears that the person is haunted, his/her self-reproaches, the grief he feels are always the same.
- **Obsessive suicide** - is caused by no motive, real or imaginary, but solely by the fixed idea of death without clear reason.
- **Impulsive or automatic suicide** - is as unmotivated as the preceding and has no cause either in reality or the person‘s imagination.

If people fail to find a solution to some challenges they encounter in life, they may decide to terminate life as an escape route. When youth is overwhelmed by challenges they usually have the following options at their disposal (O‘Connor, Connery & Cheyne, 2000): threatening to hurt or kill oneself, or talking about wanting to hurt or kill oneself; looking for ways to kill oneself, such as searching the internet for suicide methods (*cf*. 2.9) or seeking access to firearms, pills or other means of suicide (*cf*. 2.6); talking or writing about suicide; and talking or writing about death or dying in a way that suggests preoccupation.

2.2.3 Types of suicide

The forms of suicide discussed in this section include fatalistic, egoistic, altruistic and anomic suicide. Egoistic suicide pertains to abnormal individualism, which is due to weakening of society‘s control over individuals and groups and reduced immunity against the collective suicidal inclination. This type of suicide, according to Masango, Rataemane and Matojesi (2008), is caused by the individual‘s lack of concern for the community and inadequate involvement with it. Both the community and the individual are at fault. Egoistic suicide includes most suicides

due to physical and mental illness as well as the suicides of the deprived and the bereaved.

Altruistic suicide refers to people over whom society has too strict a hold and who have too little individualism. These people could be driven to self-destruction by excessive altruism and a sense of duty. This kind of suicide is more common in primitive than highly developed societies (Masango *et al*. 2008).

Anomic suicide occurs when society fails to control and regulate the behaviour of an individual, resulting in disturbances of the collective or organisation which in turn reduce the individual's immunity against suicidal tendencies (Drydne-Edwards, 2011). Egoistic and anomic suicides are linked to too little social integration and regulation whereas altruistic and fatalistic suicides result from too much social integration and regulation (Holmes & Holmes, 2005).

2.2.4 Suicide warning signs

There is lack of consensus about what a warning sign is and how it should be defined (Mandrusiak, Rudd, Joiner, Berman, Van Orden & Witte, 2006). Rudd, Berman, Joiner, Nock, Silverman, Mandrusiak, Van Orden & Witte, 2006) define suicide warnings as the earliest detectable heightened risk for suicide in the near-term (such as within minutes, hours or days). A warning sign refers to some features of the developing outcome of interest (suicide) rather than to a distant contrast (including a risk factor) that predicts or may be casually related to suicide (Miller *et al*., 2009: 156). Warning signs may include the following according to Van Orden, Witte, Gordon, Bender and Joiner (2008) and Rudd *et al*. (2006):

- Preparing for death where someone who is planning suicide will give favourite things away or even say goodbye;
- Self-criticism including saying things such as – I can't do anything right, "I'm hideous and pathetic", which may mean that they are feeling suicidal;

- Changes in personality: someone who is usually sociable may not want to go out; he/she may become negative, aggressive or irritable or lose friendships; dramatic mood changes and perceiving no reason for living; no sense of purpose in life; being unable to sleep or sleeping excessively;
- Loss of interest in appearance resulting in a drop in hygiene: no longer caring how they look like; not getting dressed or even bathing or washing;
- Risk-taking behaviour: often people who are feeling suicidal do risky, dangerous things like drinking and driving, having unprotected sex, or taking drugs. It includes acting recklessly or engaging in risky activities, seemingly without thinking;
- Excessive feelings of guilt, self-blame, failure: if someone is depressed, he/she often feels guilty and blames himself/herself, and it can be very difficult to talk to them;
- Suddenly feeling better after depression: The person heals suddenly without treatment. This could be dangerous. It may mean that the person has set a date for their suicide and know the pain will soon end;
- Writing poems, essays about death; sending text messages or painting images of death. This is a cry for help.
- Threatening and looking for ways to hurt or kill themselves, such as seeking access to pills, weapons, or other means; and
- Withdrawing from friends, family or society.

Warning signs for suicide are more dynamic and proximal factors that suggest that a person increased his or her probability of suicidal crisis (Van Orden *et al*. 2008).

Moreover, many if not most youth exhibit several of these warning signs but never engage in suicidal behaviour and it is not clear how many of these warning signs or what combination of them are best predictors of suicide. Esposito and Clum (2002) argue that if a person is determined to go ahead with

suicide,he/she may go out of her or his way to not give out warning signs or clues. They may really not want to be rescued at all.

Some people may not show any outward signs, even though they are feeling suicidal. Some may show many of the signs, but be coping well. The only real way of knowing for sure is to ask. If someone is feeling so desperate, and has formed a plan to commit suicide they could do so at the first available opportunity (Grunbaum 2004).

The primary aim of this chapter is to identify suicide risk factors as they are an important component of assessing risk for future attempts. To accomplish this, it is necessary to provide a brief overview of the nature and severity of the problem.

2.3 SUICIDE PREVALENCE

According to Bah (2004), demographic variables of the deceased, spatial and temporal details of the injury event, the manner and external cause of death are recorded. This makes it possible to compare all socio-demographic groups for the same time period and geographical level (Wasserman & Wasserman, 2009). There are however problems regarding a reliable statistics system. Suicide misclassification is overwhelmingly problematic (Alonso-Betancourt, 2012) and suicides are usually hidden in other cause-of-death categories (Dobson, 2008). The data presented in this study were taken from ad-hoc studies due to the unavailability of systematic data in South Africa and many other countries. For these reasons the statistics in this document should be analysed with caution. Actually, according to Rockett (2010), globally the true annual suicide toll could be double or triple the conservative death estimations.

As indicated earlier, globally suicidal behaviour in adults and children is an increasingly serious public health problem (Wasserman & Wasserman, 2009). This trend has been observed in both high-income and low-income countries,

including all major ethnic groups in South Africa (Dobson, 2008). Worldwide, approximately one million people of all ages die from suicide every year, with an overall yearly rate of 11.6 to 16 per 100 000 of the population, that is 18 per 100000 for males and 11 per 100000 for females (Schlebusch, 2012:436). Bertolote *et al*. (2009) predict that this number will increase by 2020 to approximately 1.53 million people per annum. The rate of suicide in South Africa, according to Burrows, Vaez, Butchart and Laflamme (2003), is 17.2 per 100 000 people, slightly higher than the world average. According to Burrows and Schlebusch (2009), an estimated 877 000 lives have been lost worldwide through suicide. Worldwide suicide is among the top five causes of mortality among 15-19 year olds (World Health Organisation, 2002) and the third leading cause of death in people aged 15-34 years (World Health Organisation, 2004).

Estimated figures suggest that one death by suicide occurs every hour in South Africa (Govender & Schlebusch, 2013:58) and one suicidal attempt is made every one to three seconds (Bertolote, Mello-Santos & Botega, 2010). One third of non-fatal attempts were recorded among youth in 2010 (Govender & Schlebusch, 2013:58). Bertolote *et al.* (2009) report an approximate 60% rise over the last five decades increasing suicide rates by about 49% for males and 33% for females, and representing about 1.8% of the global burden of disease. The implication, according to Schlebusch (2012:437), is that these rates translate into approximately one to two suicides and 20 or more attempts per hour. Although suicide is not a leading cause of death in South Africa; it is a serious concern (Burrows & Laflame, 2005). South Africa has the eighth highest suicide rate in the world (World Health Organisation, 2010). Van Der Merwe (2015) states that suicide is the third greatest cause of unnatural death in the country.

Age is an important socio-demographic marker for suicide mortality. The average age of those who commit suicide in South Africa is 25 years. In a study conducted by Andriessen, Beautrais, Grad, Brockmann and Simkin (2007) black

youth aged 18 years and younger were identified as a possible high-risk group because they presented as high as 24% of a total sample of suicidal behaviour cases admitted to hospital and of these 91.3% were females. These statistics indicate that females have a higher rate of ideation and non-fatal suicidal behaviour than males. Rutter and Behrendt (2004:43) concurs with this statement, indicating that adolescent girls make more suicide attempts and are more prone to suicide ideation than boys. In most countries suicide rates are higher among boys than girls indicating that boys and men complete suicides. Mann (2002) argue that non-fatal suicide attempts by males may be under-reported because of the stigma associated with this behaviour. According to Rockett (2010) and Burrows (2005) there has been an increase in the incidence of suicide in young males, particularly those between 15 and 24 years of age.

According to the National Injury Mortality Surveillance System report (Dobson, 2008), adult suicides peaked in the 25-29 year age group (16.24%), followed respectively by the 30-34 year age group (15.84%) and the 20-24 year age group(15.38%). Nearly 50% (47.64%) of all suicides recorded in this report were in the 30-34 year old age group, but in young people most suicides occurred in the 15-19 year age group (8.35%), followed by the 10-14 year age group (1.57%), givingan average of nearly 10% (9.92%) in the 10-19 year age group. About 9% of allnon-natural deaths among young people can be attributed to suicide (Schlebusch, 2004; Burrows, 2005). Between 4% and 47% of school childrensurveyed by Apter *et al*. (2009) expressed suicide ideation. According to Schlebusch (2005) and Govender and Schlebusch (2013:58), the increasing occurrence of suicide among youth and men is consistent with the international trend.

These statistics show that more suicides are committed by people in the 10-44 year age group (55%) (Bertolote, Mello-Santos & Botega, 2010). Traditionally, suicide rates have shown a positive relationship with age, in that they tend to increase in older people (some six to eight times higher than in younger people).

However, recent statistics show that, on a global spectrum, younger people die from suicide than older people (Bertolote *et al*., 2009).

Flisher, Ward, Liang, Onya, Mlisa, Terblanche, Bhana, Parry and Lombard (2004) postulate that suicide rates are higher among Whites compared to Asians and Coloureds. The reason for this is that the Asians tend to adhere to religious beliefs that forbid suicide. Black cultures have close family ties and cultural taboos against suicide (Schlebusch, 2005). However, the protective effects are severely tested. People from traditional upbringings have to cope with new roles and more western-orientated culture, repeatedly giving rise to conflicts in their ways of living (Wassenaar, Pillay, Descoin, Goltman & Naidoo, 2000).

2.4 FACTORS INCREASING RISK OF SUICIDE

Being young often means having a lot of emotional ups and downs. School, parents, friends, relationships can be confusing and frustrating and things can be great one minute and horrible the next. In addition to the emotional rollercoaster that youth find themselves on, rapid political social and cultural change in South as they respond to these challenges in addition to the usual developmental crisis (Meintjies, Hall, Hugh-Marera & Boulle, 2010). Being overwhelmed by this tension can easily lead to a sense of despair that in turn often leads to suicide.

However, in the majority of suicides, there has been at least one psychiatric disorder present and mood disorders and substances-use disorders, in particular, have been implicated (Wassermann & Wassermann, 2009).

In addition, researchers have persistently cautioned that the prevalence of suicidal behaviour can increase dramatically during later childhood and adolescence if risk factors are not timeously recognised and dealt with (Schlebusch, 2005).

2.4.1 Psychological factors

Data from the South African Stress and Health study on the prevalence and correlates of suicidal behaviour (Khasakhala, Sorsdahl, Harder, Williams, Stein & Ndetei, 2011) reveal that having a psychiatric disorder is a risk factor for suicidal behaviour. Psychiatric disorder is the most significant risk factor for youth suicide. The most common psychiatric diagnoses include affective, conduct and substance use disorders (Shain, 2007). Multiple psychiatric diagnoses increase the risk of suicide. Because youth are in the life stage associated with the onset of major mental health disorders, it is not surprising that suicide rates also rise in this age group (Kirby & Keon, 2006). A study conducted by Mpiana, Marincowitz, Ragavan and Malete (2004) exploring factors contributing to suicide in the Waterberg District of Limpopo Province in South Africa found that participants expressed feelings of depression, loneliness, emptiness and hopelessness. The relative or interactive effects of these factors are not yet understood (Beuatris, Fergusson, Coggan, Doughty, Ellis, Merry, Mulder & Poulton, 2007). Suicidal behaviours arise as daily life reactions to emotional chaos or disappointment and mostly reflect the misery that exists in a society or cultural system (Tseng, 2001).

It is a shared public understanding to view suicidal behaviour among young individuals as normal acts following careful evaluation of old age issues. However, just as for any other age group, suicidal behaviour among youth is a response to marked psychological agony, aggravated by the presence of psychiatric disorders and poverty, which may render youth more vulnerable due to feelings of worthlessness (Fergusson, Beautris & Horwood, 2003). Tondo and Ross (2001) argue that although a high number of suicides are caused by a psychiatric disorder, only a small number of psychiatric patients kill themselves. Quite often the suicidal decision is triggered by a distressing life event. Psychiatric disorders discussed in this sub-section include: mood disorders; aggression and impulsivity; depression; stress; hopelessness; negative self-concept and isolation.

2.4.1.1 Mood disorders

Both international (Van Heeringen, Hawton & Williams, 2000) and national research (Schlebusch, 2004) have acknowledged numerous comorbid, psychopathological conditions, in particular mood disorders, as critical features in the aetiology of suicidal behaviour.

Mood disorders are correlated with an increased risk of suicide ideation in girls. In contrast, the most important risk factor for suicide attempts in boys between the ages of 9-17 years are previous suicide attempts, mood and anxiety disorders, disruptive behaviour that is behaviour associated with attention deficit or hyperactivity disorder, conduct disorder, and oppositional disorder and substance abuse (Nock, Park, Finn, Deliberto, Dour & Banaji, 2010).

Schlebusch (2004) reports that mood disorders are the most common diagnosis. They present in nearly two-thirds (64%) of non-fatal suicidal Black patients in South Africa (Schlebusch, 2005). Kauye (2008) confirm this by indicating that 45%-70% of suicides are a result of mood disorders. Nock *et al*. (2010) indicate that the presence of multiple disorders is associated with especially elevated risk.

Nevertheless, the main concern is that mood disorders associated with suicidal behaviour are often clinically undetected in South African youth (Schlebusch, 2005). There are several reasons for this. Firstly, in the young, clinically depression and suicide ideation frequently tend to be more prevalent and/or severe with increasing age. Secondly, the boundaries are sometimes unclear and can be influenced by developmental issues and age that affect the expression of depressive symptomatology (Lonnqvist, 2000). Thirdly, children's moods and risk for attempting suicide are also often associated with family discord, abuse and neglect (Bertolote *et al*. 2009). Moreover, mood disorders interacting with stressful life events may lead to suicide ideation and then suicidal attempts (Pompili, Innamorati, Rihmer, Gondo, Serafini, Akiskal, Amore, Niolu, Taterlli, Perugi & Girardi, 2012:481).

2.4.1.2 Aggression and impulsivity

Bushman and Anderson (2001) define human aggression as any behaviour directed toward another individual that is carried out with the immediate intent to cause harm. The perpetrator must believe that the behaviour will harm the targeted person, and that the victim is motivated to avoid the behaviour. Dawe, Gullo and Loxton (2004) on the one hand express impulsivity in terms of the inability to resist impulses, which results in explosive and prompt, automatic or semi-automatic psychomotor actions that are characterised by their sudden and incoercible nature. Dobson (2008) on the other hand use a more behavioural definition, which considers impulsivity as a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions to the impulsive individual. An impulsive reaction can therefore be regarded as a failure to control one‘s emotion. From these definitions it can be deduced that impulsive suicide is not premeditated and the victim may use any means available to attempt or commit suicide. Impulsive individuals are more likely to display suicide ideation and poor impulse control may predict suicidal behaviour (Dougherty, Mathias, Marsh, Moeller & Swann, 2004; Pompili *et al*., 2012). –Spur of the moment behaviour is responsible for higher rates of suicidal behaviour among impulsive people (Ghaffari, Ahmadi, Abedi, Fatehizade & Baghban, 2011).

According to Nock *et al.* (2010), aggressive and impulsive suicidal attempters are more hostile than others and are more apt to generate hostility in others because of their dependency and immaturity. They are often poorly able to verbalise their emotional experiences. Hawton and Van Heeringen (2000) state that the culprit in aggressiveness and impulsivity is reduced serotonergic input to the orbital pre-frontal cortex, which is part of the brain involved in behavioural inhibition and

decision-making. In such instances, there are decreases in presynaptic binding sites in the prefrontal cortex, also called altered receptor population and serotonergic hypo function, which may be associated with more lethal methods of choice in suicidal behaviour (Wasserman & Wasserman, 2009).

Aggressiveness or impulsiveness are not only common co-morbid variables in suicidal behaviour, but can also be associated with violence. Schlebusch (2005) maintains that there is a link between suicidal behaviour and violence which concerns certain lethal methods of choice. Dysfunctional decision-making and reasoning and an underlying biological or genetic predisposition could result in increased aggressiveness and violent acting out and suicidal behaviour (Mann, 2002; Schlebusch, 2005).

Extended suicide and murder-suicide are possibly some of the most extreme examples of the link between violence and suicidal behaviour (Nock & Marzuk, 2000; Schlebusch, 2005). An escalation in 'crimes of passion and family murders have been reported in South Africa. Studies have examined the role of psychopathology and personality disorder (especially the dependent personality disorder) and the distinction between murder suicide and aggression and impulsivity (Schlebusch, 2005). Murder suicide refers to a situation where the perpetrator of a homicide has taken his or her own life after the death of the victim(s) has occurred (Malphurs & Cohen, 2005).

A family murder occurs primarily as an act of murder, and secondarily as a suicide, in order to avoid facing legal consequences of the murder(s) of family members. In extended suicide there is an original intention to commit suicide, but before doing so, the perpetrator kills the family as part of the planned extended suicide (Eliason, 2009; Wasserman & Wasserman, 2009).

In South African research murder-suicide has been found to be constant across cultures, being more akin to suicides than homicides in which work-related stress

and Post-Traumatic Stress Disorder (PTSD), as well as the availability of and familiarity with firearms are common (Townsend, 2003). Additional precipitators of family slayings cited in South Africa include socio-economic pressures, the trauma resulting from child abuse and various psychological factors or disorders, including personality disorders, depression and substance abuse (Schlebusch, 2005).

Murder-suicide can occur amongst all cultural and ethnic groups, but early South African studies indicate that in the 1980s this predominated among white people (Bertolote *et al*., 2009). Later South African studies report more Africans to be victims of murder-suicides, which probably reflect the major ethnic composition of the geographical study areas (Townsend, 2003).

Two of the primary motives for suicidal behaviour include murderous impulses and the need to escape from unbearable psychological pain/anguish, which can develop when love objects or social support systems are threatened, lost or become unobtainable (Schlebusch, 2005). This, in turn, can result in feelings of intolerable aloneness, severe hopelessness and intense self-contempt with murderous impulses being directed at the threatened or unattainable love object, such as the immediate family (Nock & Marzuk, 2000). Murderous impulses may then be turned not only on the self, but through the processes of introjection and projection, also on the family as discussed in the foregoing paragraphs. The result will be family murder as an extended suicide (Nock & Marzuk, 2000).

Sometimes children are murdered as a first step to annihilate the family, but when there are surviving children, they are frequently the first to face the full horror of the events, and are often the ones who summon neighbours or the police. Evidently, the emotional sequelae of such experiences can have a devastating impact on the psychological health of the surviving children with future suicidal implications (Otsuki, Kim & Peterson, 2010).

2.4.1.3 Depression

Depression is the leading cause of suicide as the majority of suicide and suicide attempts are caused by despair and depression. It is commonly associated with suicide and suicidal thoughts (Meehan, Peirson & Fridjhon, 2007). Depression is an illness. It is not a character weakness or something that people bring on themselves or can change at will.

Depression may develop after a particularly upsetting event or situation, but also develops in adolescents who don‘t seem to have any reason to be depressed. It is often caused by negative life experiences that include the death of a loved one, a divorce, separation, or the break-up of a relationship, a serious loss of a job (Cheung, Law, Chan, Liu & Yip, 2006; Cottin, Gould, Cantin & Caruso, 2011) and others. Moreover, brain pathology can trigger depression, suicide ideation and dis-inhibition or lack of restraint (Lishman, 2005; Wasserman & Wasserman, 2009). There is also a high rate of lifetime suicide risk associated with depression (Badee, Badee, Helmy & Morsy, 2011). According to the South African Depression and Anxiety Group (2011:1-4), between 70% and 90% of youth who die by suicide have an underlying mental illness.

A study conducted by Samm, Tooding, Sisask, KÕlves, Aasvee and Värnik (2010) reveals that gender differences for depressive feelings start to emerge from 13 years of age and for suicide ideation from 15 years, with girls having higher risk in both. Additionally, the higher rate of depression in girls compared with boys after the onset of puberty is attributed by Zalsman (2012) to different coping styles or hormonal changes during puberty. Other reasons for a higher rate of depression in girls indicated in the literature include: more symptoms of anhedonia and negative self-esteem (Aluja & Blanch, 2002); and a higher pessimistic view of one‘s coping ability at school and feelings of being unloved (Samm *et al*., 2010).

Depression may manifest with sadness, hopelessness, helplessness, guilt, anxiety, emptiness, irritability and agitation or lethargy and apathy (Galaif, Sussman, Newcomb & Locke, 2007). There may be changes in eating or sleeping patterns: overeating and anorexia, hypersomnia or insomnia, social withdrawal and isolation. Youth may abuse drugs and/or alcohol, often in an attempt to –medicate‖ their depression.

Mpiana, Marincowtz, Ragvan and Malete (2004), exploring factors contributing to suicide in the Waterberg district of Limpopo province in South Africa, found that participants expressed feelings of being depressed, lonely, empty and hopeless. Many people believe that sadness is just the normal part of growing up, but youth who feel really down or unhappy for two weeks or more may be depressed.

Suicide often occurs in conjunction with depression as a —state-dependent‖ characteristic. The suicide risk often increases when the depressed person is showing signs of recovery (Schlebusch & Burrows, 2009). Untreated mental illnesses, specifically depression, bipolar disorder and schizophrenia are the leading contributory causes of suicide in young adults (Goldsmith, Pellar, Kleinman & Bunney, 2002). In someone with major depression, a number of these symptoms persists every day over a period of at least two weeks, and represent a noticeable change from the person‘s previous functioning (Goldsmith *et al*., 2002).

The changed behaviour includes: sad, depressed mood; an angry and irritable mood; markedly diminished interest or pleasure in activities the person used to enjoy; a persistent feeling of boredom; significant weight loss or weight gain and change of more than 5% of body weight in a month (Nixon, Cloutier & Jansson, 2008). It becomes difficult for such people to sleep or they sleep too much, move or speak very slowly, or do the opposite such as moving or speaking very quickly or in an agitated manner. Fatigue or losses of energy, feelings of worthlessness or inappropriate guilt are the order of the day. Depression also affects the brain in that people have a diminished ability to think, concentrate or make decisions as

they have recurrent thoughts of death or suicide. They would be busy making specific plans for suicide, or engaging in self-harm behaviour or making a suicide attempt (Fossey *et al*., 2002).

Soukas, Suominen, Isometsa, Ostamo and Lonnqvist (2001) state that adolescent girls are more likely than boys to be diagnosed with depression, possibly as a result of hormonal differences that become marked around the time of puberty. Through most of the lifecycle, women continue to have higher rates of depression than men, for reasons that are not yet well understood. The boundaries are sometimes unclear and can be influenced by developmental issues and age that affect the expression of depressive symptomatology (Lonnqvist, 2000).

Signs of serious mental disorders in teens are often misinterpreted as normal adolescent mood swings or attributed to characteristics such as laziness, poor attitude or immaturity Reeves, Brock, and Cowan (2008). Depression is a common problem that can interfere with adolescents‘ ability to function well in school, enjoy previous hobbies or activities or interact effectively with friends or family members.

Depressed teens may have a particularly hard time understanding and talking about what they are experiencing, and may work hard at hiding their feelings (Samm *et al*. 2010). Sometimes, teenagers may express their pain through themes of death in their diaries or hopelessness in their artwork, poetry, short stories or essays. These can provide openings to talk to adolescents about what they may be feeling. At other times, depression in adolescents may be expressed through physical complaints, such as frequent stomach distress or headaches (Burrows & Laflamme, 2005). Cassimjee and Pillay (2000) state that young people are often not able to put their feelings into words. They may also be associate the sense of low energy and -malaise that accompanies depression with feeling physically sickness.

2.4.1.4 Stress

According to Netshiombo and Mashamba (2012:98) and (Meintjies, Hall, Hugh-Marera & Boulle, 2010), the interplay of extreme social, cultural, political, and economic factors impact upon the lives of South African adolescents and play a role in stress and possible suicide ideation. South African citizens have endured years of discriminatory apartheid policies which ruthlessly traumatised them through gross human rights violations, and left a legacy of stress-related psychological problems (Schlebusch & Bosch, 2002) with potential suicidal implications. Stress becomes inevitable when vulnerable youth respond to challenges posed by socio-economic conditions in addition to the usual developmental crises. Acute and chronic stresses are critical co-morbid etiological variables in suicidal behaviour in both adults and children (Hawton & Van Heeringen, 2000; Wasserman & Wasserman, 2009). several stress-diathesis models, with significant advantages for treatment and prevention, have been advanced to provide a better understanding of the suicidal process and interactive stress-related dynamics. Two such important models are the stress-diathesis model and the stress-vulnerability model.

The stress-diathesis model comprises a comprehensive practical, explanatory and predictive model of suicidal behaviour (Mann, 2002). It proposes that the stress component includes factors such as a psychiatric disorder, as well as life events. The diathesis includes elements like impulsivity, aggression, pessimism/hopelessness and neurobiological correlates and a range of other potential variables such as gender, religion, familial and genetic components, chronic diseases, alcohol/substance abuse, traumatic childhood experiences and psycho-social support systems. This model can be supplemented by the stress-vulnerability model (Wasserman, 2001) that involves factors such as the suicidal individual‘s cognitive style, personality, environmental issues, culture and various protective factors against individual vulnerability. These stressors often overwhelm the coping skills of youth because of their inexperience with such life situations.

The collective consciousness of the South African society as embraced in the ubuntu philosophy is getting weaker and weaker. Ubuntu is defined as the principle of caring for each other's wellbeing and a spirit of mutual support (Department of Social Development, 2013). Ubuntu means that people are people through other people, acknowledging both the rights and the responsibility of every citizen in promoting individual and societal wellbeing. According to Netshiombo and Mashamba (2012), the basic tenet of ubuntu on which the South African society thrived is being eroded. The caring socio-cultural imperatives of people are diminishing. There is growing evidence that traditional culture in South Africa is undergoing a period of transition and is largely influenced by westernisation.

Micronutrient deficiencies can have adverse psycho-physiological consequences, more stress-related symptoms and progressively reduced stress tolerance (Schlebusch, 2000). These factors can impact adversely on brain structures and memory which, in turn, may impair appropriate coping strategies in a suicidal person (Wasserman, 2001). Inordinate stress can result in the secretion of endogenous stress hormones that affect how memories are laid down. Stress-related elevated cortisol levels, for examples, are known to be toxic to the hippocampus, a brain structure that constitutes a major component of the memory system that has a primal role in learning, retention and rapid association of information received from different cortical areas (Lezak, Howieson & Loring, 2004). Stress, therefore, can have major implications for disturbances in various neurotransmitters (Wasserman, 2001) and neurohormones with significant co-morbid aetiological considerations for suicidal behaviour (Schlebusch, 2005), also in young people.

Some anxiety disorders like post-traumatic stress disorder and obsessive compulsive disorder also produce suicidal thoughts among men (Khasakhala, Sorsdahl, Harder, Williams, Stein & Ndetei, 2011). In addition, South African researchers (Schlebusch & Bosch, 2002) have, among others, clearly documented:

- The role of dysfunctional perceptions in stress arousal associated with a range of psychological problems in young people, including suicidal behaviour.
- Suicidal implications of stress-related conflicts in social roles in young people from traditional upbringings who have to cope with new roles and more Western-oriented culture in a multicultural South African society.
- Stress that can act as suicidal triggers precipitated by factors such as acculturation, socio-economic pressures, high crime and violence rates, human rights violations, difficulty to cope with the process of transformation, rising expectations, and an increasing competitiveness in education.
- A reduced appreciation of traditional roles and value systems.
- Trauma-producing behaviours in the young that result from emotional injuries sustained from exposure to direct or indirect violence (Wasserman & Wasserman, 2009).

Retrospective analyses of stress-related risk factors in South African youth have shown that repeated suicidal behaviour can increase in order to secure help, as attempts at non-fatal suicidal behaviour do not get the desired effect from significant others on whom the suicidal behaviour is supposed to impact (such as when the cry for help fails), and lethal methods being used until the precipitators causes are appropriately addressed (Schlebusch & Burrows, 2009; Wasserman & Wasserman, 2009).

In assessing the impact of stressful life events on teen suicide, it should be kept in mind that the large majority of youth who experience stressful life events do not become suicidal. In some teens, however, the normal feelings of sadness, grief or humiliation that result from upsetting life experiences can precipitate depression, anxiety or another mental disorder, which in turn increases suicide risk. It should also be kept in mind that mental disorders can precipitate stressful

events, as in the case of school failures that result from an inability to concentrate due to depression or anxiety (Galaif *et al*., 2007).

Therefore, youth who attempt suicide may be motivated by a desire to escape from unbearable stressors, difficulties or aversive self-awareness, including realisation of inadequacies and unmet expectations (Goldston, 2004). If they fail to find solutions to some challenges they encounter in life, they may decide to terminate that life as an escape route. Although stressful experiences may precipitate suicidal behaviour, stress without the presence of psychopathology rarely appears to lead to suicide (Mazza & Reynolds, 2008).

2.4.1.5 Negative self-concept

Rutter and Behrendt (2004) identified negative self-concept as one of four psychological factors that correlate with youth suicide risk, the others being hopelessness (*cf*. 2.4.1.5), hostility (*cf*. 2.4.1.2) and isolation. Among various factors, low self-esteem was found to be one of the stronger predictor of suicidal behaviour, especially in psychiatric patients (Troister, Links & Cutcliffe, 2008:578).

The association of low self-esteem with suicidal behaviour in major depressive disorder has been widely studied and is well illustrated in literature. During a depressive episode an association between low self-esteem and suicidality was found in Tarrier (2008:578) study. Holmes and Holmes (2005:578) determined the association between feelings of inferiority and suicide ideation and suicide attempt among youth. They found that feelings of inferiority were associated with a significantly increased likelihood of suicide ideation and a suicide attempt. The results also showed evidence of interaction specifically between anxiety disorders and inferiority in the likelihood of a suicide attempt.

A substantial amount of research also demonstrates the association of self-esteem with suicidal behaviour in schizophrenia. For example, Fialko (2006:579)

the clinically significant trend of suicide ideation in psychosis and found that suicide ideation was related with mood, anxiety, low self-esteem, negative evaluative belief about the self and others, and daily alcohol consumption. Tarrier, Barrowclough, Andrews and Gregg (2004:579) found that negative self- esteem correlated significantly with measures of depression, hopelessness and suicide ideation, whereas positive self-esteem was negatively correlated only with hopelessness in schizophrenia patients. They concluded that isolation and poor self-worth/negative self-evaluation work through a common factor of hopelessness to increase suicide risk in schizophrenia patients.

Researchers have also indicated low self-esteem to be one of the factors associated with suicidal behaviour in drug dependence disorders. Wilke (2004:579) designated a significant link in the predicted direction between self-esteem and abstinence and no effect for gender. Conversely, it was also assessed that those who had lower levels of self-esteem, regardless of abstinence or continued use, had a practically indistinguishable likelihood of suicide ideation. Likewise, Demirbas, Celik, Ilhan and Oğan (2003:579) evaluated correlations of self- esteem, depression, and state-trait anxiety with suicide probability in alcohol dependence. Self-esteem has profound consequences for people‘s existence. Baumeister, Campbell, Krueger and Vohs (2003:587) explain that it is difficult, if not impossible, for people to remain indifferent to information that has a bearing on their self-esteem, such as being told that they are incompetent, attractive, untrustworthy, or loveable. Groves and Muskin (2005:587) illustrated that for many people, feelings of accomplishment, productivity, and usefulness are important for their self-image. Thus, self-esteem is damaged when people lose this important source of gratification. They start personalising negative information about the self and perceive themselves as worthless and unproductive, as indicated by Groves and Muskin (2005:587).

McGee and Williams (2000:282) have shown that low levels of self-esteem at ages 11-13 do predict suicidal thoughts in the presence of a depressed mood at

age 15. McGee and Williams (2000:283) also identified three levels of self-esteem, namely low, medium and high. In the first instance, the level was based upon the availability of two successive measures of self-esteem to identify children with persistent low, medium and high levels of self-esteem over time. The next section presents information about individual factors that impact negatively on mental health.

2.4.2 Individual risk factors

A further set of risk factors for youthful suicidal behaviour encompasses individual and personal factors. They comprise of dysfunctional problem solving, and risk-taking and temperamental factors.

2.4.2.1 Dysfunctional problem solving

Suicidal youth are often poor at solving interpersonal problems (Hawton & Van Heeringen, 2000). In this context, suicidal behaviour has been viewed as an unsuitable, maladaptive problem-solving strategy and method of communication. It is meant to reduce anxiety or bring about relief but the consequences are non-productive. Poor personal skills limit youth‘s ability to solve problems, thereby increasing the likelihood of considering suicide as the only solution. In addition, the experience of a disproportionate number of stressful life events may, according to Otsuki *et al.* (2010), compound problem-solving difficulties present in youth. One of the components of problem-solving is decision-making, the process of forming preferences, selecting and executing actions, and evaluating outcomes (Ernst & Paulus, 2005:2).

Schebush (2005) maintains that about 80% of suicidal behaviours are preceded by either verbal or non-verbal behavioural clues that indicate the suicidal person‘s intentions. The commonly held belief is that young people who threaten to commit suicide are not serious about it, is an artefact. More than two-thirds of people who engaged in suicidal behaviour communicate their intent to do so within three months preceding the suicidal act or consult their general practitioners

for treatment for a psychological disorder (usually depression) at least two weeks before the suicidal act (Madu & Matla, 2003). This is consistent with international research which indicates that a substantial proportion of people who commit or attempt suicide have either indicated a need for help or have had some contact with a medical health professional (Fox & Hawton, 2004). However, in South Africa, a significant number of suicidal youth do not have access to specialised mental health services or even a general practitioner at the time of a suicidal crisis (Flisher, Ward, Liang, Onya, Mlisa, Terblanch, Bhana, Parry & Lombard, 2006). This is extremely disturbing, given the gravity of the problem.

2.4.2.2 Rebellious behaviour

The youth stage is generally characterised by a preference for being less reliant on parental advice (Runeson & Asberg, 2003), yet parents are most frequently identified as a source of help. Teenagers become rebellious in an attempt to be autonomous and thus aggravate suicide behaviour. Teenagers who do not submit to parental control are more prone to seek alternative means of expressing themselves and suicide is one such option (Meehan *et al.,* 2007). These risk factors can be ongoing, with the suicidal behaviour occurring at a threshold point in the crisis build-up, indicating the young person's inability to function appropriately within the family environment (Hawton & Van Heeringen, 2000). Risk behaviour is regarded as a precondition and consequence of suicide ideation by Samm, Tooding, Sisask, Kõlves, Aasvee and Värnik (2010: 45).

According to Moffitt, Caspi, Rutter and Silva (2001), rebellion against adults' rules and expectations during the teen years is developmentally normative to some degree, with youth from disparate backgrounds drawn to behaviours such as experimenting with substance use and delinquent acts. Such behaviours are signs of personal maladjustment among some youngsters, but according to (Luthar & Latendresse, 2005:32), they also occur among some individuals who are apparently psychologically healthy and socially competent.

Lewinsohn *et al*. (2001) state that the period of adolescence is characterised by multiple transitions including puberty, relationships, school and abilities and by an increase in risk-taking behaviours. Problematic behavior can be seen as a means of accomplishing age-typical goals of peer-group identity and adult status. Gullone and Moore (2000:393) define a negative risk as -the participation in behaviour which involves potential negative consequences or loss, balanced in some way by perceived positive consequences or gainǁ. Adolescents engage in these behaviours with the intent to be autonomous. These risk behaviours usually occur relatively early in a person‘s life and may be considered an integral part of becoming an adult (Dennison & Coleman, 2000).

Samm *et al*. (2010:45) maintain that the most frequent risk-taking or risk-associated behaviours among high school adolescents are consumption of alcohol, smoking cigarettes, early sexual intercourse, substance abuse, bullying and fighting. An inability to communicate these problems and needs to others results in many youth expressing despair through engagement in increased risk behaviour rather than in words (Hawton & Rodham, 2006). The results of a study conducted by Meehan *et al*. (2007) confirm that suicide ideation is more common among adolescents participating in risk behaviours. Moreover, they argue that girls participating in risky behaviours are likely to be more concerned and disturbed about their perceived impermissible behaviour and they might feel more ashamed, as they know that their behaviour is frowned upon in their communities.

Wilcox, Conner and Caine (2004) show that there is an association between completed suicide and drug abuse. Moreover, Litwiller and Brausch (2013) maintain that substance abuse such as alcohol and drug abuse and smoking are said to be triggers of suicide behaviour. Substance abuse disorders contribute substantially to the risk of suicide, especially in older adolescent males when co-occurring with mood disorder or disruptive disorders. Drugs and alcohol may be

abused as a desire to escape problems or as a yearning for self-medication (Hufford, 2001).

Aseltine, Gore and Colten (2002) examined the relationship between heavy episodic drinking and adolescent suicide attempts. They found that adolescents 13 years or younger who participated in heavy episodic drinking were at 2.6 times greater risk of reporting a suicide attempt as compared to those who did not participate in heavy episodic drinking. Heavy episodic drinking by youth who were 18 years or older increased their suicide attempt by 1.2 times as compared to adolescents of this same age who did not participate in heavy episodic drinking. The results indicate an association between alcohol consumption and suicide attempts. High alcohol consumption and consumption of stronger alcoholic drinks such as spirits (Aseltine *et al.,* 2002) also indicate a significant association between suicide ideation and alcohol use. Schilling, Aseltine, Glanovsky and Jacobs (2008) found that drinking while feeling down results in a threefold increase in the risk of self-reported suicide attempts.

According to Wilcox, Conner and Caine (2004), alcoholism among youth is a particular concern, given the fact that half of the South African population is categorised as young people under 35. Alcohol use among youth is common and increases with age for both males and females. There is also a tendency towards more harmful binge drinking. Reasons for the use and misuse of alcohol include peer pressure and a desire to fit in, poor home environments and boredom, ignorance about alcohol‘s harm, and the relative cheapness of alcohol products and their ease of access (Setlalentoa, Pisa, Thekiso, Ryke & Loots, 2010:S12). High youth unemployment and academic failure rates are exacerbating factors. In South Africa alcohol is easily purchased from bottle stores, supermarkets, bars and shebeens and other unlicensed liquor outlets, which outnumber licensed ones, particularly in disadvantaged communities. Setlalentoa *et al*., (2012:S12) add that unregulated outlets which have multiplied over the years operate according to demand. Although the age restriction is 18 years, unregulated outlets

ignore this regulation. This problem is not peculiar to South Africa as many countries express their concern regarding drinking by youngsters. Furthermore, for attempted suicide, certain characteristics of alcohol consumption appear to be predictive of an association, such as high consumption and strong alcoholic drinks.

Excessive alcohol use heightens psychological distress, aggressiveness and suicide-specific alcohol expectancies and inhibits adaptive coping strategies. In such circumstances, suicidal thoughts may be moved to action. Fatal and non-fatal suicide attempts are associated with elevated rates of alcohol abuse and intoxication among adolescents (Pompili *et al*., 2012:480).

Smoking has been associated with suicide attempts and suicide ideation but it is unclear whether this association is direct and whether there are any gender differences. A study by Hughes (2008) reveals evidence that smoking cessation could precipitate a clinical depression, which may lead to increased suicide. Hughes (2008) posits that smoking worsens the user's mood, impulsivity, aggression and other behavioural factors that predispose to suicide. Smoking causes physical illness, which is a leading cause of suicide.

Drug-taking appears to increase the risk of suicide attempts and probably suicide ideation. Examples of illegal drugs that may produce suicidal thoughts include marijuana, cocaine, methamphetamine, phencyclidine and liquid crystal display. Drug abuse, according to Galaif *et al*., (2007:30), is strongly associated with a lifetime prevalence of depression. Hufford (2001) suggests that the acute effects of intoxication may represent a proximal risk factor for suicidal behaviour.

2.5 IMITATION, SUICIDAL TRANSMISSION AND MEDIA REPORTS

The influence of the mass media and information technology on vulnerable youth with suicidal behaviour has received considerable attention because of imitation or copycat effects (Wasserman & Wasserman, 2009; Schlebusch, 2012: 437).

Gould, Greenburg, Munfakh, Kleinman and Lubell (2006) support the idea that the media increases the risk of suicide attempts. Copycat suicides occur when one or more suicides are reported in a way that contributes to another suicide (Vernont Youth Suicide Prevention Coalition, 2012:44), and as suicide is a public health issue, media and online coverage of suicide should be informed by using best practices. Thus, some suicide deaths may be newsworthy but the way the media cover suicide can influence behaviour negatively by contributing to contagion or positively by encouraging help seeking. Suicide contagion, a term for the spread of suicidal activity usually with reference to media influences, may be associated with sensationalist media reporting of suicide events in the community (Beuatrais *et al*., 2009).

A significant direct association with suicide attempts (but not suicide ideation) was found for television viewing of suicides, surgery and funerals. There now is substantial evidence that newspaper reporting of suicidal behaviour can be a contributory factor in suicidal behaviours, especially in young people (Pirkis & Blood, 2001; Schmidtke & Schaller, 2000).

In addition, modern communication methods are apparently increasingly tolerance of suicidal behaviour and the concept of suicidal transmission is becoming extremely relevant among young people who learn about suicide through mass media publicity (Schlebusch, 2005). Schlebusch (2012:437) indicates that websites exist that graphically describe suicide methods. The National Association of Boards of Pharmacy (2011:196) concurs with this, adding that the Internet has provided a way for people to obtain how-to descriptions of suicide as well as lethal means to kill themselves. Explicit description of a particular suicide method may lead to increases in actual suicidal behaviour employing that method (Schmidtke & Schaller, 2000). Messages, boards or forums have been used to spread information on how to die by suicide. According to Morii, Yasusuke, Nakamae, Murao and Taniyama (2011:196), 220 cases of people attempting suicide via hydrogen sulphide gas resulted in the deaths of 208 people in Japan in 2008.

This suicide outbreak was blamed on the introduction of the gas-related method on message boards via the Internet. Family members, paramedics, and care-givers were reported to have been injured or even killed in attempts to save suicide victims because of three toxic gas methods used.

The media Influence on suicidal behaviour, especially suicide methods used, has been well documented (Naito, 2007:196), and social media may possibly increase the risk of the media contagion effect, especially among young people. Dunlop, More and Romer (2011:196) specifically examined possible contagion effects on suicidal behaviour via the Internet and social media. Of 719 individuals aged 14 to 24 years, 79% reported being exposed to suicide-related content through family, friends, and traditional news media such as newspapers, and 59% found such content through Internet sources. Additional analysis revealed no link between social networking sites and suicide ideation, but it did find a connection between suicide ideation and suicide-related content found on online forums (Dunlop *et al*., 2011:196).

Technology has created expanded opportunities to influence vulnerable people, enhancing the contagious effects of suicidal behaviour. A case in hand is that of the -Werther effectll a term derived from a character in Goethe‘s novel, –The sorrows of young Werther published in the eighteenth century. Soon after its publication, a spate of young people in Europe committed suicide in a similar way to that of the novel‘s hero, Werther (Van Heeringen *et al*., 2000). The Werther effect can be thought of as a form of suicide contagion that is similar to suicide clustering, except that the index suicide is reported or portrayed in the media rather than occurring on a given social network (Pirkis & Blood, 2010:269). The effect is accentuated when the person described in the story and the reader or viewer share similar characteristics (Stack cited by Pirkis & Blood, 2010: 269) or when the person described in the story is a celebrity and is revered by the reader or viewer (Cheng, Hawton, Lee & Chen, 2007).

Biddle, Donovan, Hawton, Kapur and Gunnell (2008:195) conducted a systematic web search of 12 suicide-associated terms such as suicide, suicide methods, how to kill yourself, and best suicide methods. This research was to simulate the results of a typical search conducted by a person seeking suicide methods. They analysed the first ten sites listed for each search, for a total of 240 different sites. Approximately half were pro-suicide websites and sites that provided factual information about suicide. Pro-suicide sites and chat rooms that discussed general issues associated with suicide most often occurred within the first few hits of a search. Recupero, Harmss and Noble (2008:195) also conducted a study that examined suicide-related sites that can be found using Internet search engines. Of 373 web site hits, 31% were suicide neutral, 29% were anti-suicide, and 11% were pro-suicide. The remaining sites either did not load or included suicide in the title but were not suicide sites. Together these studies show that obtaining pro-suicide information on the Internet, including detailed information on suicide methods, is very easy. Shah (2010:195) conducted a cross-national study that examines the association between general population suicide rates and the prevalence of internet users, using data from the World Health Organization‘s and the United Nations Development Programs websites. Shah (2010:195) showed that the prevalence of Internet users was positively correlated with general population suicide rates.

Internet and cellular telephone use in South Africa have blossomed among young people and worrying trends about their influence on suicidal behaviour are clearly discernible in media reports (Pirkis & Blood, 2010). Youth who are predisposed or vulnerable to suicidal behaviour through imitation effects appear to be the most vulnerable to these modern influences (Kaplan & Haelein, 2010). Cyber-bullying and cyber harassment increase the risk of suicide among youth (Hinduja & Patchin, 2011:106). According to Kowalski, Limber and Agatston, (2008:196), cyber-bullying refers to when a child or adolescent is intentionally and repeatedly targeted by another child or teen in the form of threats or harassment,

or humiliated or embarrassed by means of cellular phones or Internet technologies such as e-mail, texting, social networking sites, or instant messaging. Hinduja and Patchin (2011:196) reported results from a survey conducted to approximately 2000 middle-school children that indicated that victims of cyber-bullying were almost twice as likely to attempt suicide as those who were not. Hinduja and Patchin (2011:196) argue that although cyber-bullying cannot be identified as a sole predictor of suicide in youth, it can increase the risk of suicide by amplifying feelings of isolation, instability, and hopelessness for those with pre-existing emotional, psychological, or environmental stressors.

2.6 FAMILY FACTORS

Bren and Mann (2005:13) maintain that there is a growing recognition that suicide and suicidal behaviour are familial and heritable.

2.6.1 Suicide due to death in the family

Youth who are suicidal often come from families in which there was death of a parent during their childhood. Therefore, individuals who lose a loved one to suicide become preoccupied with the reason for the suicide while wanting to deny or hide the cause of death. Moreover, they wonder if they could have prevented it, feeling blamed for the problems that preceded the suicide (Dahlberg, Waern, & Runeson, 2008), and feeling rejected by their loved one and stigmatised by others. According to Ghaffari, Ahmadi, Abedi, Fatehizade and Baghban (2011), the loss of an important person, a family member or a friend would be an important predictor of suicide ideation in university students.

Many people, particularly parents of children who commit suicide, take some comfort in being able to use this terrible experience as a way to establish a memorial to their loved one (Schilling, Aseltine, Glanovsky & Jacobs, 2008). That can take the form of everything from establishing a scholarship fund in their loved one‘s name to teaching others surviving the suicide of someone close to them. Friends and family may be more likely to experience regret about whatever

conflicts or other problems they had in their relationship with the deceased, and they may even feel guilty about living while their loved one is not (Mittendorfer-Futz, Rusmussen & Wasserman, 2008).

2.6.2 Family disruption

Fallow (2007:158) maintains that it is possible that a broken home in childhood may create emotional and social instability, thereby predisposing the individual to the kind of crises which tend to result in suicidal acts. Parental divorce is one of the aspects that appear to be linked to suicidal phenomena. The high rate of divorce and marital discord has contributed to young people having to take on greater responsibilities (Meintjies *et al*., 2010). Many of the problems experienced by youth in families, in which parents subsequently divorce, can be observed long before separation and the intensity and frequency of conflict are predictors of child adjustment. Kelly, Soloff, Lynch, Haas and Mann (2000) however contend that marital conflict is a stronger predictor than divorce. Furthermore, Brent and Mann (2005) point out that marital disruption is more common in parents with psychiatric disorder.

In a study by Hawton and Williams (2001) conflicts and arguments within the home were clearly and directly associated with the prevalence of suicidal phenomena, whereas family harmony and cohesion appeared to have a protective effect. A young person‘s perceptions of suicidal behaviour may be a significant factor in this regard, giving rise to an unpremeditated, impulsive suicidal act in the face of a predominant interpersonal or family crisis. Qin, Agerbo and Mortensen (2003) is of the opinion that dysfunctional cognitive schemata in children, caused by growing up with unhappy rather than happy memories can, from a cognitive behaviour therapy perspective, lead to the later manifestation of depression and other psychopathology, all contributing to suicidal behaviour.

Mittendorfer-Rutz, Rusmussen and Wasserman (2008) argue that suicide is associated with the absence of fathers but not mothers. However, it may have been that in their study too few youths were living apart from their mothers for any impact on suicidal phenomena to be detected. The presence of a step-parent is associated with suicide attempts and ideation (Hawton & Williams, 2001).

According to Mhlongo and Peltzer cited by Netshiombo and Mashamba (2012:98), there are many youths who have relinquished the freedom and innocence of youth. Children are increasingly adopting the full responsibility of parenthood. At a very young age children find themselves having to carry the burden of proving livelihood either for their siblings or their ailing parents/grandparents. Child-headed households are becoming a common phenomenon in South Africa. According to Meintjies *et al*., (2010), the proportion of children in South Africa living in child-headed households in 2006 was 67%. Children in child-headed households live in conditions that are on average worse than those in mixed generation households. Death caused by HIV and AIDS-related illnesses leave older children as caretakers of their younger siblings.

Suicidal youth often have a neglectful, rejecting, and psychiatrically ill parent, and/or a parent who committed suicide. They may blame themselves for their parents' unavailability and may harbour feelings that they must be unworthy for their parents not to care (Norman, Matzopoulos, Groenrwald & Bradshaw, 2007). These feelings of being isolated, humiliated, angry, guilty and depressed often are overwhelming during this stage of emotional turmoil. According to Gladwell (2000), the motivation for suicidal gestures and attempts often is not the wish to die. The most common motivating factors include the wish to alter an intolerable situation and relieve painful feelings, the wish to join a dead relative or a friend to lessen isolation and provide comfort, the wish to retaliate and the wish to gain affection and sympathy. These motivations reflect the immaturity in youth

thinking processes. They feel that their death will bring about a positive change and they will benefit from that change (Norman *et al*., 2007).

Having unsupportive parents was directly associated with suicidal phenomena in a study by Tuisku *et al*. (2009). It is unclear whether the associations with other emotional aspects of the relationship between youth and their parents are direct. Too little or too much parental supervision or over-protectiveness is also associated with an increased prevalence of suicidal phenomena, as is poor general family functioning (Tuisku e*t al*., 2009).

2.6.3 Poor communication

The findings of Guo and Harstal (2002) indicate a significant relationship between suicidal phenomena and communication with family members. Good communication with, and feeling understood by family members are associated with a lower prevalence of suicidal thoughts and behaviours. In that case emotional aspects of the parental relationship are also relevant. Samm (2010:27) indicates that a human being is part of a family; problems arise when an individual is treated in isolation to his/her important relations or support systems. Samm (2010:28) concludes that mental health symptoms are not only the outcome of the person‘s inner processes, but also the relationship with other people. Thus, the direct environment and social context to which he/she belongs helps him or her to remain constant.

Self-harm and suicidal behaviours are associated with a family‘s communication style, according to Wedig and Nock (2007). Both good communication with and feelings understood by family members appear to reduce risk (Berg-Cross, 2000). It is therefore the communicative behaviour between people that creates relationships and upholds them. The family setting can have either a curative effect or facilitate the appearance of health problems. Slee, Garnefski, Van Der

Leeden, Arensman and Spinhover (2008) found that adolescents who indicated that their communication with their mothers and or fathers was difficult had an increased likelihood of suicide ideations. It can be concluded that good parent-child communication is a significant resource for decreasing suicide among youth.

2.6.4 Family history of suicide

Suicidal behaviours in family members have long been cited in the literature as a predisposing factor. Suicide runs in families (Zalsman, Levy & Shovel, 2008). Family factors, including parental psychopathology and family history of suicidal behaviour are associated with an increased risk of adolescent suicidal behaviour (Beautrias, 2000). The attempted or completed suicide of a close relative can have a tremendous impact on children and can lead them to consider or attempt suicide. This statement is supported by Wolfe, Foxwell and Kennard (2014:12), who maintain that due to the close proximity of youth and their parents, parental suicide attempts may be the most significant form of exposure.

Qin *et al*. (2003) found that people with a family history of completed suicide, as compared with those without such history, were at a 2.1–fold increased risk of committing suicide. In addition, youth who engage in suicidal behaviour often have a high rate of suicidal behaviour in their families, and studies of familial transmission indicate that parents of youth suicidal behaviour victims have higher rates of suicidal behaviour, independent of the presence of psychopathology (Mann, 2002). Men who have a history of previous suicidal threats or attempts are at higher risk of attempting suicide in the future (Mpiana *et al*., 2004). Zalsman (2012) maintains that the prevalence of suicidal behaviour in families could be caused by the genetic transmission of underlying psychiatric illnesses.

According to Mittendorfer-Futz *et al*. (2008), there is strong and convergent evidence that behaviour is familial, and perhaps genetic, and that the liability to

suicidal behaviour is transmitted to families independently of psychiatric disorder. Whether or not the liability to suicidal acts manifests itself will depend on circumstances facing the individual later in life. More conclusive evidence of an association between family mental health and suicidal phenomena was established by Melter, Lader, Corbin, Singlton, Jenkins and Brugha (2002) but it is unlikely that this association is direct. A mediating variable may be an effective disorder which is a major depression, thought to be at least partially genetically determined.

Mann (2002) and Zalsman (2012) state that although genetic factors account for about 45% of the variance in suicidal thoughts and behaviour, the specific genes that contribute to vulnerability for suicidal behaviour are unknown.

2.6.5 Family history of drug use

There is some evidence for an association between drug and alcohol use by family members and an increased prevalence of suicidal phenomena in adolescents, but again this association appears to be indirect, factors such as family dysfunction and parental criminal behaviour explaining the association (Samm *et al.,* 2010).

2.6.6 Poverty in the family

A negative home environment can also influence suicidality in children. According to Burrows and Laflamme (2010), youth appear to be at a greater risk for suicide ideation and attempt if they come from a socially and economically disadvantaged home. Poverty is therefore linked to suicidal behaviour.

According to the Daily Maverick (2015), the socio-economic context has significant bearing on the prevalence of suicide in South Africa. This is due to high levels of unemployment and poverty. Statistics South Africa (2015) indicates that in the second quarter of 2015 the official rate of unemployment fell to 25.0%.

However, the expanded definition shows an unemployment rate at 34.9%, including discouraged workers. The unemployment rate for youth younger than 25 years is 63.1%. Although there is an improvement in employment, by global standards these figures remain exceedingly high.

Cubbin, Leclere and Smith (2000) state that most often people living in low socio-economic status areas have an increased risk of suicide. Although some studies on the relationship between socio-economic changes have produced divergent results, others have highlighted the impact on suicidal behaviour of both adverse socio-economic factors, as well as economic development (Soukas *et al*., 2001). Contemporary research has shown that low socio-economic status increases the risk of suicidal behaviour, as do low educational levels and long-term unemployment. Economic development can also result in social problems that can increase suicidal behaviour (Van Heeringen *et al*., 2000). In such cases, suicide becomes a reaction to major economic losses in families, increased pathological gambling, increased health care costs that make it difficult for families to access it, weakening of family ties and social support, and an increasing economic and social gap between the rich and the poor, resulting in high levels of frustration (Weare, 2000).

South African studies have found that the role of socio-economic correlates that contribute to suicidal behaviour risks in particular are: financial problems and associated feelings of loss of parental support, the effects of rapid urbanisation, an increased competitiveness in education and employment, as well as rising expectations in the young, as young people move away from traditional values systems and norms (Alonso-Betancourt, 2012).

In most societies men remain the chief breadwinners in the family. Even in the situation where the wife works, men continue to earn disproportionately higher salaries than women. The notion of being the main financial contributor puts men

under extreme pressure to maintain the status of the breadwinner. In cases where men fail to live up to these expectations, their ego is seriously undermined. This low ego strength may be viewed by men as stripping them of their masculine role in the family (Drydne-Edwards, 2011).

2.6.7 Family history of sexual and physical abuse

There appears to be a direct association between physical abuse and suicidal phenomena. An important mediating factor in the relationship between sexual abuse and suicidal behaviour may be low self-esteem, according to Mandrusiak, *et al.* (2006). Berman and Jobes (1995) found that retrospective recall of corporal punishment during adolescence was associated with later life suicide ideation. However, the association may be dependent on the severity of suicidal phenomena, such as suicide attempts, but not with suicide ideation. There may also be differences depending on the perpetrator of the abuse and the severity and duration. Furthermore, serious abuse by parents may be associated with additional risk factors, such as a family history of mental health problems or drug and alcohol abuse (Flouri, 2005).

Esposito and Clum (2002) found that exposure to child sexual abuse and child physical abuse leads to significant increase in the occurrence of a variety of poor mental health outcomes, including suicide ideation and behaviour, experienced between ages 16-25, and that exposure to child sexual abuse had more deleterious effect on mental health outcomes than exposure to child physical abuse only. According to Seedat, Van Niekerk, Jewkes, Suffla and Ratele (2009), approximately 50% and 33% of suicide attempts among women and men respectively, are attributable to the experience of childhood adversity including physical abuse, sexual abuse and witnessed domestic violence, indicating that even a small reduction in these childhood experiences could have a dramatic effect on reducing the prevalence of suicide attempts in the general population.

Considerable evidence for a strong and direct association of sexual abuse and suicidal phenomena was found by Esposito and Clum (2002). In addition Ghaffari *et al.* (2011) concluded that reactions to sexual assault differed by gender: females were more likely to be affected by medico-psychological symptoms such as nightmares and somatic complaints, whereas males expressed symptoms such as repeated suicide attempts and substance use. An important mediating factor in the relationship between sexual abuse and suicidal behaviour may be low self-esteem (Brent, Oquendo, Birmaher, Greenhill, Kolko, Stanley, Zelazny, Brodsky, Bridge, Ellis, Salazar & Mann, 2002).

Childhood physical or sexual abuse is a common factor among adolescents who attempt or complete suicide. Studies that have controlled for the presence of other risk factors, such as individual or parental mental disorders, have found that adolescents with a history of physical abuse are five times more likely to make a suicide attempt than those who have not been abused. Adolescents who have been sexually abused are more than seven times more likely to attempt suicide (Brent *et al*., 2002).

2.7 FACTORS IN SCHOOLS

Poor school attendance was positively associated with suicide attempts and suicide ideation by Gould *et al*. (2006). King and Smith (2000) also established that a negative attitude towards school and school work was associated with an increased prevalence of suicidal phenomena. Poor school attendance was positively associated with both suicide attempts and suicide ideation (Lishman, 2005).

Experiencing peer-driven violent behaviour (such as bullying, extortion, or coercion to use alcohol or drugs) is also a significant risk factor in that it can quickly lead to feelings of hopelessness and despair (Schlebusch, 2004).

Particularly strong and direct links were found between suicidal behaviour and exposure to suicidal acts by friends (Flouri, 2005). Exposure to peer suicide is related to increased suicide ideation and suicidal behaviour (Crepeau-Hobson & Leech, 2014). The strong modelling influence on youth of suicidal behaviour by peers is also shown by the clustering of suicide that can occur in the age group.

Klomek, Kleinman, Altschuler, Marrocco, Amakawa and Gould (1999) found that boys who were both bullies and victims of bullying had a higher likelihood of suicidal behaviour as compared with those who did not exhibit bullying behaviour or who were only victims. On the other hand girls who were victims of bullying were more likely to exhibit suicidal behaviour as compared to those who were neither bullies nor victims. Barker and Barker (2000) examined the developmental trajectories of bullying and victimisation during adolescence on delinquency and self-harm in late adolescence. For both boys and girls, those in the bully-victim trajectory showed significantly higher levels of self-harm than their same-sex counterparts in all of the other trajectories. The girls in the bully- victim trajectory had higher rates of self-harm than their male counterparts (Smith, 2004). It is a common problem in schools and many children and youth who are bullied feel worthless and hopeless. Being bullied can make people feel depressed and sadly many youth who are targets of physical or cyber bullying attempt suicide or become very depressed (Litwiller & Brausch, 2013:2).

2.8 SOMATIC CO-MORBIDITY

There can be a relationship between physical disease and suicidal behaviour (Schlebusch, 2011; Wassermann & Wasserman, 2009). For example, in some instances a link has been shown between indirect self-destructive behaviour resulting in analgesic nephropathy (end-stage renal disease as a result of analgesic abuse), and suicidal behaviour and potentially life-threatening disease such as cancer and HIV/AIDS (Schlebusch, 2011). These diseases can

constitute a life crisis resulting in a gamut of psychological problems (Schlebusch, 2011).

There is also growing evidence of the long-term sequelae in childhood cancer that can contribute to suicide risk factors in adulthood due to the traumatic experience of children with cancer emanating from hospitalisation, oncology treatment and altered social contact (Schlebusch, 2012:438). However, knowledge in this area regarding young people remains sparse. Van Dyk (2001) indicates that suicidal behaviour in patients with chronic illnesses, such as cancer is a poorly researched area in South Africa. Nevertheless, such patients can be psychologically severely affected should there be an adult suicide or attempt in their family and this can be a risk factor for later suicide attempts in children (Bertolote, Fleischmann, De Leo & Wassermann, 2004). Feelings of helplessness and hopelessness are two signs of depression that occur in people with life-threatening illnesses (Meel, 2003).

South Africa is experiencing a quadruple burden of diseases comprising of communicable diseases (HIV and TB), non-communicable diseases including nutritional deficiencies and emerging chronic diseases, poor living conditions, injuries and HIV/AIDS (Bradshaw, Richel & Anderson, 2003). Globally suicide and HIV and AIDS remain two of the greatest health care issues, particularly in low and middle income countries where approximately 85% of suicide occur (Govender & Schlebusch, 2013:58). The risk of suicide appears to be increasing in the context of the HIV epidemic. The risk factors for suicide are diverse and interrelated and may be particularly complex in HIV-infected individuals. In South Africa HIV/AIDS sufferers have been shown to have a high suicide risk under certain conditions (Go vender & Schlebusch, 2012). There is a substantially increased likelihood of suicidal behaviour (Catalana, Harding, Sibley, Clucasc, Croomec & Sherr, 2012), with an association between HIV testing and suicide ideation before the test results, not being reported (Van Dyk, 2001).

Govender and Schlebusch (2012) found that among HIV positive persons in South Africa, suicide ideation increased over a six week period and was present in 24% of the HIV positive participants following HIV counselling and testing. Although the international findings on the correlation between suicide and HIV and AIDS are diverse, the results show compelling evidence to screen for suicide risk (Catalan *et al.,* 2012).

One systemic literature review conducted by Catalan *et al*. (2012) showed a high suicidal risk in persons with HIV: 19.7% were described as generally suicidal, 26.9% as having suicide ideation and 9.4% completed suicides. According to Schlebusch (2004), the contributory factors to an increased risk of suicidal behavior comprise of critical psychosocial stressors of HIV/AIDS with social stigma, discrimination and isolation, lack of support from family and friends, and social devaluation as main culprits.

2.9 METHODS USED IN SUICIDAL BEHAVIOUR

Numerous factors influence the choice of technique used in suicidal behaviour, such as: (a) accessibility; (b) knowledge or lack thereof; (c) experience and familiarity; (d) meaning, symbolism and cultural influence; (e) the suicidal person‘s state of mind; and (f) level of intent (Schlebusch, 2004). With regard to the methods used for fatal suicides, hanging is usually reported to be the most common, typically accounting for between 34-43% of suicides, followed by firearms (29-35%), poison ingestion (9-14%), gassing (6-7%) and burning (2-4%) or jumping (2-4%) (Burrows & Laflamme, 2006; Schlebusch, 2012:437). According to Nouma, Ammar, Bardaa and Hammami (2015:4), victims aged 10-34 years mainly use hanging. Madu and Matla (2003:126) also found that the most frequent methods used for attempted suicide was self-poisoning (44%) followed by drug overdoses (25.3%) and hanging (22%). The latter findings were based on school adolescents in the Limpopo province of South Africa. However, where

observed, these devices typically differ significantly across sociodemographic groups (Burrows *et al*., 2006). the above pattern is characteristic of male suicides as poison consumption is prevalent among female suicides followed by firearms or hanging.

The main choice of methods in non-fatal suicidal behaviour includes about 90% overdose and 10% self-injury (Schlebusch, 2012:437). Across different age groups, hanging dominates until middle age, after which firearms become the prominent way. Blacks and Coloureds use hanging extensively more often than any other method (Bertolote *et al*., 2004). For Coloured males the most common method was usually hanging, while the most popular method for Coloured females was poison ingestion.

Whites are the only ethnic group for whom gassing suicides are remarkable, accounting for about 15% of white suicides. Eckert, Miller, Du Paul and Riley-Tillman (2010) reported that four-fifths of adolescents‘ suicide took place in their homes, and most of the firearms were owned by parents. This highlights the importance of limiting youth‘s access to firearms, as discussed in Chapter 3 (*cf*. 3.2.1.4). Different methods of committing suicide are used across ethnic groups for males and females.

For non-fatal suicides, collectively the research by Bertolote *et al*., (2004) shows that the overall choice of method in 90% of non-fatal suicidal behaviour is overdose of a variety of substances including over-the-counter analgesics (painkillers), benzodiazepines (tranquilizers) and anti-depressant. Other methods used, especially among Blacks, include self-poisoning by household utility liquids, such as paraffin, rat poison and various poisons, hanging and throat lacerations (Schlebusch *et al*. 2009). Many people believe that youth who cut or hurt themselves are suicidal. This isn’t always true. People hurt themselves as a way to cope with problems (Bertolote *et al*., 2010).

Self-harm accounts for about 10% of acute medical admissions. Clark (2004) maintains that South Africa has a severe problem with self-destructive behaviour which needs to be addressed. Epidemiological studies indicate that deliberate self-harm is more common in younger adults, particularly women between 15 and 30 years, those from lower socio-economic groups and the unemployed. Stressful life events, especially quarrels or relationship difficulties, can be precipitating factors (Bostwick & Pankratz, 2000).

The leading choice of method in young people, according to Dobson (2008), consists of hanging, poisoning (including overdose with a medical substance), fire-arms, gassing and fenestration (jumping from high places) and overdosing. In non-fatal suicidal behaviour, overdosing and self-lacerations are most common. Drug overdose is the major method of female suicide, while men are more likely to choose more violent means of death. Thus, a person having decided to end his life or acting on a sudden impulse to do so kills himself having chosen the most effective method available and having made sure that nobody interferes (Fallow, 2007:159).

The peak time for suicides is 07:00-20:00, mostly over weekends (Mondays – 16.4%, Saturdays – 14.6% and Sundays – 14.5) and towards the end of the year. The latter, also because of examination pressures and attempts to enter university, is a high-risk period for suicidal behaviour in the young (Schlebusch & Burrows, 2009; Schlebusch, 2012:437).

2.10 CONCLUSION

This chapter discussed epidemiological trends in suicidal behaviour, which can range from being lethal to non-lethal attempts. Non-fatal suicide is prevalent among females, with fatal suicide more prevalent among males. Figures reflect only a part of the problem because of the lack of reliable data and reported prevalence rates are diverse.

The section on factors increasing the risk of suicide indicates very complex, multi-causal human behaviour with many causes and several biological as well as psychosocial and cultural components. Furthermore, many studies point out that suicide could be interplay of a wide array of factors, including biological or genetic, sociocultural, psychological, and behavioural factors (Hawton & Van Heeringen, 2000).

The many factors that put youth at risk of suicide should be recognised in order to develop and implement preventative and protective strategies. It is believed that only strategies from multiple levels and disciplines can help in reducing suicides substantially. The next chapter focused on suicide intervention.

CHAPTER 3

SUICIDE INTERVENTION

3.1 INTRODUCTION

As indicated in Chapter 2, suicidal behaviour in youth has become exponential and constitutes a major public health problem with significant implications for the future of youth in South African schools. In such situations preventative measures have to be taken to mitigate the risks. The question that comes to mind is: which interventions would be appropriate for youth at risk?

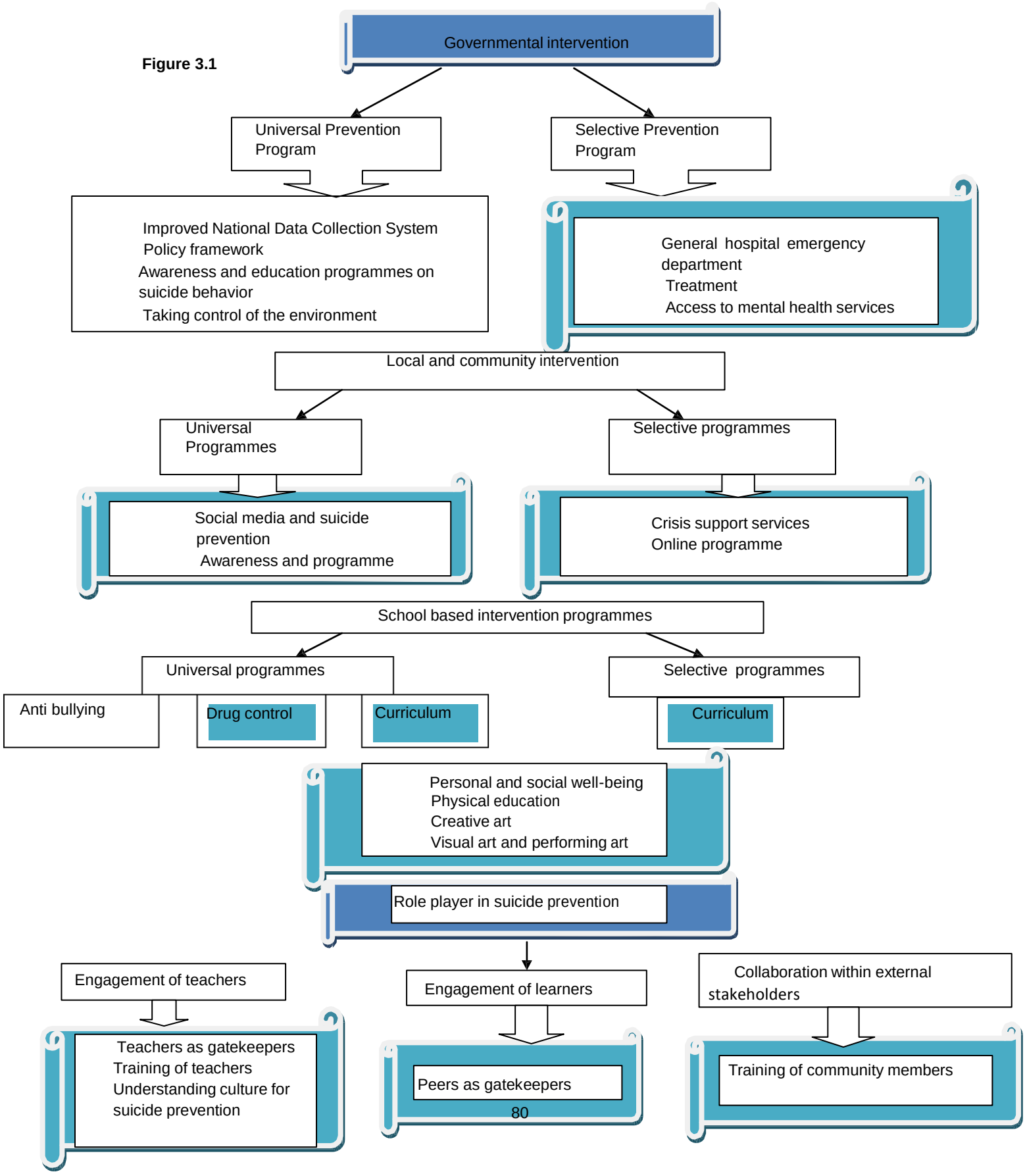
The outline and structure for suicide prevention indicated in this chapter is underpinned by research undertaken locally and internationally, based on existing initiatives for suicide prevention in South Africa. The preventions for reducing suicide behaviour that form the basis of the following discussion are also from research conducted in health. There has not been much research conducted in schools in South Africa about mental health.

The objective of this chapter, therefore, is to obtain a better understanding of prevention strategies and identify priorities for reducing suicidal behaviour in youth in South Africa on the one hand, and on the other, to assist in developing a framework for effective preventative strategies (*cf.* 6.6).

Prevention programmes differ in their approach and implementation. There are universal, selective and indicated programmes. Universal programmes, which focus on education and awareness to the benefit of the whole population, are discussed first, followed by selected programmes, which mainly target youth at risk of suicide. The indicated programmes will not be discussed in this research as the focus is on youth at risk and not those who attempted suicide or who are suicidal. The school programmes are also presented.

The summary of this chapter is illustrated in figure 3.1 below.

Figure 3.1


Governmental intervention
Universal Prevention Program
Selective Prevention Program
Improved National Data Collection System
Policy framework
Awareness and education programmes on suicide behavior
Taking control of the environment
General hospital emergency department
Treatment
Access to mental health services
Local and community intervention
Universal Programmes
Selective programmes
Social media and suicide prevention
Awareness and programme
Crisis support services
Online programme
School based intervention programmes
Universal programmes
Selective programmes
Anti bullying
Drug control
Curriculum
Curriculum
Personal and social well-being
Physical education
Creative art
Visual art and performing art
Role player in suicide prevention
Engagement of teachers
Engagement of learners
Collaboration within external stakeholders
Teachers as gatekeepers
Training of teachers
Understanding culture for suicide prevention
Peers as gatekeepers
Training of community members

Mental illness prevention is defined by the World Health Organisation (2004) as aiming –t0 reduce the incidence, prevalence, recurrence of mental disorders, time spent with symptoms, or risk factors for a mental illness, preventing or delaying recurrences and decreasing the impact of illness in the affected persons, their families and societyll. Governmental interventions should therefore focus on these issues. It should be mentioned though that there is no evidence of effectiveness of universal mental interventions. Government strategies, according to Talane (2009), are intended to draw together various government departments and other efforts to broaden the public's awareness of suicide and its risk factors; enhance population-based and clinical care services/programmes, policy guidelines on child and youth mental health and life skills programmes; and suicide prevention through effective monitoring systems and research. Stoep, Weiss and Kuo (2003) state that no national programme exists in South Africa. There is therefore, no comprehensive multi-sectoral approach in the implementation of programmes.

3.2 GOVERNMENT INTERVENTIONS

The burden of suicidal behaviour in South Africa accentuates the need for suicide prevention as a national priority.

3.2.1 Universal prevention programmes

The whole population is the recipient of universal programmes designed to mitigate suicide in the society. In addition to their utility for a large proportion of people, universal programmes create an environment conducive to implementing selective and indicated programmes. The goals of universal programmes are to: reduce suicide deaths and non-fatal suicidal behaviour; lessen risk factors and encourage protective factors; promote the early recognition of new trends and a reversal of developing problem areas; arouse public awareness of suicidal

behaviour, its sources and potentials for prevention; and intensify support available to individuals, families and communities affected by suicidal behaviour (Wassenaar *et al*., 2000).

These programmes are presented to the whole given population regardless of their level of risk. The public health approach, according to the World Health Organisation (2010:4), focuses on identifying the patterns of suicide and suicidal behaviours of a group or population. To allow for a change in the environment to protect people against mental ill health and changing the behaviours that put them at risk of suicide there is a need to install a surveillance system to estimate the occurrence of suicide across a nation (Mercy & Rosenberg, 2000). Suicide prevention and its programmes attempt to mitigate risk factors and promote protective factors.

3.2.1.1 Improved national data collection system

Constant and precise information on suicidal behaviour is of imperative in detecting high risk individuals, groups and places, and in observing trends so that suitable interventions can be timeously established and assessed (Burrows, Bowman, Matzopoulos & Van Niekerk, 2001). The World Health Organisation (2010:5) indicates that many countries use surveillance to identify suicide patterns and different suicide rates according to age and geographical location. The surveillance system may include information on the characteristics of individuals who die by suicide. Data gathered help to identify and define the problem.

The National Injury Mortality Surveillance System (NIMSS) is the only origin of constant epidemiological information on suicide mortality in South Africa (Schlebusch, 2004). It has critically heightened the understanding of the suicide profile across various groups of the population. From 2001, the NIMSS has had full coverage in six cities, namely Johannesburg, Tshwane/Pretoria, Durban, East London, Port Elizabeth and Cape Town and, from 2007 to 2010, has also had full

coverage for the province of Mpumalanga and for most of Gauteng. This system has yet to extend to other areas of South Africa and cover all nine provinces. Data are collected at state mortuaries by the police and forensic pathology departments (Matzopoulos, Prinsloo, Butchart, Peden & Lombard, 2006: 29). Definite suicides in the NIMSS report are based on the decision made by the medical practitioner performing the autopsy (Burrows & Laflamme, 2005:109).

Having a reliable and valid suicide data is particularly relevant for South Africa considering its poor historical record keeping of statistics. However, the limitation in the NIMSS data collection is the lack of full coverage of all the provinces, particularly the rural areas (Schlebusch, 2011:436). Burrows and Laflamme's (2007) study which examined the accuracy of NIMSS data for the city of Tshwane, found that the sensitivity, specificity and predictive values were generally high, and varied only slightly across socio demographic groups. In the medico-legal system, one-third of cases could not be tracked, had not been finalised, or had unclear outcomes. The validity of the data has not been checked in other cities.

Schlebusch (2011:436) argues that suicide mortality represents only a small proportion of all instances of suicidal behaviour and is the endpoint of the process of suffering. There is therefore a need for similar surveillance system for non-fatal cases, with the possibility of intervening earlier in the process. As indicated in Chapter 2 (*cf*. 2.3), a system for monitoring the prevalence of mental illnesses cannot be effective if it is not combined with other systems to provide accurate statistics keeping.

Literature highlights a number of challenges pertaining to data collection which render the final reports unreliable. These include: inadequate classification of injuries; often only the nature of the injury was reported for injury deaths; the incidences of many important mechanisms of injuries such as firearm injury, poisoning and burn injury cannot be determined from the summary lists (Bhalla, Harrison, Shahraz & Fingerhut, 2010:833). These are serious shortcomings that

hamper the development of strategies to deal reduce injuries. Reliable estimates of the incidence of external causes of injuries are needed for such initiatives, according to Lawrence, Miller, Weiss and Spicer (2007).

In South Africa, there is a need to improve the data collection system. Fulltime centres across all provinces to continuously collect and assess the data for communities and cities are imperative. Full coverage is also needed in rural areas where suicide has a high rate. As McKenzie, Enraght-Moony, Harding, Walker, Waller and Chen (2008) suggest, the national data should be validated and data quality should be improved. This has not been done effectively in South Africa.

Policies have to be developed in order to guide the implementation of mental health programmes.

3.2.1.2 Policy framework

Few policies that are meant to curb mental ill health have been developed in South Africa over the years. These policies include the national health policy guidelines for improved mental health (Department of Health, 1997). More recently, there have been reforms in mental health legislation in South Africa through the adoption of the new Mental Health Care Act (No. 17 of 2002). According to the World Health Organisation (2005), the act is consistent with international human rights standards, and sets in place mechanisms for decentralisation of services, integration of mental health into general health care and the development of community-based care. The national health policy was, however, not published for dissemination, as indicated by the World Health Organisation (2007). In the absence of a national policy, the Free State and North West provinces developed their own provincial mental health policies, using the Mental Health Care Act (No 17 of 2002) as a guide. Without an endorsed national health policy it becomes difficult for any country to meet the needs of mental health. It is therefore not surprising that this situation led to a

lack of separate strategic plans for mental health in all nine provinces in South Africa, except for KwaZulu-Natal. This also meant that mental health plans would be integrated within the general health plan for the provinces (Lund, Kleintjes, Kakuma & Flisher, 2010:402), resulting in the lack of a strategic focus in dealing with mental health issues.

Research conducted by Lund *et al.* (2010) indicate the continued unmet need for mental health care in South Africa. This is so because without clear imperatives from the National Department of Health, provincial departments have been free to address mental health according to their own priorities. This has led to inconsistency with regard to resource allocation and data collection and a lack of standardisation of the training of public health and a formalised inter-sectoral collaboration with other departments and stakeholders.

These challenges led to the development of the National Mental Health Policy Framework and Strategic Plan (2013-2020) by the Department of Health, which was approved as policy in 2012 and adopted by the World Health Assembly in 2013 (Stein, 2014:115). This means that South Africa has only recently started to focus on addressing mental health issues. Stein (2014:115) also argues that perhaps less attention is paid to the question of the individual and social factors that promote the development and implementation of such policy-making.

According to the National Mental Health Policy Framework and Strategic Plan (2013-2020), mental health care continues to be under-funded and under-resourced, compared to other health priorities in the country. Kauye (2008), Ssebunnya, Kigozi, Kizza and Ndyanabangi (2010) postulate that the absence of funding remains the dominant reported impediment to programme implementation. It remains to be seen how these complexities will be addressed in future.

Other initiatives discussed elsewhere in this research include the development and implementation of policies guiding child and youth mental health

interventions, the Health Promoting Schools initiative (*cf*. 4.5) and a life skill programmes (*cf*. 4.6). These initiatives are intended to draw together other other departments for a concerted effort to equip youth to deal with life‘s challenges (Department of Health, 2003).

3.2.1.3 Awareness and education programmes on suicidal behaviour

Programmes which increase knowledge of mental illness and of health-promoting measures as postulated by Wasserman (2001), intend to remove the fears and misunderstandings surrounding suicide. For example these determinations will provide well-formulated information that does not incite suicidal behaviour among helpless individuals. Kakuma, Kleintjes, Lund, Drew, Green and Flisher (2010) highlight the importance of awareness to reduce stigma. They advocate a strategy that is culturally appropriate as mental illness and its causes can be interpreted differently, according to people‘s beliefs. For example, mental illnesses are often believed to be the result of bewitchment or a failure to appease one‘s ancestors, or having insufficient faith in one‘s religion (Kakuma *et al*., 2010:122). In some African cultures a psychotic episode closely resembles the ‗calling‘ to become a traditional healer (Buhrmann cited by Kakuma *et al*., 2010).

In addition, not only are there direct influences in terms of support due to general training programmes for people coming into contact with suicidal individuals the trainees may be equipped with skills for handling the situation, as indicated below (*cf*. 3.6.1.2 and 3.6.3.1). Part of this process is to promote the activities of World Suicide Prevention Day, held annually on 10 October. The aim of this commemoration is to create public awareness and to make issues related to mental health a global priority.

It is important to celebrate World Suicide Prevention Day and make the public and victims aware that the government is not concentrating only on illnesses such as HIV/Aids, Cancer, TB etc. but also on suicide prevention. The problem is

that the awareness campaign is only for a day and people forget about mental illness for the rest of the year. Suicidal behaviour in South Africa can decrease if there is a concerted effort to deal with mental illness.

3.2.1.4 Gun and drug control

It has been proposed that the environment should be controlled to decrease the incidence of suicidal behaviour (Leenaars, Wenckstern, Appleby, Fiske, Grad & Kalafat, 2001). Within this approach the government reduces the availability of and access to means of suicide. For example gun possession control, detoxification of domestic gas and car emissions, control of availability of toxic substances including pharmaceutical drugs, fencing high buildings and bridges, as well as toning down reports in the media will be some of the approaches embarked on.

According to Norman *et al*. (2007), nearly half of South Africa‘s deaths are due to injury caused by interpersonal violence. Furthermore, an estimated 3.5 million people seek health care for non-fatal injuries every year (Butchart, Peden & Burrows, 2001), of which half are caused by violence, as indicated by Matzopoulos *et al*. (2006). Many injuries in violent confrontations are caused by sharp objects and just over a third are as a result of gun shots (Dobson, 2008).

A number of initiatives has been coordinated by the government departments and non-governmental organisations. However, gun ownership and gun-related incidents remain high (Seedat *et al*, 2009:1018). The progress regarding gun control has been slow due to a violent crime problem in the country. David, Luxton, Jennifer, June, Jonnathan and Fairall (2012) maintain that there are several reasons for this sluggish process: farmers feel under threat; the private security industry is one of the biggest in the world; and there is a vibrant commercial hunting industry. Seedat *et al*. (2009) postulate that there are no policy initiatives directed at either further restriction of firearm ownership or enforcement of existing laws, including those regulating care of firearms carried

by police. This is of concern as guns are easily accessible, and can be used as a method of self-harm. Gun-related deaths could be prevented with tight laws regarding gun ownership.

There have been some restrictions on alcohol advertising and sponsorship, modest efforts to apprehend drunk drivers, and increased taxation on alcohol products, but beyond these efforts the government has shown little concrete evidence of reduction of national alcohol consumption, which is not yet a prominent policy goal. Welchsler and Nelson (2010) advocate for raising the minimum legal drinking age from 18 to 21 years. It is believed that when higher minimum drinking laws are introduced deaths by accidents and suicide will be reduced. Currently in South Africa youth succeed in buying liquor regardless of the minimum drinking age.

Carney, Myers, Louw, Lombard and Flisher (2013) and Myers, Kline, Doherty, Carney and Wechsberg (2014) reported high levels of alcohol use by learners in high schools. A study by Chauke, Van der Heever and Hoque (2015) about alcohol use among learners in rural high schools in South Africa found that high school learners, both male and female, were binge drinking. According to Chauke *et al*. (2015: 4), availability, accessibility, socio-economic and environmental factors contribute to hazardous drinking patterns. Inconsistent enforcement of liquor laws and lack of community support for under-age alcohol sales enforcement are said to be the main challenges to the reduction of alcohol intake by youth (Welchsler & Nelson, 2010).

Restricting access to locations as means to suicide is one of the few prevention methods listed by the World Health Organisation as strongly evidence-based (Mann *et al*., 2005). International evidence from the Golden Gate Bridge in San Francisco, the Empire State Building in New York, the Grafton Bridge in Auckland, and Oshima in Japan, to name but a few, has shown that restricting access to known suicide hotspots will result in people not substituting with

another method of death or even another location for jumping (Beautrais, Gibb, Fergusson, Horwood & Larkin, 2009).

Mail and Guardian (2013) has reported that the department of justice is in the process of amending the Drugs and Drug Trafficking Act (No 140 of 1992). According to this act, drug dealers of *nyaope* or *whoonga* (a drug made up of, among other things, rat poison, dagga, heroin and anti-retroviral medication), mostly used by youth, cannot be arrested for possession and dealing. This is because it is not yet listed among drugs that are illegal. It is only when people are found in possession of substances containing prohibited drugs that they are liable to be arrested in terms of the act. Such drugs may include heroin and dagga.

The next section pertains to selective programmes that are offered at national level. As indicated in the foregoing paragraphs, selective interventions involve youth identified as at risk of suicide. As this research focuses on youth at risk, indicated interventions which target individuals identified with mild to moderate symptoms of suicide behaviour (Fleischmann, Bertolote, Wasserman, De Leo, Bolhari, Botega, De Silva, Phillips, Vijayakumar, Värnik, Schlebusch & Thanh, 2008:703) do not fall within the scope of this research.

3.2.2 Selective programmes

As indicated in Chapter 2, the high suicidal behaviour prevalence rates have considerable implications for mental health care facilities in South Africa. It is suicidal thinking that typically indicates a high risk of suicidal behaviour. These factors suggest that preventive strategies should provide evidence of intervention in order to track and measure mitigation of risk. The strategies discussed in this research include treatment, and access to mental services.

3.2.2.1 General hospital emergency department

The most common site of service following a suicide attempt is the general hospital's emergency department. Although the emergency department of a general hospital has been found to reduce depression and suicidality in adolescents who use the service (Hazell, 2000), using adult services for youth has long been questioned. Crisis support services and mental health intervention services are rarely age specific in general hospitals. The treatment discussed below is for people having depression and mental ill health problems, including youth.

3.2.2.1.1 Treatment

There is strong research evidence that early treatment with psychotherapy and medication can stop the symptoms of depression from becoming more severe and long-lasting. It can lessen the possibility of recurrence and reduce the risk of suicide as an outcome. Generally, regular, on-going monitoring by a physician or a mental health professional warrants that symptoms are kept under control. The essential point to remember, according to Masango *et al*. (2008), is that effective treatments are available for adolescent mental disorders. Once in treatment, most youth with one of the disorders described in Chapter 2 (*cf*. 2.4.1) will show not only improved mental health, but also marked improvement in their attitude and behaviour in relation to school, social interactions and use of alcohol or illicit drugs (Masango *et al*., 2008).

Yet, in spite of these gains, Lund *et al*, (2010:394) argue that mental health services in South Africa have been chronically under-resourced. This situation is even worse for children and youth experiencing mental health problems. According to Lund *et al*. (2010:396-397), there are 3,460 outpatient facilities in all nine provinces of South Africa offering mental health services. Only 1.4% of general health facilities provide services exclusively for children and adolescents. The situation is dire even in psychiatric in-patient units in general hospitals. Of these there is a total of 41 in the country with 2.8 beds per 100,000 of the population, of which only 3.8% of the beds are reserved for children and

adolescents. Furthermore, the Free State has the second highest number of outpatient clinics, namely 670, after Limpopo which has 700. However, there is only one adolescent outpatient clinic, one psychiatric in-patient unit and one mental hospital for the whole Free State. This information indicates the extent of the problem regarding mental health services in South Africa.

Another problem highlighted by Hazell (2000) is that general health and emergency services staff that often respond to suicide crises have minimal mental health training. The ability of staff to adapt basic training to be youth-specific is therefore restricted.

3.2.2.1.2 Access to mental health service

While not all young people who are suicidal may have a clinical disorder, mental health services of varying forms are often the best placed services to respond to their needs. Appropriate services that provide effective treatment and management to young people with mental distress and mental disorders should be prioritised to respond to suicide risk (Beautrais, 2000). Young people are typically avoidant of health and mental health services in particular. Their reluctance to seek professional help is identified as a challenge to effective early intervention approaches (Rickwood, *et a.l*, 2007: S35).

Reasons highlighted in the literature include shame, stigma and fear, which hinder youth help-seeking. Top of this list is mental health illiteracy. Youth are more likely to seek help when they are aware that they have a mental health problem. Without this recognition, the mental health seeking behaviour will be null and void. Therefore, public mental health services can play a major role in educating youth about mental illness.

Youth without access to specialised mental health services, general practitioner services and other health care staff, according to Guardian News and Media (2016), often do not have anyone to turn to when they are overwhelmed with problems.

Despite this, estimates suggest that fewer than 50% of young people get a referral following a suicide attempt, and up to 75% may not attend follow-up appointments (Breaking the Silence, 2010). This suggests that teachers in schools should be highly trained in recognising mental health problems and about mental health information and services.

In-patient hospital care, while sometimes necessary, can be very distressing for young people. Gould *et al*. (2003) state that there is no empirical evidence of the effectiveness of in-patient hospital care on long-term suicidality. This could mean that alternative inpatient and outpatient services need to be considered.

Greenfield, Larson Hechtman, Rousseau, and PLatt (2002) found that rapid-response outpatient treatment could reduce the need for adolescent hospitalisation for suicidality, while providing similar benefits to inpatient care. Similarly, Rudd, Joiner, Rajad, and Hasan (1996) established that intensive problem-solving group therapy was as effective as in-patient care, but additionally provided lower attrition rates for high-risk patients.

Cognitive Behavioural Therapy in an outpatient setting is one of the most recognised effective treatment interventions; contributing to marked reductions in depression, suicidality, and self-harming behaviours in patients, according to Slee *et al*. (2008). More recently, Robinson, Hentric & Martin (2011) undertook a meta-analysis of all randomised control trials conducted into youth suicide prevention in a clinical setting. Their findings indicate that the research in this area is sparse, but that Cognitive Behavioural Therapy demonstrated the best results for preventing youth suicidality, while attachment-based family therapy was worthy of future investigation.

3.3 LOCAL AND COMMUNITY INITIATIVES

As suicide is regarded as a complex issue with numerous contributing factors, community-based prevention strategies become the premier consideration in the

development and delivery of any initiative. Community-based programmes safeguard the safety and effectiveness of such approaches. Some strategies that are found in communities in South Africa will be discussed below.

3.3.1 Universal programmes

The universal programmes discussed in this section include: education and awareness programmes using media as a medium and also focusing on out-reach programmes. Media is used as both universal and selected programmes, as some sites focus on giving general information while others offer a platform for support groups and sharing of information.

3.3.1.1 Social media and suicide prevention

Social media is a relatively new phenomenon that fuses technology with social intervention via internet-based applications that allow the creation and exchange of user-generated content. The use of online chat rooms and virtual bulletin boards and forums provide an unmediated avenue to share one‘s feelings with others who are experiencing the same problems or are in the same situation. Such problems are easier to tackle in such mediums than talking about these thoughts and feelings in person. Social media platforms contain chat rooms and blogging web social networking sites including Facebook, My Space, Twitter, Google and others, electronic bulletin boards or forums, as well as e-mail, text messaging, and video chat. Kaplan and Haenlenin (2010:195) state that these platforms have transformed traditional methods of communication by allowing the instantaneous and interactive sharing of information created and controlled by individuals, groups and organisations. Social media have become fundamental in people and organisations to communicate and share opinions, ideas and information.

According to Luxton, June and Kinn (2011:1), social networking sites for suicide facilitate social connections among peers with similar experiences and increase

awareness of prevention programmes, crisis help-lines, and other support and educational resources. For example, the National Suicide Prevention Lifelines Facebook page had more than 29 300 fans as of November 2011, and the American Foundation of Suicide Prevention Facebook page had more than 77 200 fans (David *et al*. 2012:197). Both of these Facebook pages provide links to suicide prevention websites and hotlines, as well as information about warning signs of suicide. This shows how popular social networking sites are among youth.

Moreover, David *et al.* (2012:197) postulate that social media sites allow interacting and sharing of relevant information, stories and events in local areas. You Tube also has many videos devoted to suicide prevention, including those in the form of public service announcements. Other videos on social networks are created by individual users and feature support and prevention content such as memorials for loved ones who died by suicide and personal stories of getting help (David *et al.*, 2012:197).

Cheng, Hawton, Lee and Chen (2007:197) indicate that the National Suicide Prevention Lifeline‘s lifeline-gallery.org website features an innovative social media platform in which suicide survivor stories are presented by animated avatars. These are graphical representation of the user or the user‘s alter ego or character. Site users can create and design the appearance of their avatars, write a description about their personal experience with suicide, and record their voices or choose a computer- generated voice-over to narrate their stories. The site also provides contact information for the National Suicide Prevention Lifeline and links to other suicide prevention organisations. According to Pirkis and Blood (2010:197), this site seems to be popular, as in November 2011 users shared more than 880 stories. The use of this form of social media provides an anonymous, personalised and interactive experience geared toward suicide prevention. There are examples of features on web and social media sites that allow for proactive prevention capabilities. Google‘s internet

search engine has a feature that displays a link and message about the National Suicide Prevention Lifeline at the top of the research page when keyword searches suggest suicidal ideation or intent such as ‗I want to die''. Although the establishment of these sites is helpful to the youth, the negative part is that pro-suicide sites are also produced (David *et al.*,2012:197).

Two other community-based strategies involve the education of media regarding responsible reporting of suicides and provision of crisis hotlines (Gould, Greenberg, Velting & Shaffer, 2003). Online communication and education are important in reaching people who are geographically and socially isolated, those without access to face-to-face services, and those who feel more comfortable with the convenience and anonymity of the Internet (McGrath & Van Vugt, 2009). In order to educate young people about the existence and risk of suicidal behaviours as well as the support systems available to them, McGrath and Van Vugt (2009) suggest that it is important to first understand the way in which youth are most likely to communicate and seek information. The Internet and new media are undeniably prominent features of youth culture. They represent growing sites for socialisation, education and recreation, as indicated in the foregoing paragraphs. Young people see the use of technology as a vital part of their social life, and often use it to express their identity (McGrath & Van Vugt, 2009). Online services therefore provide appropriate and accessible sites for young people to increase their mental health literacy and seek information about suicide prevention.

The problem arises when inappropriate and irresponsible media reporting of suicide occur; this can have negative consequences for vulnerable populations (Pirkis & Blood, 2010). The portrayal of specific websites or methods of suicide and the glamourisation of the individual and normalisation of their suicide can cause contagion behaviours, especially among vulnerable youth, as discussed in Chapter 2 (*cf*. 2.5). The media can help or hinder suicide prevention efforts by either being an avenue for public education or by exacerbating suicide risk by glamourising suicide or promoting it as a solution to life problems. Media

blackouts on reporting suicide have coincided with decreases in suicide rates. However, establishing media guidelines for reporting suicide has had mixed results (Gould, 2001). The potential benefits of positive media reporting upon increased awareness of suicide warning signs and the public domain suggest that the media could be further utilised to promote suicide awareness and prevention (Pirkis & Blood, 2001).

3.3.1.2 Awareness and education

Community organisations such as LoveLife, the South African Depression and Anxiety Group (SADAG), Samaritan Befrienders Worldwide and the World Health Organisation have done tremendous work in communities in South Africa. Their contribution in mitigation of suicide is discussed in this subsection. Because they all focus on awareness there is a slight difference in terms of their approaches.

LoveLife focuses on the country as a whole including rural areas, while the Samaritans Befrienders Worldwide focuses on a few selected areas in South Africa. The Love life to Live'campaign is aimed at adolescents, and focuses on the prevention of three current problems: suicide, HIV/AIDS, and substance abuse (Moodley, 2003). Very importantly, the campaign emphasises positive messaging in its public health approach towards suicide prevention. This is necessary considering that little attention has been paid to a positive framing'or health promoting approach in suicide prevention awareness efforts (Chambers, Pearson, Lubell, Brandon, O'Brien & Zinn, 2005:142).

The campaign involves a multifaceted programme. Firstly, it focuses on outreach programmes to increase awareness through educational programming and prevention, and demonstrating that the counselling centres can help youth on its path toward mental health. It creates an overall umbrella campaign which consists of messages revolving around the concept of Soul Buddies. Buddies are friends, in this sense friends look out for friends. As a non-governmental organisation LoveLife runs multimedia campaigns, peer outreach, youth centres

and peer education programmes as part of their prevention campaigns (Sangonet, 2015).

SADAG serves as an advocacy and support network for those suffering from depression, bipolar mood disorders, panic disorders, post-traumatic stress disorders, social anxiety disorders, obsessive compulsive disorders and generalised anxiety disorders. It is a non-profit organisation with a board of psychiatrists and general practitioners (SADAG, 2005). SADAG's –Suicide Shouldn't Be a Secret programme was developed to address depression and suicide education as an effective means towards decreasing the morbidity and mortality associated with adolescent depression. SADAG's public awareness campaigns are a significant component of community-based suicide prevention efforts. Raising awareness and educating people about the resources in the community must be among the major goals of such programmes (Garland & Ziglar, 1993).

South African Society of Psychiatrists (SASOP, 2016) has formed partnerships with the schools and universities, community- based organisations such as churches, youth groups, prisons and corporations. It has initiated outreach projects in rural areas where mental health care services are not available. These programmes have been recognised and endorsed by the South African Society of Psychiatrists (SASOP, 2016).

Another community organisation, the Samaritan/Befrienders Worldwide, has four such centres in South Africa, namely in Bloemfontein, Botshabelo, Mitchells Plain and Umkomaas. The focus of this organisation is on people in need of emotional support, enabling them to explore their feelings in a confidential and non-judgmental manner by means of providing counselling sessions. Another entity of the Samaritan/Befrienders, the Global Linking project aims to expedite the exchange of knowledge and experience from around the world through its work with rural communities, prisons and at-risk groups. Thus, the project aims at

increasing awareness around issues of emotional health and suicidality among community members (Beer, 2010).

The World Health Organisation initiated the Suicide Prevention-Multisite Intervention Study on Suicidal Behaviour (SUPRE-MISS) that was launched in 2000. The goal was to address the public health problems of attempted suicide and to reduce mortality and morbidity associated with suicidal behaviours. The SUPRE-MISS includes the evaluation of treatment strategies for suicide attempters, a community survey of suicide ideation and behaviour, and a community description aimed at assessing basic socio-cultural indices (World Health Organisation, 2002). Its objectives are to: increase awareness regarding suicidal behaviours; identify reliable and valid variables for determining suicidal behaviour risk factors; describe patterns of suicidal behaviour; identify variables that determine the presentation or not at health facilities following non-fatal suicidal behaviour; and improve the efficiency of general health services through the identification of specific interventions effective for the reduction of suicidal behavior (World Health Organisation, 2002).

The next section pertains to selective programmes provided by organisations to communities in South Africa.

3.3.2 Selective programmes

The selective programmes discussed in the sub-section below include the crisis support services which are comprised of drop-in centres and online programmes. Both these programmes offer selective and indicated support for youth at severe and immediate risk of suicide or self-harm.

3.3.2.1 Crisis Support Services

Crisis support programmes are comprised of online services and drop-in centres.

The drop-in centres are open during daylight hours, where people can come in with or without appointment to talk to someone without being judged, and receive counselling or therapy free of charge. Emergency outreach teams, or rotacal, termed —flying squads, go out in exceptional crisis circumstances (Preidt, 2016).

As much as some drop-in centres are available 24 hours per day, evidence shows that young people feel empowered online, unashamed and confident, and are more likely to talk about sensitive issues informally other than having face-to-face counselling (Gould *et al*. 2003) at these centres. The reason could be that online the person does not see who she or he is speaking to, making it easier to say things that would have been difficult to convey in person.

Durkin and Burns (2008) indicate that a Reach Out online cross-sectional survey, implemented to help understand what young people want from the service and its impact on them, found that the majority of respondents scored a high (19.4%) or very high (51.8%) range of psychological distress. However, only 40% of users reported visiting the site because they were going through a tough time and looking for help. The implication of this data is that Reach Out could be reaching a subsection of young people who do not yet recognise their need for support or intervention but who might be at risk.

The opportunities that online services create have been recognised in the use of the Internet and new media to reach young people at risk of suicide, as discussed in the foregoing paragraphs. Programmes such as Reach Out and Kids helpline web-based counselling have harnessed the potential to reach people by providing easily accessible services, free and convenient to young people in need. The second online service provided by Kids Helpline provides over 50,000 web and phone-based counselling services a year, with one out of every five young people requiring support for suicidality and self-harm (Kids Helpline, 2010). According to Young (2002), the users of the service reported satisfaction with the service as it helped them work through their issues; being

able to disclose and seek help for more serious problems through e-mail counselling rather than through phone counselling. This indicates that web counselling may be more accessible for suicidal young people.

The third form of service is that of help-lines which receive calls from suicidal people. According to Lifeline Southern Africa (2005), around 8% of Lifeline‘s calls were from youth (24 years and under). This constitutes 40,000 calls a year, with mental health the most frequently discussed issue (28%), followed by relationship challenges (8%) and sexual adult and abuse (8%) (Lifeline, 2010). Gould *et al*. (2006), Kalafat, Ryerson and Underwood (2001) and Patterson, Jepsonc, Strasser, Loughead, Perkins, Gur, Frey, Siegel and Lerman (2009) indicate that after counselling youth often experience reduced levels of hopelessness, confusion, depression and anxiety.

In addition to other community organisations, Lifeline Southern Africa provides a free 24-hour crisis intervention service which is available to all sectors of the community. The service is primarily based on a telephone counselling service because of its immediacy and obscurity. It is also a very intimate means of communication. A wide range of other services offered throughout Southern Africa, include the national HIV/AIDS workplace programmes and a Toll Free Aids Helpline, Van Staden‘s Bridge Crisis Line, crisis and rape response teams, counselling for teenagers (Teen Line) and for abused women (Stop Women Abuse Helpline, House of Safety for Women), face-to-face counselling, trauma debriefing, support groups, outreach programmes and training courses in communication, and basic counselling and life skills in each centre. It benefits locals that the counsellors can speak a range of different languages (Lifeline Southern Africa, 2005); this is important in a country that has 12 official languages.

Free telephonic counselling is the main focus for SADAG. It has a referral service to health professional and free medical treatment where appropriate. Explicit

consideration is directed at a huge operation to de-stigmatise mental illness and to inspire people to consider being treated (SADAG, 2005). SADAG offers workshops and educational programmes throughout the country, and delivers educational material including videos, audiotapes and publications on the several illnesses, as well as a newsletter (SADAG, 2005). As much as online/web and telephonic crisis support is available in South Africa, the problem is whether these services are readily accessible to youth, especially in poor communities.

The next section focuses on prevention programmes in schools. This information becomes imperative as youth spend most of their time in schools. If there are no mental health programmes at schools and in their communities their situation would be dire as they would be left with no other alternative but to engage in suicidal behaviour.

3.4 SCHOOL-BASED INTERVENTION PROGRAMMES

The majority of suicide prevention strategies are aimed at either reducing risk factors for suicide (Ali, Dwyer & Rizzo, 2011) or screening and finding potential suicidal people for referral and treatment (Shropshire & Thornton, 2011). Public awareness and education programmes are a popular and widely used public health intervention to reduce death by suicide (Van Backergem, La Rosa & Garr, 2011). Vossekuil, Reddy, Fein, Borum and Modzelski (2000) maintain that the current comprehensive universal school-based prevention programmes are designed to increase the likelihood that school gatekeepers (administrators, faculty and staff) and peers who come into contact with at-risk youth can more readily identify them, and are consistently inclined to take action. In that case the role of the school in this endeavour is critical but limited to the identification and referral to specialised school or community-based mental health services.

White and Kelly (2010) indicate that schools schedule school-based programmes rendering psychologically and culturally focused services to parents and learners. These programmes, if accessible, also promote protective factors, including

stronger connection with schools. Comprehensive universal prevention programmes that fit within schools‘ resources and culture may be suitable, having an educational rather than clinical focus.

3.4.1 Universal programmes

The universal programmes discussed in this section include anti-bullying, drug control and gun free school initiatives, school safety and those that are curriculum-based. These initiatives are intended to reduce the level of violence in schools, thereby creating conducive environment for mental health due to feelings of being secured. The curriculum-based programmes are intended to promote health literacy and reduce mild risk of suicide among learners. The policy guiding the implementation of curriculum-based programmes is the Curriculum Assessment Policy Statement (Department of Basic Education, 2012). The results of a search on policies that deal with mental health in schools revealed that only the Integrated School Health Policy (Department of Health and Education, 2012) outlines mental health issues such as drug and substance abuse, depression and anxiety and suicide as part of the package of health services that are provided by the Department of Health to schools. The nurses are to assess each learner once during the four educational phases and referrals made where necessary. Researchers have indicated the inconsistency in the provision of these services due to the large number of schools that nurses are allocated to and lack of collaboration between teachers and nurses.

The policy guiding the implementation of curriculum-based programmes is the Curriculum Assessment Policy Statement (Department of Basic Education, 2012). The results of a search on policies that deal with mental health in schools revealed that only the Integrated School Health Policy (Department of Health and Education, 2012) outlines mental health issues such as drug and substance abuse, depression and anxiety and suicide as part of the package of health services that are provided by the Department of Health to schools. The nurses are to assess each learner once during the four educational phases and referrals

made where necessary. The beneficiaries of these health services are learners in Quintiles 1, 2 and 3 (schools in poor communities). Researchers have indicated inconsistency in the provision of these services due to the large number of schools that nurses are allocated to and lack of collaboration between teachers and nurses (Mohlabi, Van Aswegen & Mokoena, 2010). Moreover, Kwatubana and Kheswa's (2014:1718) study about the integrated approach to health promotion, found that unavailability of classrooms in some schools, lack of dedicated school managers to ensure that the provision of health service in their schools is smooth running were administrative processes that rendered health services inefficient.

3.4.1.1 Anti-bullying programmes

Given the emerging evidence of the harm that bullying can cause to young people (Kowalski, Limber & Agatston, 2008), including a number of high profile suicide deaths, anti-bullying measures are recommended to increase safety and reduce psychological distress and suicide. Although bullying behaviour can occur in any environment, schools offer an opportunity to aim anti-bullying messages at youth and are also sites for the identification and early intervention of bullying distress. Teachers, school managers, parents and learners need to be aware of the rights and responsibilities of schools to intervene in bullying, including cyber-bullying, which takes place both within and outside of school (Mcgrath, 2009).

According to Rigby and Slee (2008), bullying has become increasingly prevalent through new mediums of communication, such as the Internet, social networking, and mobile phones. As bullying and its forms are varied and originate from different prejudices (homophobia, racism, gender stereotyping) and motivations (exerting control, punishment, or a form of self-promotion), Rigby (2001) suggests that measures that address bullying must be conducive to tackling the causes of the behaviour. Recognising bullying is a key concern in school populations, as postulated by Rigby and Griffiths (2011).

Research suggests that school-based anti-bullying programmes are effective in reducing bullying behaviours, particularly amongst younger learners in pre-secondary schools (Rigby, 2001; Rigby & Slee, 2008). In particular, programmes that feature a problem-solving approach to bullying, rather than punitive measures, such as rules and consequences, show more consistent positive results (Rigby, 2001). The direct impact of anti-bullying programmes on suicide rates, while promising, has not yet been fully determined. Preventing bullying outside of the school population is considerably harder and may require cultural and social changes, including legislation and anti-discrimination law compliance. Lack of adherence to such laws might aggravate the situation.

3.4.1.2 Drug control

A drug as defined by the World Health Organisation refers to any substance that, when taken into a living organism, may modify its perception, mood, cognition, behaviour or motor function (Dusenbury, Brannigan, Falco & Hansen, 2003). This definition includes tobacco, alcohol and solvents and excludes medical, non-psychoactive substances. According to Dusenbury, Brannigan, Falco and Hansen (2003), drug abuse refers to the –excessive and persistent use, usually by self-administration, of a drug without due regard to the accepted medical practice‖. Hindmarsh, Jones and Kervin (2015) take the definition of drug abuse further by mentioning the non-medical use of drugs which produces euphoria and has the ability to make the user continue to want to use the drug in spite of the health, social and physical impairments the drug causes him or her.

Drug addiction is a state of periodic or chronic intoxication produced by repeated consumption of a drug, natural or synthetic. Its characteristics include (i) a tendency to increase the dose; (ii) a psychic and generally physical dependence on the effect of the drug; (iii) an overpowering desire or need to continue taking the drug and obtain it by any means; and (iv) a detrimental effect on the individual and on society (Kalivas & Volkow, 2005). The key factor in drug addiction is drug dependence, which is a condition in which the user has a

compelling desire to continue taking the drug, either to experience its effect or to avoid the discomfort of its absence (Saad, Iganus & Marama, 2002).

All school programmes are driven by policies. The South African Schools Act (SASA) (1996b) created the legislation framework for a uniform system of public schools aimed at providing progressively high-quality education. The legal status of a public school is provided for in section 15 of the SASA, which states that every public school is a juristic person with the legal capacity to perform is functions in terms of this Act. A public school therefore stands as a separate legal entity from its members, which means that it can sue and be sued, as well as perform other legal acts in its own name (Squelch, 2001:139). A school is also a statutory institution, as it owes its existence to SASA. Since a public school is part of state administration, it is classified as an organ of the state which makes it subject to the Constitution of the Republic of South Africa Act No. 108 of (1996a). Therefore the school has a responsibility and a mandate to advance and protect human rights in the school environment and to make sure that they are reflected in all school policies. It is these rights of learners that are violated when drugs are used and sold on school premises.

In order to promote its constructive approach, schools need to encourage preventative strategies. The most comprehensive of these is a lifestyle or life skills education programme which includes lessons about drug abuse being part of a regular curriculum from primary through to high school. Such a programme can help children learn how to cope with life. It should also provide them with skills to deal with situations and pressures they face which lead them to abuse drugs.

Kalivas and Vokow (2005) further suggest that a good lifestyle education programme should focus on several issues. These include: factual alcohol and drug information and the recognition of the issues that children of various ages are dealing with in terms of alcohol and drug abuse; equipment with decision-making and problem-solving skills aimed at giving learners confidence in the

decisions they make and the ability to seek solutions; value clarification to help children ensure that their behaviour is in line with the internalised values they have accepted and to prevent a rebellion against externally imposed values; and asserting oneself by being afforded the ability to communicate one's viewpoint or opinion. A strong self-esteem and a realistic assessment of self-worth are perhaps the most vital assets a person can take on his or her journey through life. The self-concept is addressed in the curriculum of Life Orientation, which is discussed below (*cf*. 3.4.1.4).

The aim of Lifestyle Education is to create a child who is self-confident, who functions from an internalised value system and is therefore self-disciplined and responsible, with a belief in his or her own ability, and with the resources to handle life situations without resorting to maladaptive behaviours to cope. In their own interest youth must be empowered to take action.

3.4.1.3 School safety and security

As indicated in the foregoing paragraphs, a safe school enhances mental health. A safe school can be defined as a place where learners can learn and educators can teach in a warm and welcoming environment, free of intimidation and fear of violence (Stephen, Weist, Kataoka, Adelsheim & Mills, 2007:149). A safe school is physically and psychologically safe and, according to Prinsloo (2005), free of danger and without possible harm.

A safe school can be realised if there is a well-designed code of conduct for learners, which is adhered to by all. Teachers are crucial in the management of safety and security as its effective implementation can create an environment conducive to teaching and learning. As mentioned earlier, the school governing bodies (SGB) of public schools must adopt a code of conduct for learners so that educators are able to manage disciplinary problems (Education Labour Relations Council, 2003). Safety issues within schools might continually pose a threat in the absence of a code of conduct for learners.

This issue of weapons brought to schools is another contributing factor to unsafe schools. Due to learners not being searched, various weapons are brought into schools. In terms of section 8A of the Education Law Amendment Act (ELRC, 2003), the practice of random search and seizure should be carried out. The principals should carry out these searches with the assistance of the police so that the safety of learners and educators is improved.

In a study conducted by Prinsloo (2005) participants indicated not feeling safe in their schools. Learners in the schools where the research was conducted were being harassed by their teachers and bullied by their peers. The aspect of school safety is grounded in the Regulation Prohibiting Initiation Practices at South African Schools (DoE, 2002), which points out that learners are entitled to a safe learning environment, and educators are also tasked with the responsibility of ensuring a safer environment that is conducive to education. This is so because educators share the parents'and caregivers'rights and duties to protect learners as they are *in loco parentis*.

Furthermore, the Guidelines for the Consideration of Governing Bodies in adopting a Code of Conduct for learners (Republic of South Africa, 1996) empowers an SGB to maintain discipline, aiming to ensure learners' right to a clean and a safe environment that is conducive to effective teaching and learning (Republic of South Africa, 1996) and promotion of mental health. Given the fact that parents and caregivers have the right to a safe school for their children, teachers have the right to uphold authority to ensure that this right is not violated. Oosthuizen and De Waal (2005) argue that one would expect the safety of South African schools to be under control, however, the situation in these schools presents a different picture.

Learners should be protected from all forms of violence and be in an environment that is not harmful to their health or well-being. According to Varnham (2005), every educator and learner has the right to physical, emotional and cultural safety. The Bill of Rights also enshrines certain fundamental rights which the

state has a duty to respect, promote and fulfil (Vossekuil, Reddy, Fein, Borum & Modzelski 2007). Right to apply to all laws and bind the executive and all organs of state departments (SA, 1996a) and the officials of these departments, including all employees paid by the department. The art of creating a safe and peaceful school environment poses great challenges. With respect to the physical security measures, metal detectors and a number of physical security measures used are supported in the literature Varnham (2005) found that metal detectors were associated with student concerns regarding their safety. This finding might suggest that at-risk schools may employ more metal detectors which, in turn, may remind learners about the school‘s weakened norms and the potential for violence in their schools (Snell, Bernheimb, Bergec, Kuntzd, Pascale, Paris & Ricroch, 2002). Thus, although these physical security measures may be necessary for crime prevention, it could be argued that metal detectors, in particular, may have a negative impact on learners‘ perception of safety.

The visible safety measures used in schools include security guards, video cameras and bars/locked doors. Findings by Brown and Grumet (2009) and McDevitt and Panniello (2005) regarding security guards are contrary to previous research which found a positive association with school officers and learners‘ perception of safety. Initially, the purpose of school security guards was to prevent property crimes and vandalism in schools (Prinsloo 2005). With the shift in purpose, school resource officers, as opposed to school security guards, may develop a bond and trust with their learners, accounting for the positive impact on school safety.

Among all the role-players in ensuring safety in schools, the principal is the central or key component of the action plan. As the head of the school the principal implements relevant provisions of the legislation and policies. The principal also facilitates the establishment of wider school partnerships. It therefore becomes imperative that school principals be capacitated regularly, particularly in the area of safety management, by the officials from the

Department of Basic Education. It is the duty of the SGB to ensure that issues of safety and security receive the highest priority and reflect the school‘s mission statement with regard to the context in which the school wishes academic learning to take place. The emphasis on safety in the mission statement may increase the validity and credibility of the school‘s effort to create and preserve a safe school environment and will furnish proof that the SGB is making the safety of the learners a priority (Xaba, 2014).

Partnerships with the school community, including learners, police, educators, response teams, armed response companies, the Department of Basic Education and the school maintenance committee are also important. Schools need to form partnerships with the wider community in order to mobilise a system of school support networks. This will cause people to be more committed and cooperative in seeking solutions to the safety and security problem. Creating a safe school is a community function; therefore schools cannot successfully achieve this goal alone (Prinsloo, 2005:5).

The lack of proper management of safety and security in schools has a negative effect on teaching and learning in rural and township schools (Squelch, 2001: 142). Despite the presence of legislation, violence in schools still prevails. Some teenagers have attempted suicide after having been kicked and flogged on school premises. Learners and educators have been stabbed or shot dead on school premises in some provinces.

3.4.1.4 Mental health programmes in the curriculum

Prevention programmes are often best based in the curriculum (Australian Network For Promotion Prevention And Early Intervention For Mental Health, 2008). A national curriculum is usually developed with the intent to create nationwide consistency in educational content. In a national curriculum protective factors are nationalised, thereby offering an opportunity to incorporate mental health and well-being education into the school curriculum. Suicide awareness

curricula are often used as part of school-based suicide prevention strategies (Mann, Apter & Bertolote, 2005).

A number of diverse approaches to suicide prevention have been incorporated into school curricula in the past 15 years (Ploeg, Cliska, Dobbins, Hayward, Thomas & Underwood, 2004: 446). Few, however, have been subjected to rigorous evaluation and those that have been scientifically evaluated have produced mixed results (Kalafat *et al*. 2001:446), but a suicide awareness curriculum developed by Aseltine (2004) yielded a significant increase in knowledge about suicide and a small but statistically significant reduction in the use of maladaptive coping strategies among grade nine learners. Similarly, increases in personal control, problem-solving, coping, self-esteem and family support and decreases in depression were observed among at-risk high school learners who were exposed to brief supportive counselling interventions developed by Nabors and Reynolds (2000: 206). However, these modest successes are overshadowed by several other studies that have failed to observe any effects of such interventions on learners'attitudes or behaviours (Shaffer & Craft, 2004:446).

The curriculum aims to instil self-worth, positive mental well-being and resilience in young learners (Davidson & O'boyle, 2010). This could create mandated classroom time, directed towards promoting suicide protective factors, reducing risk factors, and encouraging help-seeking behaviours in youth.

In addition to promoting positive mental health, educating youth on suicide warning signs and effective help-seeking is posited as an approach to preventing youth suicide. The value and safety of targeting specific suicide prevention programmes to youth, which include measures to increase awareness of suicide risk and how to seek help for suicidality, have been questioned (Miller *et al*.2009). Gould (2003), however, warns that fears that irresponsible programmes may create initiative behaviours and inappropriate content may restrict help-seeking that underpins much of the caution for school-based suicide awareness

programmes. Yet, Gould *et al*. (2005), Miller *et al*. (2009) argue that this stance is out of date, and recent arguments propose that it may in fact hinder suicide prevention efforts.

Several studies have found that curriculum approaches may have no effect on learners or may be potentially dangerous for certain learners. Davidson and Marshall (2003), among others, found that certain learners showed less desirable attitudes about suicide after class, were less likely to seek help, less likely to refer a friend or recommend the class to other learners, and more likely after the class to view suicide as a reasonable response to intense stress.

Although these results are alarming, some important comments were made by (Kakuma, Kleintjies, Lund, Flisher & Goering, 2008), who stated that their curriculum approach focused on destigmatising suicide, which is mostly done by expressing to adolescents that suicide is commonly a reaction to extreme stress. Research acknowledges that a curriculum which present suicide as a reaction to the common stressor of adolescents is not only ineffective, but may be harmful because it normalises the behaviour and reduces protective taboos, thereby making suicide more acceptable. Kakuma *et al* (2008)

For schools that wish to utilise a curriculum approach to address adolescent suicide, a model is recommended that identifies suicide as a complicated, abnormal reaction to a number of overwhelming factors. These programmes should also emphasise the association between suicide and mental illness (Goldsmith *et al* 2002).

Ciffone (2007) indicates that the primary goals of curriculum programmes include (a) heightening student awareness regarding suicide; (b) training learners to recognise possible signs of suicidal behaviour in order to assist others, and (c) providing student with information about various school and community resources. The reported time taken to present this information has varied, with

many programmes having a duration of two hours or less, although some may be longer (Cusimano & Sameem, 2011).

Despite their popularity, however, data regarding the effectiveness of curriculum programmes are equivocal. For example, such programmes have been criticised on methodological grounds because they typically evaluate programme effectiveness through changes in learners'knowledge and attitude rather than actual suicidal behaviour (Mazza, 1997; Miller & Du Paul, 1996). In addition, some research suggests that curriculum programmes may be most unsettling and the least useful for those learners at greatest risk of suicidal behaviour (Mazza, 1997). Moreover, literature on suicide prevention indicates that there is sufficient evidence to suggest that people should proceed cautiously with school-based suicide awareness curriculum programmes (Gould & Kramer, 2001: 21). Others, however, have suggested that universal school-based interventions (a) effectively change adolescents and attitude regarding suicide, (b) positively influence more suicidal adolescents than previously recognised, and (c) may be useful for increasing the likelihood of adolescents alerting adults to their potentially suicidal peers and thus that these interventions are generally effective (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011:406; Aseltine, James, Schilling & Glanovsky, 2007:6). There is broad agreement that programs are likely to be effective if they use a sequenced step-by-step training approach, use active forms of learning, focus sufficient time on skill development, and have explicit learning goals (Bond & Hauf, 2004).

The teachers and learners in public schools in South Africa do not benefit from curriculum-based programmes as there is dearth of information in the Curriculum Assessment Policy Statement for Life Orientation about suicide behaviour and its prevention. This means that learners could get such information from unreliable sources that could cause more harm (Aseltine, James, Schilling, & Glanovysky, 2007). The in-service training on suicide for teachers is also sparse as indicated in the paragraphs below.

Another frequently used and recommended school-based suicide prevention programme is in-service training for school staff members. Similar to curriculum programmes, with the exception that information is presented to school staff rather than learners, in-service programmes typically include instructions on heightening awareness, training to recognise possible warning signs in order to assist students and providing them with information about various school and community resources (Shaffer cited by Eckert, Miller, DuPaul & Riley-Tilman, 2003:58). However, initial studies have shown that staff education programmes can produce positive effects on staff members‘ knowledge, attitudes and referral practices (Berman & Jobes, 1995:5). The use of staff in-service training was also a major component of a study that demonstrated the positive effects of a school- based suicide prevention programme on learners‘ suicidal behaviour (Zenere & Lazarus, 1997:57).

The finding by Eckert *et al*. (2003) is that school psychologists found both curriculum-based programmes and staff in-service training to be acceptable prevention programmes. This is encouraging, given that both procedures when used appropriately are considered by many to be potentially useful components of comprehensive school-based suicide prevention programmes. In the latter study it was also found that school psychologists rated the school-wide screening procedure to be significantly less acceptable than either of the other two prevention programmes in the study.

However, programmes that aim to teach skills such as problem-solving, resilience and coping have shown some positive results, but according to Gould *et al*. (2003) and the evidence of these results has demonstrated some ambiguities.

Epstein and Sheldon (2006) recommend that schools avoid a single-session approach with learners, which focuses only on suicide as it may saturate learners. It is more beneficial, and does not carry the potential to harm, if schools

use a more prolonged method for addressing adolescent suicide, such as incorporating suicide lessons into already existing semester or year-long cases.

While curriculum-based programmes increase knowledge related to mental illness and suicide, Klimes-Dougan, Yuan, Lee and Houri (2009) maintain there is insufficient evidence that this increase in knowledge translates to prevention of death by suicide or results of referral for appropriate intervention and care.

Contributing to the slow progress of bringing improved services into schools is the reality that schools are under-resourced to address non-academic barriers to learning. Most districts offer mental health supports to only a small percentage of learners, often those in or being referred to special education. Furthermore, the quality of services for emotional or behavioural disabilities provided to youths in special education is questionable (Kutash & Duchnowski, 2004:1333), with many youths receiving no or poor services to address their individual needs (Nelson, Gregory & Gonzalez, 2003: 34).

SAMHSA released a report of the first national survey of school mental health in the United States for the 2002-2003 school years (Foster & Conner, 2005:51). What is notable in this study is that education leaders at local and state levels expressed the perception that mental health needs of learners were increasing while the funding was not adequate to meet these needs and was predicted to decrease (Zins & Weisseberg, 2004:20). These school leaders also expressed concern about the many barriers to successfully referring learners for services in other community agencies. Thus, these findings suggest that the majority of schools offer some level of mental health services but that these services are not sufficient to meet youth's needs and that connections with other community systems remain a significant challenge (Bishop, Bishop & Gelbwasser, 2004:4).

In an era of paramount attention to the academic achievement of children, school mental health has the advantage of articulating a powerful message linking mental health to school success (Wilson, 2004:2). The argument for integrated

approaches to reduce both academic and non-academic barriers to learning is supported by mounting evidence demonstrating a strong positive association between psychological wellness and academic success (Wilson, 2004:3). Research suggests that 46% of the failure to complete secondary school is attributable to psychiatric disorders (Stoep, Weiss & Kuo, 2003: 44). For the transformation of children's mental health services to expand school mental health, it is necessary to generate understanding and buy-in from educators through the dissemination of clear and strong messages about the importance of mental health and the negative impact of mental illness on school success (Stoep *et al*., 2003:45). From this it can be deduced that the school mental health field needs to clearly define specific academic factors, for example grades, discipline, referrals, promotion, drop-out, and school connectedness that are influenced by mental health promotion and intervention.

The Life Orientation curriculum in South Africa comprises the following subjects in order to address, among others, mental health: Personal and Social Well-being, Physical Education, Creative Arts, and Visual and Performing Arts. Each of these themes has a specific role to play in reducing mental ill health among learners. In the South African curriculum as a whole there are no topics specifically for suicide. The information in the sections below is from the Curriculum Assessment Policy Standards (Department of Basic Education, 2012).

- Development of self in the society

Development of self in the society is the study of the self in relation to the environment and society. The study area provides opportunities for learners to practise life skills required to make informed choices regarding their personal lifestyles, health and social well-being. It provides learners with skills to relate positively with and contribute to family, community and society. Other skills are to assist them to deal with challenging situations positively and recognise, develop

and communicate their abilities, interests and skills with confidence. They learn values such as respect for the rights of others and tolerance for cultural and religious diversity in order to build a democratic society (Department of Basic Education, 2012).

Self-concept and self-awareness provide a foundation for all positive thoughts, decisions, actions and behaviour, whereas a lack of self-confidence leads to negative thoughts, negative actions, negative feelings and negative results in life.

- Physical Education Grade 10-12

The physical fitness topic is the most natural site to promote the prevention of suicide and mental illness. The positive effects of physical health on mental health are widely accepted by researchers (Brown, Mcgue & Maggs 2008). Furthermore, the psychological benefits of physical exercise for reducing symptoms of mental illness are recognised across the lifespan (SANE Australia, 2010). Physical exercise in youth is also thought to increase the release of beneficial chemicals in the brain, possibly preventing the onset of mental health problems. Involvement in collective physical activities, such as team sports, can also increase young people‘s communication and interpersonal skills, connectedness, belonging and enhance their self-esteem (Taliaferro, Rienzo, Miller, Pigg & Dodd, 2008).

Physical Education aims to develop learners‘ physical well-being and knowledge of movement and safety. During engagement in the study area, learners develop motor skills and participate in a variety of physically activities. Participation in Physical Education nurtures positive attitudes and values that assist learners to be physically fit, mentally alert, emotionally balanced and socially well adjusted. Learners directly experience the benefits of such participation and are better able to understand the importance of a physically active lifestyle (Brown, 2008). During movement activities teachers also address the development of the other skills such as relationship skills, problem-solving skills and the enhancement of

self-esteem. The Physical Education component in Grades 7-12 according to CAPS (Department of Basic Education, 2012), aims to develop learners‘ physical well- being and knowledge of movement and safety. It encourages learners to use these to perform in a wide range of activities associated with the development of an active and healthy lifestyle. It also aims to develop learners‘ confidence and generic skills, especially those of collaboration, communication, creativity, critical thinking and aesthetic appreciation. These, together with nurturing of positive values and attitudes, provide a good foundation for learners‘lifelong and life-wide learning. All Physical Education periods focus on practical physical and mass participation in movement activities for enjoyment and enrichment purposes, with a view to encouraging learners to engage in regular physical activity as part of their lifestyle.

- Creative Arts Grade 4-6

Creative Arts provides exposure to and study of a range of art forms including dance, drama, music, and visual arts. The purpose of Creative Arts is to develop learners as creative, imaginative individuals, with an appreciation of the arts. It also provides basic knowledge and skills to be able to participate in creative activities. A safe and supportive environment is created for learners to explore, experience and express thoughts, ideas and concept within an atmosphere of openness and acceptance. Creative Arts provides opportunities for learners to give expression to their feelings and understanding, individually and collaboration with others. It creates a foundation for balanced creative, cognitive, emotional and social development. Creative Arts education, when successfully applied, has been proven to improve literacy and to reduce education drop-out levels (Department of Basic Education, 2012).

- Visual Arts and Performing Arts Grade 4-6

Visual Arts provides the learner with the opportunity to discover through play, while reinforcing the skills and techniques that were mastered in the Foundation

Phase. Visual Arts encourages an awareness of art elements and design principles found in the natural and the built environment, and enriches the learners'personal experience of the world. Opportunities are provided for social, emotional and intellectual development, and through non-verbal expression and the process of creating art, the learner comes to understand symbolic language. Visual Arts in the intermediate phase provides the learner with the opportunity to explore, and make informed decisions (Department of Basic Education, 2012).

Performing Arts recognises that African arts practice and integration is fundamental; it also notes the need for overlapping areas of practice in these art forms and focus is on the inclusive nature of the arts. Since the nature of integrated practice is such that it may be difficult to develop specialised skills in the classroom within the allocated time, it is suggested that learners wanting to specialise in a particular musical instrument or particular dance form take extra-mural classes for that purpose (Department of Basic Education, 2012).

In closing, the classroom curriculum consists of packaged, self-contained lesson plans designed to be provided by teachers rather than external consultants and they fit within the existing curriculum structure without requiring pull-out activities. The student curriculum also uses appropriate instructional principles such as participatory activities, skills practice and feedback, and reinforcement and acknowledgement of learners' experience (Kalafat, Ryerson & Underwood 2001). A meta-analysis of 13 school-based suicide prevention programmes found moderate-average effect sizes of suicide knowledge and ideation and small positive effect size for attitudes for seven programmes.

3.4.2 Selective programmes in schools

Selective programmes offer an opportunity to reach groups most in need, while specialised and comprehensive care must be available for those at high risk. Selected suicide programmes also focus on the subpopulation of learners who may be at higher risk for engaging in suicidal behaviour. For example, this may

include youth who have mental health problems, youth who have access to firearms in their homes, those who are known to have family members with affective disorders or to have engaged in previous suicidal behaviour (Mann, Hendin, Rihmer, Kalmar & Zanto 2005). Possible components of a selected programme may include developing and teaching decision-making skills and strategies, identifying resources in the school and community for help, emphasising peer involvement and the role of peers in responding to someone who may be suicidal, and developing strategies for identifying high-risk youth (Mazza & Reynolds, 2008). Screening programmes are typically administered to all learners in a particular environmental context, for example the school classroom, because their purpose is to identify and intervene with high risk individuals. In my opinion selective programmes are crucial in schools, especially for youth coming from disadvantaged communities. These programmes may eliminate high risk suicidal behaviour while it is still early.

3.4.2.1 School mental health programme

The school mental health programme offers increased accessibility to learners by reducing many of the barriers to seeking care in traditional settings, such as transportation, child care and stigma, and reducing the inefficiency of ‗no shows', that is, when a learner does not keep appointments. The school-based provider has the ability to serve other learners in the time-slot (Stephen, Weist, Kataoka, Adelsheim, & Mills, 2007). School mental health programmes reduce stigma associated with seeking mental health support, increase opportunities to promote generalisation and maintenance of treatment gains (Nabors & Reynolds, 2000). They enhance capacity for mental health promotion activities as well as universal and targeted prevention efforts (Weare, 2000). Compared to traditional outpatient services, mental health services can offer more ecologically grounded roles for mental health clinicians. School mental health services have been shown to enhance clinical productivity, because learners are more accessible to mental health staff (Atkins, Hoagwood, Kutash, & Seidman, 2010). There is growing evidence that school mental health programmes can have a positive impact on a

number of learners, family, and school outcomes. These programmes have resulted in reduced emotional and behavioural problems, decreased disciplinary referral, increased prosocial behaviour, increased family engagement, and improvement in school outcomes, such as disciplinary referrals, improved school climate, and fewer special education referrals (Zins *et al.*, 2004).

Weist, Rubin and Moore (2007:53-58) outline a process for addressing concerns about school- based mental health screening that includes intensive planning, collaboration, training, supervision and support to ensure the selection of age- appropriate screening methods, parental consent and student assent, trained and available staff and mental health providers to conduct screening, follow-up treatment, and resolution of logistical and liability issues. The authors further state that despite this reality most schools do not have the capacity to respond to any level of suicide concerns among youth because of stigma, resource limitations, limited evidence-based approaches, and the failure of child-serving systems to take responsibility for the problem. Stephen *et al.*, (2007: 48) add that lack of ownership by a single community system is also reflected in schools, where suicide services are often not well- integrated into the full continuum of mental health services delivery for youths. Psychologists, social workers and socio-pedagogues are allocated schools to focus on in South African schools. These professionals do not go to schools regularly but on demand when there are learners who have been identified as having problems. The identification process used is indicated in the SIAS policy.

3.5 COMBINATION OF UNIVERSAL AND SELECTIVE INITIATIVES

The programmes that are a combination of universal and selective initiatives include Signs of Suicide and counselling.

3.5.1 Signs of Suicide

A relatively new approach to reducing the incident of suicide among adolescents is found in Signs Of Suicide (SOS), a school-based prevention programme. It incorporates two prominent suicide prevention strategies with a single programme by combining curricula to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behaviour (Shaffer & Craft, 2004:446).

In the didactic component of the SOS programme the teaching materials consist of a video and a discussion guide. The video features dramatisations that depict the signs of suicidality and depression and the recommended ways to react to someone who is depressed and suicidal. It also includes interviews with people whose lives have been touched by suicide. Learners are also asked to complete the Colombia Depression Scale (CDS), a brief screening instrument for depression, derived from the Diagnostics Interview Schedule for Children (Shaffer & Craft, 2004:446).

The goal of the SOS programme is to reduce suicidal behaviour among adolescents through two mechanisms. Firstly, the educational component of the programme is expected to reduce suicidality by increasing learners‘understanding and recognition of depressive symptoms in themselves and in others by promoting more adaptive attitudes towards depression and suicidal behaviour. Secondly, the self-screening components of the SOS programme help learners assess and evaluate the depressive symptoms and suicidal thoughts they might be experiencing and prompt them to seek assistance when dealing with these problems.

Seeking help need not be limited to referral for treatment by a mental health professional, which is likely to be constrained by such factors as availability and accessibility of providers, health insurance coverage, and social stigma, but should also be directed at the –indigenous trained caregivers‖ in the school

environment, such as teachers and guidance counsellors as well as loved ones (Miller *et al* 2009:52).

The SOS programme offers other potential advantages. Firstly, the focus on peer intervention is developmentally appropriate for the targeted age group (Kellam, Kortez & Moscricki, 2004:6). During adolescence, the peer group becomes the primary sphere of social involvement and emotional investment for most youths (Aseltine, James, Schilling & Glanovysky, 2007:446). The SOS programme capitalises on a key feature of the developmental period by teaching youth to recognise the signs of depression and by empowering them to intervene when confronted with a friend exhibiting these symptoms. Secondly, the programme can be implemented on a school-wide basis by health educators with relative ease. Data from schools that offered the SOS programme during the 2001-2002 school year indicated that the programme could be implemented with minimal staff training and would not unduly burden teachers, counsellors, or administrative staff (Aseltine, 2004). Implementation of other suicide prevention programmes that include mental health screening can be costly, difficult and time-consuming (Jacobs, Brewer & Klein-Benheim, 1999).

3.5.2 Counselling

Talking may not seem to help much, but by asking adolescents about their thoughts and getting them to talk about how they feel reduce their feeling of isolation and distress and so reduce the immediate risk of suicide. Getting adolescents to talk is a short-term strategy. It is important that professionals who know how to help resolve the problems are notified. People who have attempted suicide previously are more likely to attempt suicide again. Counselling can‘t cure problems, but it is a way of finding ways to cope and maybe resolving some of the issues that may be contributing to a person‘s suicidal tendencies. It is important that educators avoid dealing with the situation totally on their own. The best way of helping is to refer adolescents who are at risk of suicide to someone

who is equipped to offer them the help they need, while educators continue to support them (Moodley, 2003).

School-based programmes that support positive aspects of educational interventions are available, as discussed above, but most of these programmes are not evidence-based or have not been found to prevent suicidal behaviour (Brown & Grumet, 2009).

The provision of counselling services in school in South Africa is guided by the White Paper 6 (Department of Education, 2001) and the Screening, Identification, Assessment and Support (SIAS) (Department of Education, 2008) intervention strategy which is intended to provide guidelines to the implementation of the Education White Paper 6. Provision of support to learners experiencing barriers to learning is done in phases. The teacher first identifies the learner in need of support, the parent is made aware of the challenges and the teacher makes use different strategies to intervene. If the problem persists the learner is referred to the Institutional Level Support Team for more support and eventually the learner will be assisted by the District-Based Support Team. It is this latter team that can involve the services of social workers and psychologists.

Learners that benefit from counselling provided by the social workers sent to schools by the district are those who need additional support, in that case, this is an indicated intervention.

3.6 ROLE- PLAYERS IN SUICIDE PREVENTION

Mental health is not an easy aspect to deal with. Schools need all the support they can get from their communities. Besides, initiatives that become successful involve activities that are collaborated. Moreover, learners can benefit more from a whole-school approach to mental health, which includes teachers, learners, parents and external stakeholders, as discussed below.

3.6.1 Engagement of teachers

School-based suicide prevention programmes focusing on mental health promotion are the most popular approaches in most countries. As the vast majority of youth attend school until they are at least 16 years old, schools offer a prime opportunity to establish suicide prevention, intervention, and post-intervention measures. Suicide prevention experts recommend using a multifaceted approach in which the following components are implemented in a particular sequence: student education; protocol for helping learners at risk of suicide; protocol for responding to suicide death; staff education training; parent education; and screening. A three-year randomised control trial of a school-based depression initiative by *beyond blue,* as indicated by Sawyer, Pfeiffer, Spence, Bond, Graetz and Kay (2010) incorporated many of the best practice components of universal school programmes, including teacher training, curriculum input enhancements to school climates, improved care pathways, and community forums. The trial failed to find any impact on learners' depressive symptoms at the end of the period, demonstrating the difficult of proving the impact of such interventions, but also the need for more analysis of effectiveness of universal school-based initiatives.

It is essential to implement protocols for responding to learners at possible risk of suicide before implementing strategies to help identify learners at risk of suicide (such as training staff to recognise suicide risk). Identifying learners who are at risk of suicide will be more likely to prevent suicide when the procedures that ensure these learners receive appropriate service are in place (Portzky & Van Heeringen, 2006). After developing the two critical protocols, all staff should be engaged in suicide prevention. A whole--school approach to positive mental health is promoted, including activities to create a school environment that values the holistic needs of youth (ANU & Erebus International, 2008).

Portzky and Van Heeringen (2006) note that the most suicide risk factors include family background factors, relationship patterns, changes in living conditions and

potential psychopathology, such as depression and stress which teachers need to aware of when assessing learners. In this regard, Bronstein, Anderson, Terwilliger and Sager (2012) recommended coordination of activities between educators and health service providers to achieve more successful prevention. Also, a proposal on child and adolescent mental policy for South Africans, according to Petersen and Lund (2011), has recommended a multi-level system with the first tier incorporating schools as one of the many service sites at the district level. Schlebusch (2004) regrets the withdrawal of teacher-counsellors from schools as part of the changes in the education system in South Africa. Only few periods allowed then for guidance. This situation has a negative impact on the mental health of school-going children, especially those at risk of suicidal behaviour who use school support. As schools no longer have guidance, which has since 2010 been replaced by Life Orientation, the phasing out of guidance had a negative impact on mental health interventions and Life Orientation teachers only focus on the content in the Life Orientation curriculum.

3.6.1.1 Teachers as gatekeepers

According to Kutash and Dutchnowski (2004), gatekeepers are individuals who are trained and resourced to recognise and respond to suicide risk in others. Parents and teachers have been recognised as the primary gatekeepers in youth suicide prevention. Suicide prevention includes a range of interventions focused on community or organisational gatekeepers whose contact with potential populations provide an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment and can make referrals to specialised and allied health services for those at risk of suicide (Crowley, Kilro, & Burke, 2004). Gatekeepers also include clergy, first responders, pharmacists, geriatric care- givers and personal staff. Tompskins, Witt and Abraibesch (2010) maintains that gatekeepers have an opportunity to address suicide risk –at the bottom of the iceberg‖; recognising the early stages of emotional distress and intervening before a high risk of suicide occurs.

A staff member without a medical or psychology background comes into contact with suicidal learners in the school setting. These staff members have regular interactions with learners, and these relationships enable them to note and observe changes in student behaviour. These frontline staff members are natural gatekeepers for mental health problems in the community and could play a vital role in the recognition of suicidal behaviours, provision of initial support, and facilitation of access to the appropriate health services (Cross, Matthieu, Cerel & Knox, 2007).

According to Cross, Matthieu, Cerel and Knox (2006), many schools acknowledge that suicide issues are often unavoidable and school professionals are increasingly accepting the role of gatekeepers‘‘ in dealing with suicidal learners. As learners disclose information about themselves in their daily interaction through conversations with peers, their writing, and general behaviour towards school staff, they provide a gateway for teachers to detect warning signs of suicidal behaviour and to offer support or refer them for professional help. The International Association for Suicide Prevention (2012) argues that suicide prevention programmes might reduce the incidents of youth suicide at schools. However, before an effective intervention programme can be developed and implemented in school settings, the knowledge and skills base of teachers needs to be assessed. Flisher *et al*. (2006) emphasise the importance of the ability of school professionals to identify young people who are developing suicide risk behaviours. Teachers should possess accurate knowledge of suicide and be capable of referring a learner to relevant services.

According to Shilubane, Bos, Ruiter, Van den Borne and Reddy (2015:2), research in South Africa has neglected the involvement of teachers in studies on adolescent suicide. Teachers‘knowledge of suicidal behaviour is important in preventing adolescent suicide as well as in providing support to peers and the wider school environment following a suicide attempts. Mann *et al.* (2005) state that teachers‘knowledge of warning signs of suicidal behaviour could assist

in the identification and referral of learners at risk to available counsellors or psychologists. It should be noted that counselling services are available at the health institutions but not in schools. During the interviews in a study conducted by Shilubane *et al*. (2015:2) teachers indicated that failure to recognise warning signs of suicidal behaviour contributed to learners'death by suicide. Had they known that social withdrawal and talking about suicide through social networks were warning signs of suicidal behaviour, they would have referred the learners for professional help.

The suicide rate of learners might be reduced if teachers were educated about the learners'suicidal behaviour and taught skills through well designed evidence- and theory-based intervention programmes, as has been shown by previous suicide prevention strategies for physicians. Gatekeeper training programmes typically target goals of enhanced knowledge, attitudes and skills in the identification and referral of those at risk. In the school setting, links to, and support by, community resources are recommended to establish a comprehensive approach (King & Smith, 2000). An analysis of the role of gatekeepers and the other health-care professionals, conducted by the Australians Institute of Family Studies (2009), revealed that a large number of high risk young people were not being detected by their gatekeepers. As a result, many of these individuals were potentially missing out on timely intervention.

Education covers awareness of risk factors, policy changes to encourage help-seeking, availability of resources and efforts to reduce stigma associated with help-seeking. In addition to gatekeeper training, these programmes also promote organisation-wide awareness of mental health and suicide facilitated access to mental health services (Gould, 2001).

Suicide prevention gatekeepers can also administer suicide screening measures, questioning young people about risk factors and their current social and emotional well-being. Such screening can recognise those in need of further treatment and, while some false positive may be reported, the benefits of

screening in terms of being able to target those in need are apparent. The senate inquiry into suicide in Australia (Senate of Australia, 2010) recommended that all frontline services staff should receive mandatory suicide prevention gatekeeper training, in recognition of the key role that these people can play in preventing suicide.

Due to high interest levels in youth, most studies on the effectiveness of gatekeeper training programmes have focused on training for the identification of suicidal young persons. Findings have shown that gatekeeper training has positive effects on attitudes and knowledge about suicide and on referral skills (Tompkins, Witt & Abraibesh, 2010). Gatekeeper training in suicide prevention has become a key strategy recommended by both the Institute of Medicine and the National Strategy for Suicide Prevention (Goldsmith *et al*., 2002). Crowley *et al.* (2004) revealed the positive impact of gatekeeper training in recognition of suicide risk, although the specific utility in terms of recognition of youth suicide remains unknown. A gatekeeper curriculum for school counsellors conducted by Hazell (2000) showed positive effects on knowledge and skills in a three-year follow-up.

However, there is little substantial evidence to support the implementation of gatekeepers. Promising school-based programmes include screening learners for mental health problems and referring them to mental professionals. They also provide teachers with gatekeeper training to recognise depression and other mental health disorders in learners and learn the procedures for referral to mental health services. Two other school-based strategies popularly considered to be effective are peer helper programmes and post-prevention (suicide prevention activities, such as crisis debriefing interventions, aimed at youth recently exposed to a suicide). However, these strategies are not supported by sufficient positive evidence to substantiate widespread or unqualified use (Bah, 2004).

3.6.1.2 Training of teachers

According to Fox and Hawton (2004), training of teachers might cover the identification of warning signs, appropriate responses, referral, and sources of guidance for staff concerned about a student, and might involve some of the community and voluntary organisations that have expertise in these areas. It is important to have people with mental health expertise, such as a school counsellor or social worker, involved in planning and possibly leading suicide prevention activities.

Professional standards for teacher training are currently being drafted to provide an opportunity to incorporate mental health first aid and suicide prevention gatekeeper training into teacher education (Pirkis & Blood, 2001). However, despite teacher recognition of the importance of their roles in safeguarding student welfare, there is a general reticence to assign specific responsibilities to already burdened teachers. School counsellors may be better placed as key school gatekeepers for learners at risk. Teachers must also have an understanding of what to look out for and what to do if they are concerned about a student. Where it has occurred, positive results for teacher and school counsellor gatekeeper training have been found, with improved knowledge, attitudes and intervention skills observed in trainees, as well as their satisfaction with the training (Gould *et al*., 2003).

A school may have teams responsible for health or behaviour health issues, such as a crisis response team or a health promotion team. Adding suicide prevention to their mission and involving members of these teams can be considered as responsibilities assigned for suicide prevention strategies and integrating with the full range of student learning supports designed to address barriers to learning (Adelman & Taylor, 2006: 297). It is also important to understand that some staff are leery to become involved with the team may be a result of their own personal experiences with suicide or suicide risk. Such stakeholders are quick to stress that the mission of schools is to educate all learners (Adelman & Taylor, 2006:297).

Most school personnel do not receive training regarding mental health issues (Walter, Gouze & Lim, 2006) or identifying and responding to learners with these issues, including suicide, which should be a training priority for school district staff. School nurses are in a prime position to articulate this need and coordinate this training for their school communities. Training may be a challenge for local school districts to sustain; however, the benefit of intervening and responding cannot be under-estimated and every frontline staff member should know how to intervene with this potentially lifesaving response. Staff members need to be supported by school governing bodies and policy makers. The support will include the time to participate in suicide prevention training. School nurses should work to determine if the staff retained knowledge related to adolescent suicide prevention. Most personnel do not receive training regarding mental health issues (Walter *et al*., 2006).

3.6.2 Engagement of learners

The rationale behind peer support programmes, according to Gould *et al*. (2003), is grounded in young peoples' preference to confide in and respond to their peers, as opposed to an adult. Gould *et al*. (2003) argue that the evident underpinning such programmes is limited due to the lack of effective evaluations. One widespread programme operating throughout schools in Australia is the peer support programme, implemented by trained older learners to deliver a social and emotional learning programme to younger learners. The peer support programme creates a school community that fosters acceptance and positive peer relations. Internal evaluation has found beneficial impacts on student communication, problem-solving skills and self-confidence (Peer Support Foundation, 2003).

Similar to other school-based programmes, the peer support programme is reluctant to incorporate specific suicide prevention initiatives. Western Australia's youth focus programme operates an early intervention peer support programme, using a mix of therapeutic, recreational and social activities, to assist young

people identified as at risk of suicide or self-harm to develop practical life and problem-solving skills (Wynman *et al* 2008). Supported by professional individual and family counselling, Youth Focus participants have reported improvements in their lives as a whole, starting with understanding how to resolve complex personal issues, including suicidality and self-harm (Wynman *et al* 2008).

3.6.2.1 Peers as gatekeepers

Friends of suicidal adolescents may be the first to notice warning signs and need to be informed as to the most appropriate action to take, and where they are able to turn for advice (Madu & Matla, 2003).

Wynman *et al*. (2008) demonstrated that many vulnerable youth will not confide their distress to adults even if they are suicidal. In a study by Burrows and Schlebusch and Burrows (2009:755), which compared the effectiveness of a brief buddy intervention support programme with the World Health Organisation's Multisite Intervention Study on Suicidal Behaviours (SUPRE-MISS), the former was shown to be more effective in reducing the number of potential suicide attempts. Several studies have commented on the effectiveness of buddy interventions, with one suggesting that impact of buddy support would be greater if participants were guided in choosing their buddies'' (Tompskins *et al*., 2010).

3.6.3 Collaboration with external stakeholders

According to Bronstein *et al*. (2012), adolescent suicide prevention within the school setting presents many challenges and opportunities for collaboration with different stakeholders. It is the community participation that completes a model for health interventions at school, without it the programmes are ineffective. A finding of a study conducted by Kwatubana (2014: 1464) indicated that teachers had a negative attitude and lack of commitment towards health programmes that they had to implement on their own, further stating that it has always been difficult for teachers to embrace a concept that involves extra work. Community

participation is thus, the core of health programmes in a school. Community participation refers to both the processes and activities that allow members of a particular population to be heard, empowering them to be part of decision-making processes and enabling them to take action in conjunction with other structures on health promotion issues (Inter-Agency Network for Education in Emergencies, 2004:80).

A number of strategies to strengthen these partnerships have been suggested in the literature. A first strategy is reaching out to and encouraging leadership in relevant professional organisations to support mental health agenda. A second strategy is tracking strong examples of family-school-community collaboration to advance school mental health (Robinson, 2004:1335), and moving towards Internet-based evolving directories of programmes to promote networking and collaboration across communities, states and organisations. A third strategy to strengthen partnerships is to capitalise on grant opportunities that promote such partnerships, such as System of Care (SAMHSA), safe Schools/health Learners (SAMHSA and Department of Education), and Mental Health Integration Into the Schools (Weist, Evans & Lever, 2003:1335). One of the main problems inhibiting partnerships has always been the delegation of power which will allow communities to share the vision the vision of the school thereby ensuring that communities buy into the health promotion idea of the school (Kwatubana, 2014, 1461).

Schools need community support to help prevent suicide. If the community has a suicide prevention coalition or group, it should be contacted.

3.6.3.1 Training of community members

Identifying suicide prevention coalitions in a community is imperative. As the primary site for socialisation and education and a pivotal environment for children‘s well-being, families provide an opportunity to promote suicide protective factors and reduce risk factors (Fergusson, Beautris & Horwood

2003). Furthermore, families are often best placed to recognise distress or suicidality in young people. However, to do this, families must be aware of the signs and know how to help. Children are often adept at concealing their feelings. Coupled with regular youth ups and downs, the ability to distinguish young people at risk is often challenging. To help recognise and combat youth distress, parents and their children need to be educated on youth issues and pressure, as well as the importance of a strong support network (Van Vugt, 2009). Parental education and support could be incorporated as part of wider public health suicide prevention policies.

As well as restricting protective factors, a dysfunctional family environment poses a risk to youth mental well-being. Programmes aimed at diminishing conflict and enhancing cohesion have shown positive impacts on family mental well-being, but impact on suicide rates has been harder to demonstrate (Durlak, Weissberg, Dymnick, Tylor, & Schellinger, 2011). Family counselling is often incorporated into therapies for young people identified as being at risk. The involvement of families in treatment and therapies can assist to continue the benefits of the programme in the home environment (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002)

Family interventions must be geared to enhancing communication. It must be acknowledged that the adolescent‘s suicidal behaviour is an indicator of difficulties within the entire family and must be looked upon as a signal of other difficulties among the family members. Furthermore, suicidal behaviour is a process that is determined not only by one individual within the family, but by a complex state of interactions among the family members (Gould & Greenberg 2006).

Interventions must also be made with the family. Parents should be helped to deal with their unresolved dependency conflicts and given support so that they

can give more to their children. The adolescent should not be singled out as the sick member‖ but rather as the member who has alerted everyone to a trouble spot within the family which needs further investigation (Sue, Sue & Sue, 2000)

3.7 CONCLUSION

This chapter indicates a need for a comprehensive approach to suicide prevention. This requires a framework based on a set of guiding principles and a range of strategies to achieve specific objectives. In addition to incorporating the considerations already elucidated thus far, a national programme should endeavour to provide a strategic framework for action at all levels to prevent suicidal behaviour and promote mental health. In order to reduce risk factors and promote protective factors there is a need to focus on early detection of suicidal behaviour among learners. Strategies to deal with mental health need to be implemented in a coordinated and strategic manner within an interdisciplinary context.

Gatekeepers have been identified as critical and their knowledge of suicide symptoms is imperative. Partnerships and alliances between schools and their communities to create a support structure for learners should form an integral part of the schools‘strategy. From the literature it is clear that there should be a focus on multi-thronged interventions, building on existing strengths and capabilities and developing activities that are appropriate and responsive to the social and cultural needs of the learners they serve.

The next chapter focuses on the methodology used to gather empirical data from participants.