TITLE : A CASE STUDY TO INVESTIGATE PERSONALITY FACTORS PREVALENT IN ADOLESCENTS WHO HAVE ATTEMPTED SUICIDE , ADMITTED AT THE CHRIS HANI BARAGWANATH HOSPITAL.

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DEDICATION

THIS DISSERTATION IS DEDICATED TO MY PARENTS FOR

WITHOUT THEIR LOVE, SUPPORT AND

ENCOURAGEMENT, I WOULD NOT HAVE MADE IT.

ABSTRACT

This study sought to investigate personality factors prevalent in adolescents who have attempted suicide at the Chris Hani Baragwanath Hospital. The main objective was to identify personality factors associated with suicide attempt and to identify life stresses associated with adolescents suicide attempts.

It was a case study, comprising of 20 male and female adolescent respondents. The respondents attended public or private schools. One of the respondents at the time of testing was not attending school. Home languages of the respondents were Afrikaans, Zulu, Tswana, South Sotho and North Sotho. Their ages ranged from 12 to 18 years. The High School Personality Questionnaire (HSPQ) was used to assess the personality of the respondents. The instrument measures fourteen relatively independent personality dimensions. Firstly, the researcher conducted a pilot study to ensure that the respondents understood test items and to score the responses correctly.

In the main study, services of a qualified psychometrist were enlisted in the administration together with a researcher. The researcher and assistant were available throughout the testing period to monitor and assist should there be a need. The test was administered on an individual basis.

The findings agreed with the hypothesis of the study, that adolescent suicide attemptors were highly impulsive and angry people. The findings also revealed that the most common personality factors prevalent in the subjects appeared to be lack of self-control and low levels of intelligence. The least scored personality factors included

proneness to guilt feelings, submissiveness, abstract thinking ability and social boldness. Recommendations made included programs like assertiveness training, communication skills, and conflict management.

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DECLARATION

I declare that this thesis in Clinical Psychology in the Department of Psychology at the University of North West has not been previously submitted by me for a degree at this or any other University, that this is my own work in design and execution and that all the material contained herein has been duly acknowledged.

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CHAPTER 1

1.1. INTRODUCTION

South Africa is in a state of transition, a transition which places tremendous demands on its people. It is mostly the western style of living that has had the most influence and has been incorporated as part of our culture. The ever improving technology and media bridges the gap between the western and African worlds. The transition places a lot of demands in the inhabitants of this country, especially the adolescents. It is therefore, important to understand that adolescence may be a trying developmental stage, that is a transitional stage between childhood and adulthood. The demand and pressure placed on the adolescents, if not handled correctly, could push them to take drastic measures such as attempting suicide.

Some of these drastic measures which propel adolescents to attempt suicide can be based on the personality nature of the individual or the impact of the environment around them. Ovuga, (1990) concedes that issues such as stress, anger, depression and psychopathology contributes to suicide attempts. However, he is not of the opinion that those factors by themselves, account satisfactorily as to why certain persons in similar predicaments choose to kill themselves, while others do not. Thus, the rationale for this study, which seeks to investigate the personalities of those adolescent who have already attempted suicide.

Suicide has now become the third biggest killer of teenagers in South Africa, after violence and crime (Ludman, 1996). Almost daily, in the psychiatric unit at the Chris Hani Baragwanath Hospital, children who have attempted suicide are attended to by the

multidisciplinary team. The team constitutes psychiatrists, psychologists, psychiatric nurses and other professional nurses. The ages of suicidal individuals (patients) range from 7 and 18 years, predominantly female. According to the information taken from the attendance register, the number increases during the December, and June-July months. This increase could be a result of examination stress and poor performance at school. There is a slight raise before the weekend (Fridays) and after the weekend (Mondays). Other rationale for suicide stated, originate from conflict relation with parents, broken romances and abuse in the home (Ludman, 1996).

1.2. RESEARCH OBJECTIVES

This dissertation aims:

1.1.1. To identify personality factors which are associated with adolescent suicide attempt.

1.1.2. To identify specific life stresses which are associated with adolescent suicide attempt.

1.3. STATEMENT OF THE PROBLEM AREA.

Suicide has become a very common practice lately, especially amongst the youth. It is rated as the third biggest killer of teenagers in South Africa (Ludman, 1996). Any frustrated youth sees it as a solution. Research has been conducted to look into various dynamics of suicidal attempts, so that recommendations could be made as how to better manage the growing crisis. Many variables make up the South African experience and studies. One study by Balakistnen in Port Elizabeth focused on the seasonal trends of

these attempts. Another study conducted by Pillay, Naidoo and Tlou in Durban, 1990, focused mainly on the cultural aspects or connotations of these attempts. No study, so far, has been made which primarily focuses on personality factors such as anger or impulsiveness, which seem to play an important role in suicidal behavior. Thus the focus of this study to investigate personality factors prevalent in adolescents who have attempted suicide at the Chris Hani Baragwanath Hospital. This hospital serves a very big population, which includes, Soweto – Johannesburg, East Rand, West Rand and other referrals from other provinces.

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1.4. SIGNIFICANCE OF THE RESEARCH.

Peiser & Oberholzer (1985), in their research study on suicide attempt at Garankuwa Hospital in the North West, reported that adolescents constituted the highest number of attempt. The proportion is 45,5% of children between the ages 10 to 19 years. In a similar study in Northdale Hospital (Pietermaritzburg), Pillay (1987) found that there was an increase in adolescents suicide attemptors, who were predominantly female. The majority were between the ages of 16 and 19. The most common methods used were overdosage of pills, drinking detergent and attempted hanging. Almost similar methods as stated above prevail at the Chris Hani Baragwanath Hospital. The number of adolescents admitted at the hospital on suicide attempt is very high. Thus, the researcher sought to investigate personality factors of those adolescents who have attempted suicide.

1.5. HYPOTHESIS.

The following hypothesis will be tested:

1.4.1. There are specific personality factors common to adolescents who have attempted suicide.

1.4.2. Teenagers who attempt suicide are angry and impulsive.

1.4.2. There is poor communication between parents and the adolescent who resort to suicide attempts

1.6. VARIABLES

1.6.1. INDEPENDENT VARIABLE

Personality : for the purpose of the study, personality will be defined as a term that indicates the integrated and dynamic organization of an individual's psychological, social, moral and physical characteristics, as expressed in interaction with the environment and especially between constitutional and environmental factors. (Plug, Meyer, Louw & Gouws, 1986).

1.6.2. DEPENDENT VARIABLE

Attempted Suicide refers to the factitious survival of suicide (Bosch, Schlebusch & Wessels, 1987)

1.7. DEFINITION OF CONCEPTS

1.7.1. Suicide : is the human act of self-inflicted, self-intentioned cessation of life (Shneidman, 1985).

1.7.2. Suicide Attempt : refers to the fortuitous survival of suicide (Shneidman, 1995).

1.7.3. Adolescence : the period of development marked at the beginning by the onset of puberty and the end by the attainment of physiological or psychological maturity.(Reber, 1995)

1.7.4. Impulsivity : An act or event "triggered" by a stimulus and occurring with short latency and with little or no conscious control or direction (Reber, 1995).

1.7.5. Anger : feeling of extreme displeasure, hostility and indignation. (Universal Dictionary, 1988)

1.8. DIVISION OF THE DISSERTATION

1.8.1. Chapter One – Introduction

1.8.2. Chapter Two – Literature Review

1.8.3. Chapter Three – Methodology

1.8.4. Chapter Four – Results

1.8.5. Chapter Five – Discussion of Research Findings and Conclusions

In the next chapter, it is intended to review existing literature on the subject.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

This chapter reviews existing work of the subject and the study. The literature review focuses on adolescent development, etiology of suicide, with an emphasis on personality and social variables, on suicidal trends and methods, and on the structure of the suicidal thought.

2.2. ADOLESCENT DEVELOPMENT

Adolescence is a developmental stage between childhood and adulthood (Keniston in Louw, 1991). It is an intermediary stage of life beginning at puberty and extending to a period in the life cycle socially defined as "manhood" or "womanhood".
This definition is largely associated with modern urban-industrial life (Bakan, 1977). In pre-industrialized societies, adolescence as a special period was not well defined and individuals moved fairly quickly from childhood to adulthood. Adolescence is a period of variable onset and duration that marks the end of childhood and lays the foundation for maturity. Development occurs on three levels, that is biological, psychological and social, all of which are interrelated. Biologically, its onset is signaled by the final acceleration of sexual development. Psychologically its onset is characterized by an acceleration of cognitive growth and personality formulation. Socially, it is the period of intensified preparation for the forthcoming role of young adulthood. At the end of this period, the individual is awarded full status. The timing and amount of this varies among

societies (Ainsworth, 1985).

Sebald cited in Louw (1991) outlines certain tasks which follow that the adolescent needs to master:-

- Acceptance of his or her changed physical appearance.
- Development of a masculine or feminine sex role identity.
- Establishment of heterosexual relationships.
- Development of a strong emotional bond with another person.
- Preparation for marriage and family responsibilities.
- Development of independence from parents and other adults.
- Acceptance of the self as a person of worth and the development of an own identity.
- Development of socially responsible behavior.
- Acceptance and adjustment to certain groups.
- Development of intellectual skills and concepts so that the individual will in due course be able to fulfil adult responsibilities.
- Selection and preparation of career.
- Achievement of financial independence.
- Development of a value system based on a realistic and scientific world view.
- Development of moral concepts and values that can serve as guidelines for behavior.
- Development of a philosophy of life.

A major task of adolescence is to move from being a dependent to an independent person. The initial struggle often revolves around the established concepts of sex roles and identification. Old techniques that the child used earlier to master separation may

return (Ainsworth, 1985). Negativism reappears; for example adolescents may reject advice from parents and other authority figures or they may protest against rules or admonitions about dress and appearance. This negativism is a renewed attempt to tell first the parents and then the world that these growing persons have minds of their own. As in childhood, negativism again becomes an active verbal way of expressing anger. Adolescents may seize almost any issue to show that they have a mind separate from that of their parents. Parents and adolescents may argue about the choice of friends, peer group, school plans and choice of school subjects (Kaplan and Saddock, 1988).

2.3. PSYCHODYNAMIC THEORIES ON ADOLESCENCE

Adolescence is viewed by psychodynamic theories as a second process of individuation, the first having been completed towards the end of the third year of life with the attainment of object constancy (Blos, 1972). Both periods have in common a heightened vulnerability of the personality organization.

2.3.1. ADOLESCENCE: IDENTITY (ERIKSON)

As adolescents begin to feel independent of their families and their families' support, and encourage this emerging maturity, the question "Who am I?", characteristic of the 3 to 6 year old, is heard once again. The individual is faced with the task of developing an identity (Shearin, 1986). According to Erikson in Louw (1991), developing a sense of identity is the main task of the period of adolescence. The adolescent has the task of acquiring feelings of identity which consist of three components, namely the

individual's certainty about his own ability (i.e. the answer to the question : who am I?) certainty about his social identity (i.e. an answer to the question: to which group(s) do I belong ?) and certainty about his own values and ideals (i.e. an answer to the question: what do I wish to achieve?). The internal cause of this crisis, lies in the physical and psychic changes that begin with puberty, namely changes in physique, intensification of the drives (the sexual drive specifically) and the reproductive ability that comes with sexual maturity. In order to solve his identity crisis, the adolescent experiments with various possibilities- he sometimes reverts to earlier identification, sometimes form new identification, sometimes inclined to hero worship and sometimes rebels against the accepted norms of society (Erikson cited in Louw, 1991).

2.3.2. EGO DEVELOPMENT IN ADOLESCENCE (LOEVINGER'S PARADIGM).

Ego is the master trait of personality which serves as an organizing framework for one's customary orientation to one's self and the world (Kroger, 1989). For Loevinger, the ego is a structure which develops over time and is not necessarily bonded by task nor does it relate to chronological age (Kroger, 1989). Ego development is but one of four lines of development (ego, physical, psychosexual and intellectual) which are conceptually distinct. The development of the ego proceeds through a series of stages, believed to be hierarchical and invariant in sequence, which mark a continuum of increasingly complex and differentiated means by which one perceives oneself, the world and one's relationship in it (Kroger, 1989).Individuals are assessed according to ego stage or transition level through their responses. Greatest gains in ego development occur during early and mid-adolescence, with girls generally reaching the higher ego stages

earlier than boys (Kroger, 1989). However no sex difference in ego development has regularly appeared at maturity (Kroger, 1989)

2.3.3. IDENTITY AS MEANING MAKING : THE CONSTRICTIVE – DEVELOPMENTAL APPROACH (KEGAN)

According to Kroger (1989) this integrative theory posits a process which drives cognitive and affective developments and is responsible for generating logic type by Piaget and Kohlberg in the realms of physical and social cognition. The theory describes a sequence of balances and transitions in the relationship between that which is considered "self " and that taken to be "other " Kroger, (1989).

Kroger (1989) further suggests that balance give rise to the meaning one makes of the world; with transitions involving the less of an old way of knowing. Kegan in (Kroger, 1989) suggest that adolescents generally make meaning from the interpersonal balance, in which one " is" rather than " has" relationships, from the organizational balance, in which one " is" rather than " has" one's institutional affiliations; or from transitions to or from each of these balances. A 'self ' optimally evolves to a new balance in a holding environment which has three characteristics: holding securely, letting go, and remaining in place (Kroger, 1989). Bronheim (1986) points out that the period of adolescence is one in which there is a great likelihood that risks will be taken without appropriate regard for long-term consequences. During this period in development, young people often believe that they are invulnerable and immortal, and therefore do not consider the risk they are taking (Sacoor:1989). If the stage of adolescence is successfully negotiated, the individual is able to accomplish tasks including identity clarification, coping with

sexuality and separation. Failure to negotiate the stage may lead to prolonged stress, unresolved conflicts and suicidal behavior (Hansburg, 1972).

2.4. ADOLESCENT SUICIDE

Adolescent suicide attempts places heavy demands on the health care worker's practice and it has major impact on the clinician, the hospital staff, as well as the individual's family. The client who engages in suicide attempt(s) is a constant reminder to the health workers as to the importance of timing and successful intervention.(Kaye and Soreff, 1991). Suicide and suicidal behavior are complex events involving much conceptual confusion about behavior, time, intention, activity and other variables (Shneidman, 1985).

Suicide briefly defined is the human act of self-inflicted, self-intentioned cessation of life. (Shneidman, 1979). Attempted suicide refers to the fortuitous survival of suicide. The term, suicidal behavior, is an umbrella term which is used to denote a wide range of self destructive or self damaging acts in which individuals engage with varying degrees of motive, lethal intent and awareness of possible consequences (Schlebusch, 1988).

For a number of reasons, the term suicide attempt is misleading because the majority of such acts are not intended to be fatal (Diekstra, 1992). The wish to die is just among the many motives for an attempt (Bancroft & Marsack, (1977) cited in Diekstra, 1992).Three different types of motivation can be delineated :

(1) Cessation (death, to stop conscious experience now and forever)

(2) Interruption (to interrupt conscious experience for a while to sleep)

(3) Appeal (to mobilize or change others).

2.5. THE ETIOLOGY OF SUICIDE ATTEMPT

Linehan and Shearin (1988) are of the view that suicidal behavior is the result of dynamic interaction between the individual and the environment as well as the forces interacting within both the environmental system and the person / behavioral system.

The following are aspects that may lead an individual to resort to suicidal attempts. The etiology is two fold: first, the focus will be on personality variables and secondly, on social variables associated with suicide attempt.

2.6. PERSONALITY AND SOCIAL VARIABLES ASSOCIATED WITH SUICIDE ATTEMPT

2.6.1. PERSONALITY VARIABLES ASSOCIATED WITH SUICIDE ATTEMPT

2.6.1.1. ANGER

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Myers, McCauley, Calderon & Trader, (1991) suggest that anger may be common to all suicidal youths. Anger rather than depressed feelings are often emphasized in connection with suicidal behavior. Adolescents who commit suicide tend to have a history of antisocial behavior, which suggest that suicide behavior is more related to anger than is generally recognized. Without socially acceptable methods of releasing anger, individuals turn it on themselves (Rotheram, 1987).

Studies on seriously suicidal youth indicated that suicide, anger and violence were interrelated. There seems to be an outgrowth of struggle to deal with conscious rage and

murderous feelings originating from an early exposure to violence (Hendin, 1991). In a recent review of studies on the relationship between suicide and violence, it was estimated that approximately 30 percent of individuals with a history of violence also had histories of self destructive behaviors.

Psychological autopsies on young suicide victims indicated that just under half of them had history of aggressive and anti-social behavior (Hendin, 1991). Brown and Goodwin (1986) in their study also found significantly higher levels of aggression among individuals with a suicide history versus those without such history.

2.6.1.2. HOPELESSNESS AND DESPERATION

According to Beck, Grown, Berchick, Steward & Streer (1985), hopelessness plays a critical role in suicidal behavior. The above mentioned point is illustrated in the sequences of events that lead a depressed individual to commit suicide. The central role of hopelessness in the development of suicidal ideation has been supported by research. When controlling for depression, the correlation between hopelessness and suicidal intent has remained significant.

Wentzel and Reich (1989) observed high suicidal intent in some patients who showed minimal depression but whose future expectations were negative. The patient systematically misconstrues his or her experience in a negative way and anticipates the most dire outcome for his or her problems. Ultimately the patient is drawn to the idea of suicide as a way out of his or her perceived insoluble problems. Chiles, Strosahl, Jan-

Ping, Michael, Hall, Jemdka, Senn & Rete, (1989) also found that higher levels of depression and hopelessness were associated with higher suicidal risks and that hopelessness acted as a mediator in the relationship between depression and suicidal behavior. However, the presence of depression and hopelessness does not inevitably lead to suicidal behavior. Depressed and hopeless individuals may often display other dysfunctional coping responses for example substance abuse, instead of suicidal behavior.

2.6.1.3. VULNERABILITY

Everybody in life experiences stress and negative life events, but not all of them resort to taking their lives, even in the absence of a supportive environment. This suggest that there are certain personal vulnerabilities most highly related to suicidal behavior. They are summarized as follows : (1) Ineffective problem solving skills for reducing both environmental stress and regulating affective distress, (2) Hopelessness, no reason for living and low tolerance to distress, (3) high expectancy that suicide is the solution to the problem (Balakistnen, 1992).

2.6.1.4. IMPULSIVITY

According to Perry (1989) Narcissistic, histrionic, antisocial and borderline personality disorders represent the impulse spectrum. Perry (1989) is of the opinion that these disorders constitute the great risk of suicidal behavior. These individual act quickly prior to thinking and calculating correctly the consequences or impact of their actions.

However, Breetzke (1988), in his suicide study in Cape Town came up with the findings

that with 80% of cases the act was premeditated since, notes were left behind, there were change remarks or outright statements of intent and even telephone conversation on the issue. It was only in 10% that it appeared impulsive. In the remaining 10%, the nature was a bit uncertain.

2.6.2. SOCIAL VARIABLE: ASSOCIATED WITH SUICIDE ATTEMPT

2.6.2.1. STRESS

One interpretation of the phenomenon of suicide attempt is that it is a response to stress. This perspective suggest that stress is external to the individual and emanates from those social conditions which govern their lives. When the individual is subject to stress, so much can be tolerated, but no more and when this point is reached pathological internal processes such as depression are said to take over (Jack, 1992). This may result in a person attempting suicide.

2.6.2.2. LACK OF SOCIAL SUPPORT

One other social variable predisposing to suicidal behavior is lack of social support. Topol and Reznickaff (1982) cited in Linehan and Shearin (1988) found that amongst adolescents, lack of confidence, particularly among females, distinguished adolescents who are prone to attempting suicide from normal but not psychiatric controls. Those individuals who are socially isolated, or those who lack confidants, do not experience social support, which places them at risk of suicidal behavior. Social isolation is one other important immediate social determinant of suicidal behavior.

2.6.2.3. SOCIAL CONFLICT

Social conflict can be seen as either environmentally generated by which the individual is exposed to an additional source of stress, or as that which is generated solely by the person within the question (Balakistnen, 1992.) In most cases of suicidal events, interpersonal problems are the cause. One find that most of these events are dyadic, or two person events (Shneidman, 1979). Precipitating interpersonal problems can further be subdivided into parent, family, gender identity or peer group conflict, mental problems associated with personality disorder (Bosch, Schlebusch & Wessels, 1987).

One of the most common conflicts is between adolescent and their parents. This was the most common or prevalent problem at the Chris Hani Baragwanath Hospital. Suicidal adolescents often indicated difficulties in communicating with their parents. The feelings that their parents do not understand them and there is a lack of positive emotional warmth and closeness in their families (Schlebusch, 1992).

In most cases an argument with a significant person in the individual's life takes place a day or two before the attempt and this constitutes one of predominant precipitants of suicidal attempts. Other aspects which play a role in suicidal intentions are stressors, like dating someone against parental wishes, academic problems including scholastic underachievement and relationship problems with teachers, interpersonal problems like difficulties with romantic partners, for example, recent termination of a relationship and fear of pregnancy (Schlebusch, 1992). Other authors came up with the findings that the suicidal children had been more exposed to both violent interaction between parents and physical abuse from these parents, Kosky (1993) cited in Linehan and Shearin (1988).

2.6.2.4. NEGATIVE LIFE EVENTS

Negative life events can also be a leading cause to suicidal ideation. King (1992) cited in Paykel (1991), found that in the twelve months prior to admission, the suicidal sample had experienced more death of grandparents, hospitalization, separation or divorce of parents, remarriage and peer acceptance change, in comparison with the control group. His view of such events are associated with long term negative future. This study supports the observation that suicidal actions are a response to prior negative events occurring in the social mellieu.

2.6.2.5. A CRY FOR HELP

An act of suicidal attempt sometimes is directed at the social environment in which these individuals operate. Often the behavior is directed towards a key person and thus it may be viewed as a cry for help. The suicidal behavior functions as a form of communication between the patient and the key figure. Thus the hopelessness and despair the person experiences is communicated in a pathological manner most often conveying an appeal for attention and help (Krietman, Smith & Tan, 1970). Attempting suicide becomes a behavioral option for the adolescent whose previous cries for help have gone unheard.

2.6.2.6. A MANIPULATIVE ACT

Schlebusch (1992) says that often the first attempt is para-suicide. The intention is not to die, but the person is young, has a problem and does not know how to solve it. Sometimes it is a way of manipulating parents as stated Alex O' Neil in (Ludman, 1996). Patros and Shamoo (1989) suggest that adolescents' attempts are a way of

manipulating others in order to gain love and affection or to punish others or to change an impossible situation. These manipulation attempts, usually against the parents, are the adolescents' effort to take control of a situation where there are feelings of vulnerability and hopelessness.

Schlebusch and Wessels (1988) maintain that, at a certain level of hopelessness, para-suicide (first attempt) becomes a problem solving skill. Thus, most adolescents who attempt suicide harbor along self destructive urges, a wish to live of varying strength, or at least a wish not to die. Schlebusch (1992) continue to state that a suicide attempt is a swift and certain way of gaining craved adult attention. Paradoxically, where the attempt is unsuccessful, it has the power to set the family on a healing course. Problems are forced into the open, specialist help is often sought and coping strategies devised.

2.6.2.7. PEER INFLUENCE

It is a widely known factor that adolescents are susceptible to the influence of their peers. Kroger (1989) suggest that the peer group provides support in meeting the individuation challenge as well as an index of adolescent separation- individuation status.

In their study, King, Raskin, Gdowski, Butkus & Opipari, (1990) found that adolescent suicide attemptors reported a greater dependency on peers for emotional support than did non attemptors. Thus it appears that the adolescent with poorer quality friendship is more at risk for suicide. This suggests that high-risk adolescents have significantly poorer quality friendship than did low risk. This goes to show that good friendship has pivotal importance in an adolescent's life.

2.7. INDICATORS TO SUICIDAL IDEATION

Brain (1986) points out that an increased in the index of suspicion for the presence of adolescents difficulty should be exercised. These can serve as indicators to suicidal ideation:

- when several behavioral changes occur and persist over time.
- when the adolescent is preoccupied with thoughts or expressions of death or dying and has made or implied threats of suicide or has made previous attempts.
- If the adolescent is under stress from an important life crisis or life event.

Behavioral equivalents of depressive symptoms in teenagers may be truancy, somatic complaints, restlessness and anti-social acting out. e.g. An addition of the danger sign outlined by the social worker of Witwatersrand mental health found in (Ludman, 1996) includes:

- Previous attempts
- Available means
- Alienation
- Self doubt or feeling of uselessness
- Cynicism about one's self
- Sullenness and truancy
- Drugs / alcohol abuse
- running away from home

2.8. TRENDS

In the child psychiatric unit of Chris Hani Baragwanath Hospital there was a slight rise of suicidal attempts, especially on Fridays and Mondays. This was evidenced by the present author. The most popular months where there was a rise in suicidal attempts were June-July and December-January. The clinic professionals on their explanations associated this high rise of attempts to poor academic achievements and conflict with parental figures.

Most of the patients who were attended to were girls and very few boys. (Hawton, 1987) supported this presentation by stating that far fewer teenage boys attempt suicide. Other views are that there are fewer boys admitted in the clinics because they use very dangerous methods which really take their lives, unlike girls.

The age difference ranges from 12 to18. There are sometimes those rare cases whereby children of under the age of twelve were seen at the psychiatric clinic (Chris Hani Baragwanath Hospital). Borst, Naom & Bartok (1991) reports that suicide attempt under the age of 12 is a rarity.

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2.9. METHOD

There are various methods used by attemptors to take their lives. By far the most frequent method chosen, accounting to over 90% of "attempted suicide," involve self poisoning by an overdose of drugs (Hawton & Catalan, 1982). Pillay, Naidoo & Tlou, (1992) found that at the Addington Hospital in Durban, self poisoning, 89% was by far the most common method of self destructive behavior. Self poisoning is also the popular

method used by adolescents seen at the Chris Hani Baragwanath Hospital. This includes overdosing substance like pills, drinking detergents, benzine and paraffin. Other rare cases of severe self destructive behavior included self stabbing or self burning. Other self injurious behavior used include wrist cutting, attempts at hanging, drowning, self-immulation and fenestration. (Kok, Du Preez & Bosch, 1992) Self incineration, strangulation, broken glass ingestion and laceration of the throat were other self injurious behavior observed by Pillay, Naidoo & Tlou, (1992).

2.10. THE STRUCTURE OF THE SUICIDAL THOUGHT

One point of interest is to understand what takes place in the cognitive processes of suicide attempts.

2.10.1. RIGIDITY AND CONSTRICTION OF THINKING

Suicidal individuals tends to have a rigid mode of thinking, which makes it difficult for them to develop new or alternative solutions to overcome emotional difficulties. According to Neuringer (1976) rigidity and constriction of thinking have debilitating consequences for all humans but the consequences can be lethal for individuals disposed to suicidal behavior. The rigid person finds it difficult to change and entertain new behavior options. This traps the individual in a closed system from which there is no escape. Even when possibilities for change are suggested to such an individual, he finds it impossible to accept them. At the end, death can be seen as an escape from an impossible situation (Baumeister, 1990)

2.10.2. NEGATIVE THINKING

Other views are that suicide and suicidal behavior are the product of negative thinking. Beck, Brown, Berchick, Stewart & Steer, (1975) are of the view that suicidal behavior is derived from specific cognitive distortions, the patient systematically misconstrues his experiences in a negative way, and without objective basis, anticipates a negative outcome to any attempts to attain major outcome or goals. One of the most important thing they forget to do, is to think through the implications of their thoughts.

2.10.3. DICHOTOMOUS THINKING

Dichotomous thinking is the tendency to polarize thought in an extreme manner, which has been found to be an important ingredient in the cognitive structure of suicidal individuals. All people think dichotomously but most individuals have the capacity to moderate or even ignore dichotomies. Suicidal individuals lack the flexibility and cling to extreme polarized views.

Such rigid clinging to polarized thinking precludes the possibilities for moderation, compromise, and shifting of perspectives. This leads to diminished problem solving adaptation as well as making the use of cognitive facilities extremely difficult. Dichotomous thinking can be lethal because if the individual is dissatisfied with something in his life he finds it difficult to modulate his extreme polarized expectancies, and therefore, cannot conceptualize compromise. This rigid adherence to extreme which cannot be realistically realized, makes life miserable for the suicidal individual (Neuringer, 1976).

2.10.4. IDEAS ABOUT DEATH

Maltsberger in (Williams, 1997) Summarizes the sorts of ideas about death that might be apparent in the suicidal person.

(1) Suicide is a gateway leading into a dreamless sleep (nothingness).

(2) It will effect a reunion with someone or something that has been lost.

(3) It will be a way of escaping from a persecutory enemy, interior or exterior.

(4) It will destroy an enemy who seems to have taken up a place in the patient's body or some other part of himself or herself.

(5) It will provide a passage into another, better world.

(6) One can get revenge on someone else by abandoning him or her or by destroying his or her favorite possession (one's own body) and one can then watch him or her suffer from beyond the grave.

2.11. CONCLUSION

The literature review suggests that suicidal attempts is increasing predominantly among female adolescents. This view is corroborated by three studies made in Durban at the Addington Hospital by Pillay, Naidoo and Tlou and Oberholzer at Garankuwa Hospital. The same pattern is also evident at the Chris Hani Baragwanath Hospital. The most prevalent method used is drug overdosage.

Literature also suggests that adolescents who attempt suicide are exposed to various life stresses which encompass both personality and social variables. These include amongst

others hopelessness and desperation, lack of social support, social conflict and a cry for help. One important realization is that, not all attemptors want to die. They used the suicidal attempt as an instrument to mobilize change in their lives. Others only want to interrupt conscious experience for a while to sleep.

In conclusion facing different tasks and life challenges could be a heavy assignment for an adolescent. Without proper skills to deal with problems and without support, she or he can find herself or himself pushed to the limit and end up attempting suicide. The best thing that society can do is to love their adolescents so that they can in turn love themselves and grow up as healthy, mature adults.

THEORETICAL PERSPECTIVE

The researcher takes the psychoanalytical perspective on suicide by Sigmund Freud. The first important psychological insight into suicide came from Sigmund Freud. In His 1917 paper, "Mourning and Melancholia", he stated his belief that suicide represents repressed aggression that is turned inward either from the death instinct or from the loss of a love object for whom there are ambivalent feelings (Kaplan & Saddock, 1991).

When an individual suffers severe psychic pain, every effort is made to disengage from the source of pain. Often the disappointing object is loved as well as hated, and as a result the hostility and anger cannot be directly expressed. In such instances, anger and death wishes are turned against self (Balance & Leenaars, 1991).

This hostility is often strikingly obvious when young people use suicide as an expression of revenge towards their parents. Such youngsters usually feel overwhelmed by murderous feelings towards their parents and being fearful of venting these emotions outward, they would rather turn it onto themselves to destroy the hated internalized love object (Borst, Naom & Bartok, 1991)

Suicide is therefore seen as an act of anger and need for revenge. The suicidal person does not use direct revenge, but it is still revenge since the object is likely to hold himself or herself responsible for the act (Furst & Ostew, 1979).

CHAPTER 3

METHODOLOGY

3.1. INTRODUCTION

Methodology is defined as the philosophy of the research process, which includes the assumptions and values that serve as a rationale for the research and the standards of criteria the researcher uses for interpreting data and reaching conclusions (Bailey, 1987). To adhere to the methodological requirements of the study attention was given to the research design, instrument, sample, procedure, the study and data analysis.

3.2. RESEARCH DESIGN

The research study is descriptive in nature. It holds quantitative description of the phenomenon under study. The use of a case study served as a research design. The case study refers to the investigation of an individual or a group of individuals in the absence of experimental control (Marshall and Rossman, 1989).

The design is chosen because experimental manipulation of conditions is not possible or permissible due to ethical or practical constrains. The case study draws inferences by attempting to isolate casual relationship between interventions and their side effects. It is often a first attempt to understand a phenomenon and its consequences. Case study research has several purposes to chronicle events, to construct and try out, prove or test (Guba and Lincoln, 1981).

3.3. INSTRUMENT

The researcher used the High School Personality Questionnaire (HSPQ) for identifying personality factors prevalent in adolescents who have attempted suicide. The HSPQ was developed in the USA by Raymond B. Cattell and Mary D. Cattell. The aim in developing the HSPQ was to create a questionnaire that could give a valid and reliable picture of the personality of a person aged between 12 and 18 years. The questionnaire included all the major dimensions of personality that could factorialy analyzed (Cattell & Cattell , 1975). The HSPQ was later standardized for South African usage by Madge (1968) and re-standardized by Visser, Garbers – Strauss & Prinsloo, (1992).

The HSPQ is a paper and pencil questionnaire consisting of 142 items of each of the questionnaire. Four forms (Form A, B, C, and D) of the HSPQ have been constructed, of which Forms A and B have been standardized for South African groups. These two forms, A and B of the HSPQ were administered in 1989 to 4769 high school pupils aged 13 - 18 years in order to make current norms available to the HSPQ.
It takes about 40 - 50 minutes to finish one form but there is no time limit . For the purpose of this study the researcher has divided the sample age category, in the following manner: 12 -14 as lower adolescents and 15-18 as upper adolescents. Form A since it was the easier one was given to the lower adolescents, and Form B was given to the upper adolescents. Both forms measure the following personality factors :

FACTOR A: Warm-heartedness

B: Intelligence

C: Emotional stability

D: Excitability

E: Dominance

F: Carefreeness

G: Conscientiousness

I: Tender-mindedness

J: Individualism

O: Guilt proneness

Q2: Self-sufficiency

Q3: Self-control

Q4: Tension

(NB: High School Personality Questionnaire (HSPQ) is a protected psychological test, thus it could not be attached as an appendix to this dissertation.)

3.4. SAMPLE

The respondents of the study were 20 adolescents. The sample was chosen randomly from adolescents who presented at the child, adolescent and family unit, Department of Psychiatry at the Chris Hani Baragwanath Hospital, following a first suicide attempt between the 1st July 1999 to 31st March 2000. Consent to participate in the study was obtained from the adolescents' parents since the respondents were underage. (See appendix A for consent form). The characteristics of the sample follows.

TABLE 1 GENDER

	GENDER	
GENDER	**NUMBER**	**PERCENTAGE**
MALE	1	5%
FEMALE	19	95%
TOTAL	**20**	**100%**

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TABLE 2 AGE

	AGE	
YEARS	**NUMBER**	**PERCENTAGE**
12-14 (Lower adolescents)	6	30%
15-18 (Upper adolescents)	14	70%
Total	**20**	**100%**

TABLE 3 LANGUAGE

	HOME LANUAGE	
LANGUAGE	**NUMBER**	**PERCENTAGE**
ENGLISH	-	-
AFRIKAANS	1	5%
ZULU	11	55%
XHOSA	-	-
TSWANA	4	20%
SOUTH SOTHO	3	15%
NORTH SOTHO	1	5%
SWAZI	-	-
VENDA	-	-
TSONGA	-	-
NDEBELE	-	-
TOTAL	**20**	**100%**

TABLE 4 SCHOOL

	SCHOOL	
SCHOOL	**NUMBER**	**PERCENTAGE**
PRIVATE SCHOOLS	4	20%
PUBLIC SCHOOLS	15	75%
NOT ATTENDING	1	5%
TOTAL	**20**	**100%**

3.5. PROCEDURE

First, a pilot study was conducted. The sample consisted of 5 adolescents who were referred to the Unit from the medical wards for attempting suicide. This procedure was followed to ensure (i) that test the respondents understood the test items; (ii) scored the responses correctly. The results of the study showed that:

- All respondents concentrated and coped well with the length of the test.
- The majority of respondents have a high standard of English.
- Only two respondents needed clarification of words such as ,fad and anchor, for such cases the administrator was present all the time to assist by explaining difficult concepts.

3.6. THE STUDY

- The services of a qualified psychometrist were enlisted in the administration.
- As indicated earlier, the sample was drawn from adolescents between the period 1st July 1999 to the 31st March 2000 at the Unit.
- A request was made to them by the researcher and staff members to partake in the study.
- Written consent of parents was obtained, as all participants were underage.
- The test was administered on an individual basis. All the respondents who were referred to the Unit, whose parents had given consent, were tested within 48 hours after the suicide attempt.
- The researcher and the assistant were available throughout the testing period, to

monitor and assist, should there be a need.

3.7. DATA ANALYSIS

Data analysis is the categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions (Kerliger, 1980) in (Reid,1984). Descriptive analysis was used. The researcher, used bar graphs to present the findings.

3.8. CONCLUSION

The preceding section was on research methodology. The following chapter will focus on the results.

CHAPTER 4

RESULTS

4.1. INTRODUCTION

This chapter will be presented in the following manner: Firstly, the researcher will explain the factor, then present the bar graphs which displays (1) an overall distribution of respondents (2) age distribution (3) language distribution (4) school distribution and there after interpret the graph.

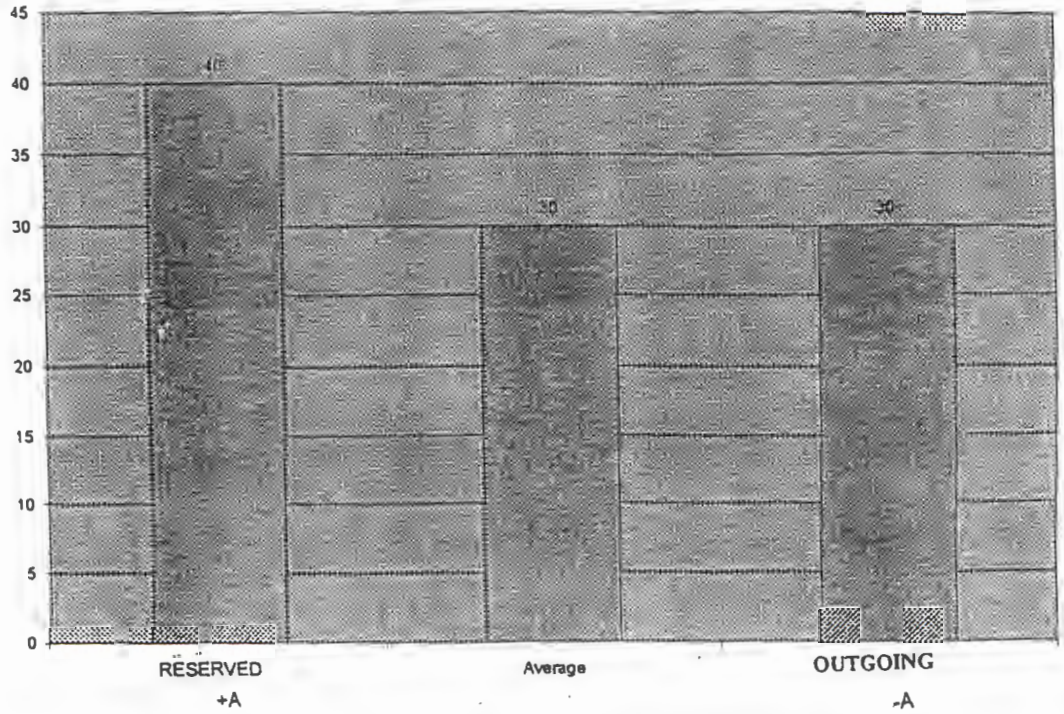
The HSPQ measures fourteen relatively independent personality dimensions of primary factors. In all the factors that will be presented there is a bipolar continuum and for convenience a letter of the alphabet represents each factor. The poles of each factor are named but they are not necessarily opposite traits.

(1) FACTOR A

Factor A measure warm-heartedness. Persons with (+A) display warmth and are easy going. They reveal their emotions, show interest in and are tolerant of people. (-A) persons are less accommodating and more serious than (+A) persons. They do not communicate easily with people. They prefer not to work directly with people and enjoy working alone. They prefer factual conversation in companionship and tend to be introspective.

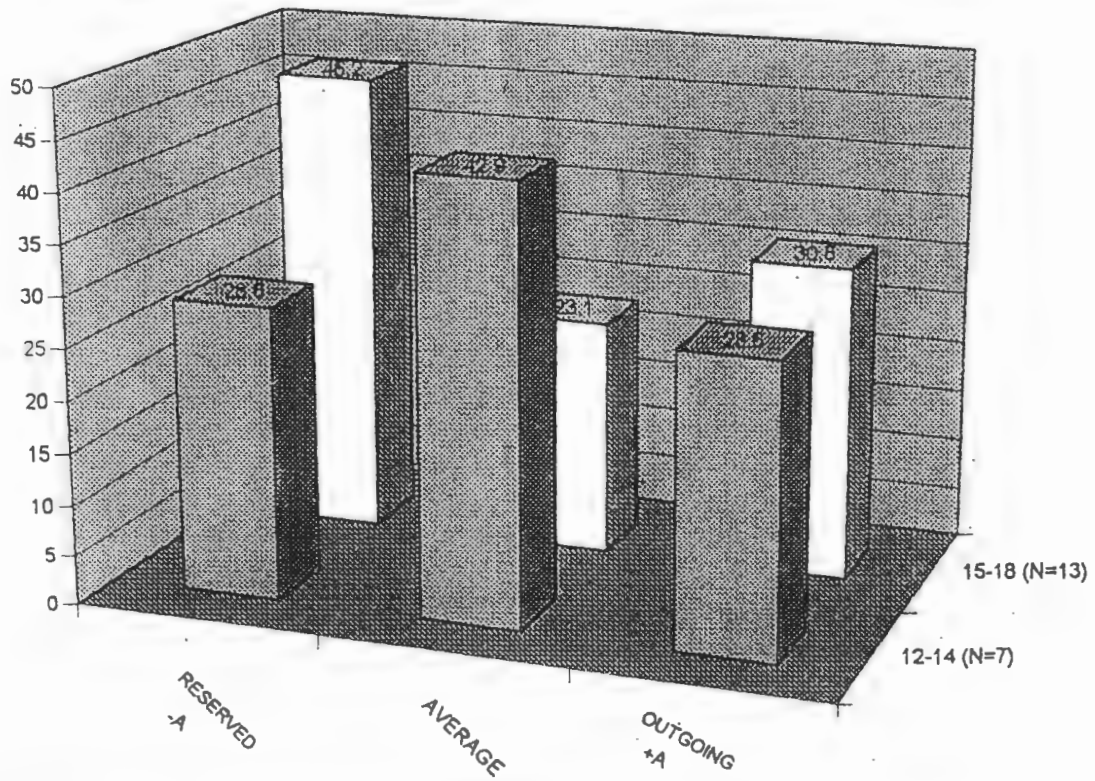
In comparison with (-A) persons, (+A) persons participate more easily in group activities, are more impulsive and generous in their relationship.

GRAPH 1 OVERALL DISTRIBUTION FACTOR A (RESERVED/OUTGOING)



According to the illustration given by graph1 above , 40% of the overall participants scored as reserved. There was an equal distribution of 30% in the average and outgoing category.

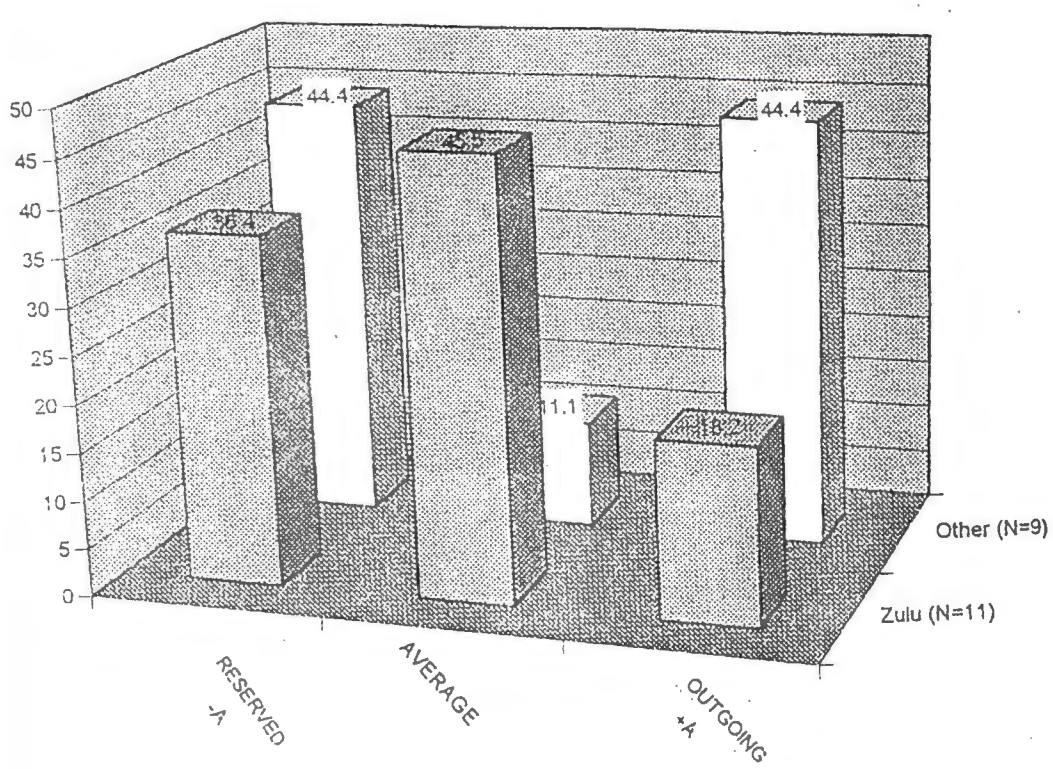
GRAPH 1.1 AGE DISTRIBUTION FACTOR A (RESERVED/ OUTGOING)



46.2 % of the upper adolescents scored as reserved while only 25% in the young adolescents group scored with this personality trait. As we look further in the

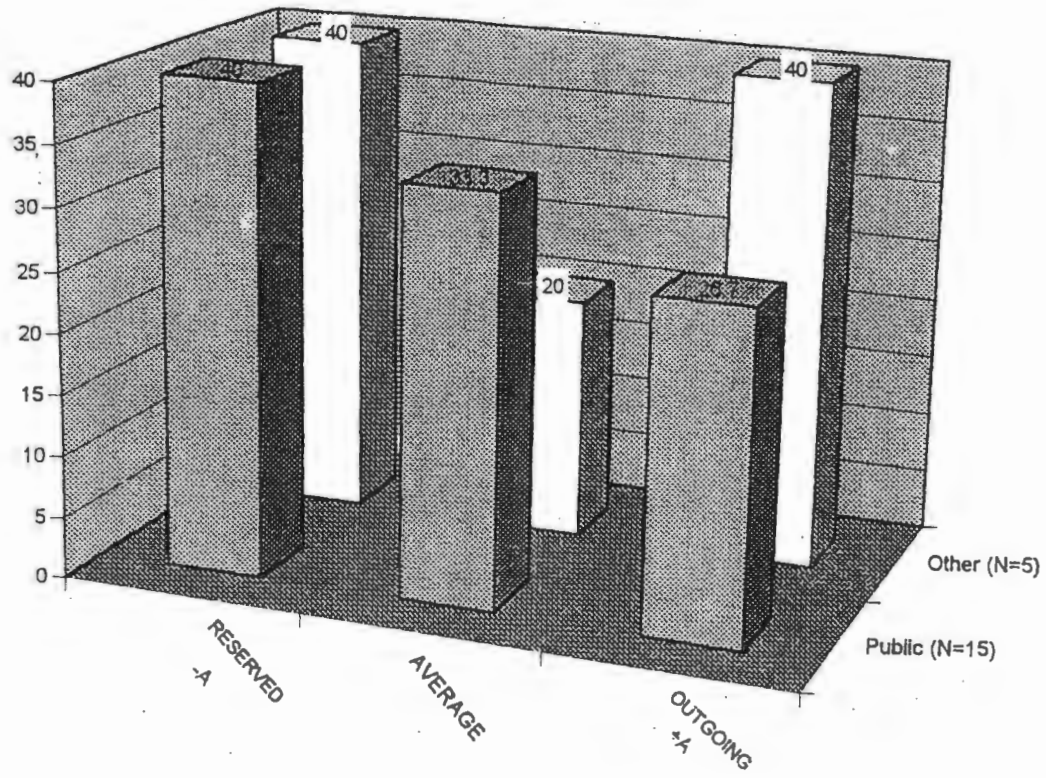
graph, we find that there is an equal contribution of 28.6% in both reserved and outgoing category for lower adolescent.

GRAPH 1.2 LANGUAGE DISTRIBUTION FACTOR A (RESERVED/ OUTGOING)



Presentation of graph 1.2 above gives the following picture: 45.5% of the Zulu speaking respondents scored as neither reserved nor outgoing. 36% scored reserved and the minority 18.2% scored as outgoing. The other language groupings scored equally on reserved and outgoing personality traits at 44.4%.

GRAPH 1.3 SCHOOL DISTRIBUTION FACTOR A (RESERVED/ OUTGOING)

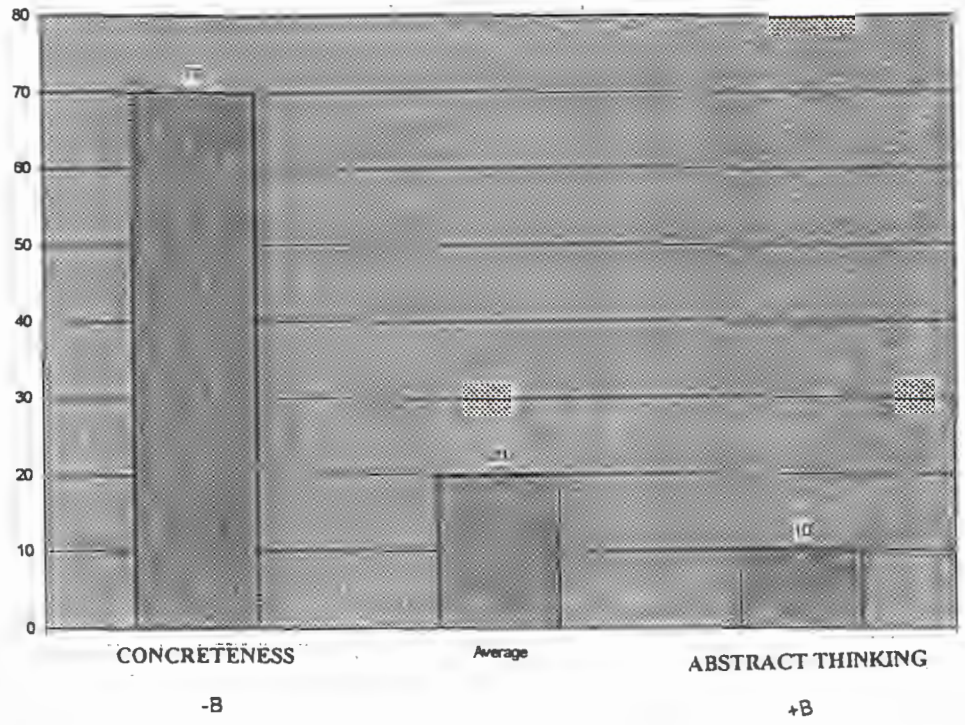


As presented by graph 1.3, the minority of respondents 26.7% in the public schools are outgoing. 40% are reserved and 33.3% are just average. There is an equal distribution of 40% on the reserved and outgoing category in the non-public schools.

(2) FACTOR B

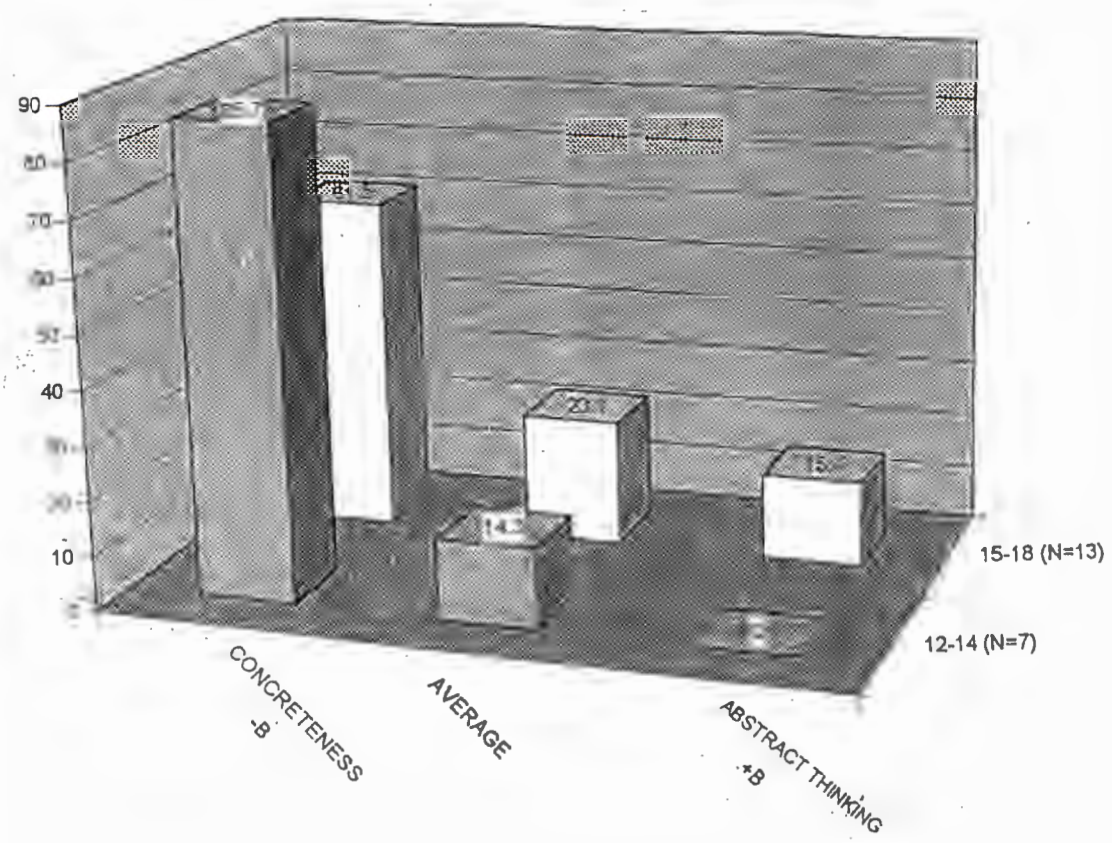
This factor "measure" a respondent's crystallized or general intelligence and the level of abstract thought (+B) is indicative of high intelligence, insight and fast learning.(-B) is indicative of low intelligence.

GRAPH 2 OVERALL DISTRIBUTION FACTOR B (CONCRETENESS/ ABSTRACT THINKING)



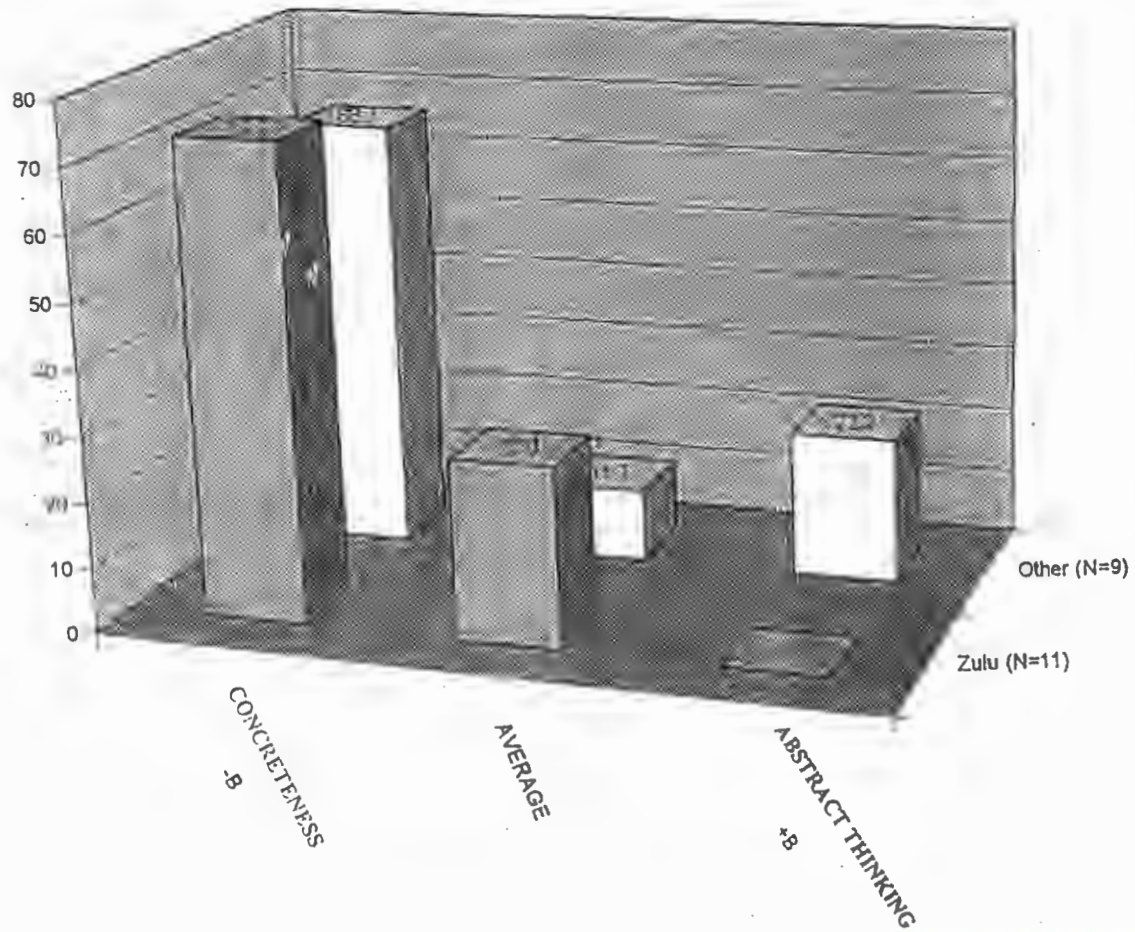
The findings of graph 2 above showed that the majority of respondents 70% fells within the low intellectual level category. Only a minority of 10% were of high intelligence. The remaining 20% were average.

GRAPH 2.1 AGE DISTRIBUTION FACTOR B (CONCRETENESS/ABSTRACT THINKING)



The majority of respondents in both lower and upper adolescent grouping were of low Intelligence in graph 2.1 above, 85.7% from the lower adolescents and 61.5% from the upper adolescent group. There were no respondents from the lower adolescent group who showed high intelligence scores. Only 10% from the upper adolescent scored with high intellectual level.

GRAPH 2.2 LANGUAGE DISTRIBUTION FACTOR B (CONCRETENESS/ ABSTRACT THINKING)



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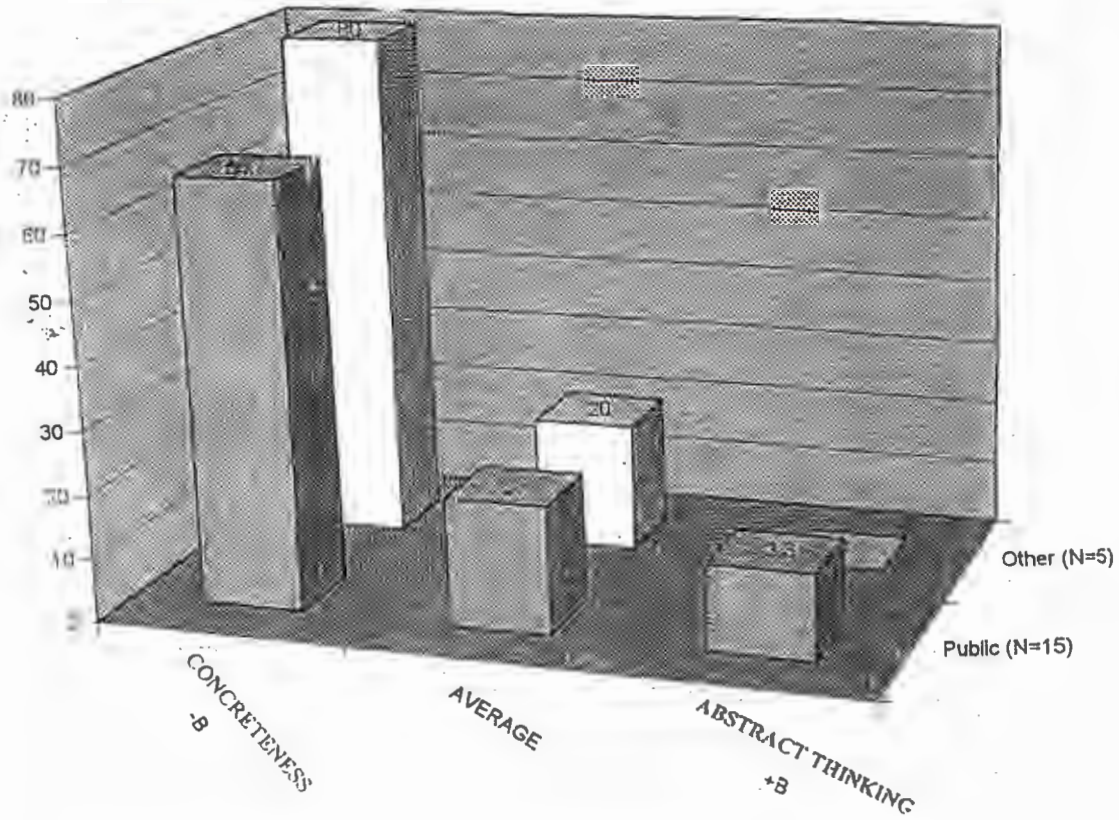
The display of graph 2.2 shows us that in both language grouping categories, the majority of respondents were of low intelligence. None in the Zulu category scored with high intelligence and 22.2% in other language groupings scored with high intelligence.

GRAPH 2.3 SCHOOL DISTRIBUTION FACTOR B (CONCRETENESS/ ABSTRACT THINKING)



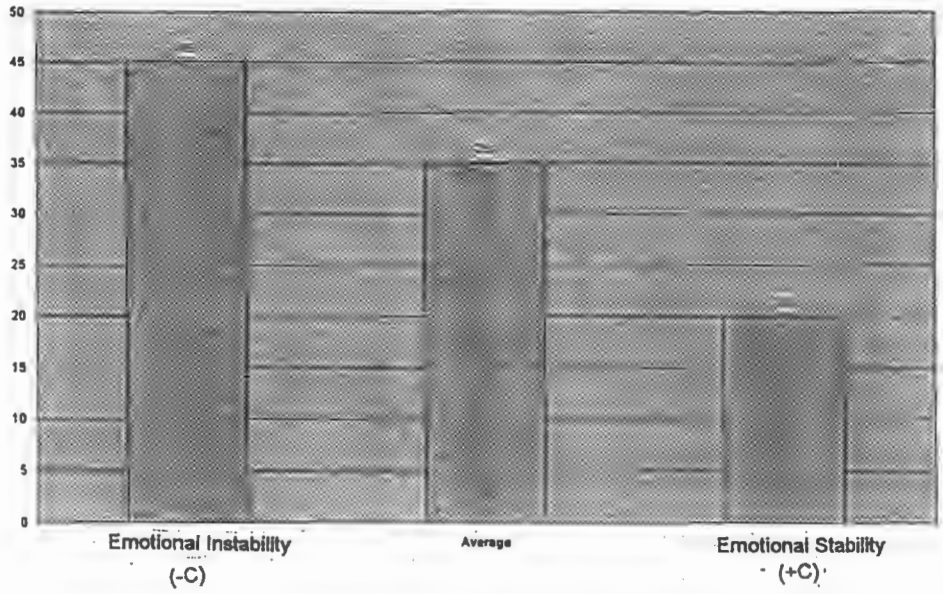
According to the presentation given by the above graph 2.3 only a minority of 13.3% in the public school category scored with high intelligence. 20% in both public and non-public schools score average. The majority 66.7% in the public school and 80% in the non-public schools scored with low intelligence.

(3) FACTOR C

This factor measures emotional stability. Persons with (+C) score are described as emotionally stable and controlled. They appear calm and behave in an adult and rational way. Persons with (-C) score seem to reveal the inability to control their emotions and impulses, and to find satisfying and realistic way of expressing them. They tend to be easily angered, are more frequently dissatisfied with their family and school. They find it

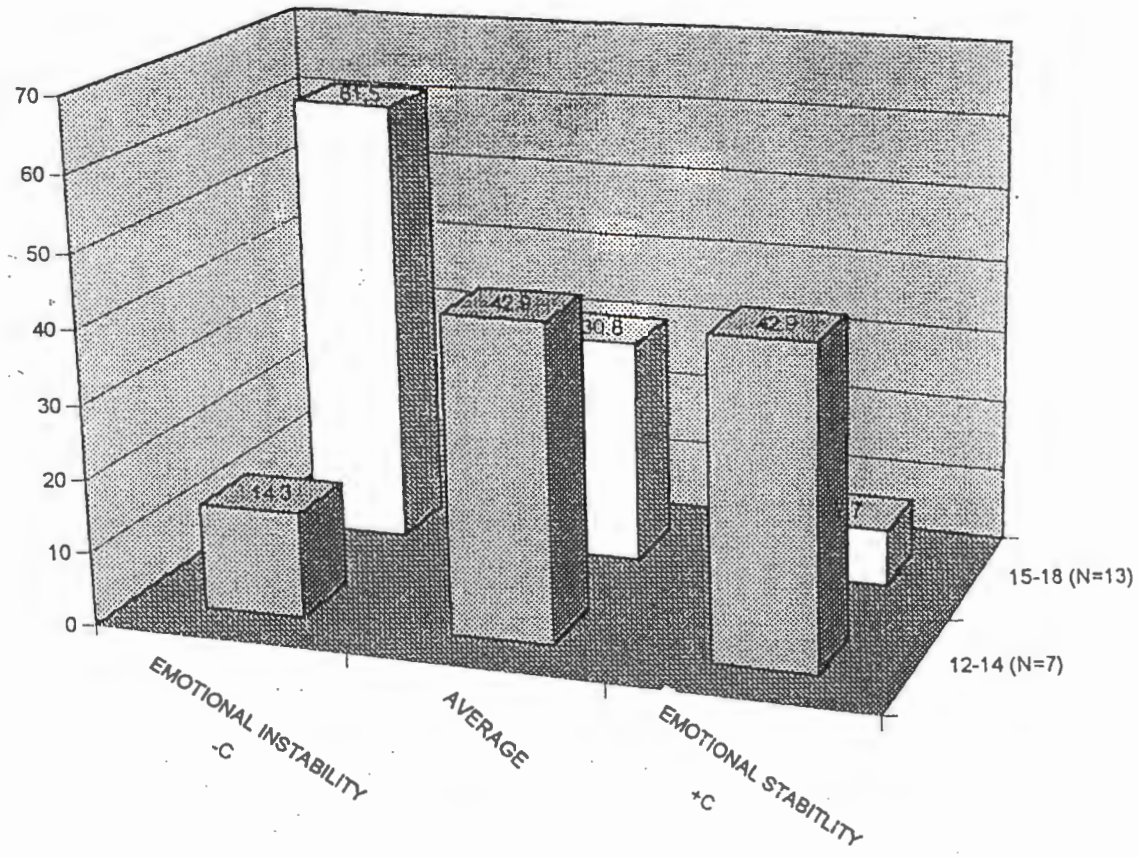
difficult to restrain themselves and are discouraged by their inability to meet good standards of behavior.

GRAPH 3 OVERALL DISTRIBUTION FACTOR C (EMOTIONAL INSTABILITY/ EMOTIONAL STABILITY)



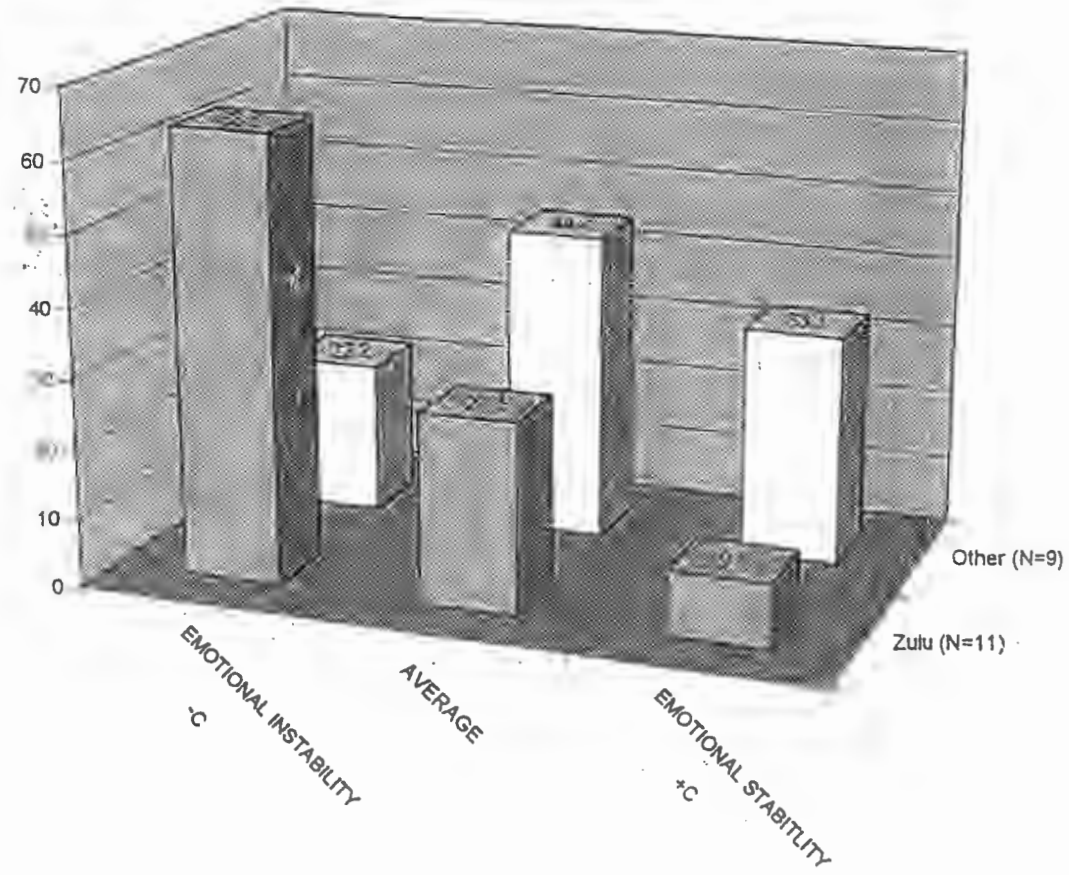
45% of the respondents in graph 3 are emotionally unstable, and 55% measure between average and emotional stability.

GRAPH 3.1 AGE DISTRIBUTION FACTOR C (EMOTIONAL INSTABILITY/ EMOTIONAL STABILITY)



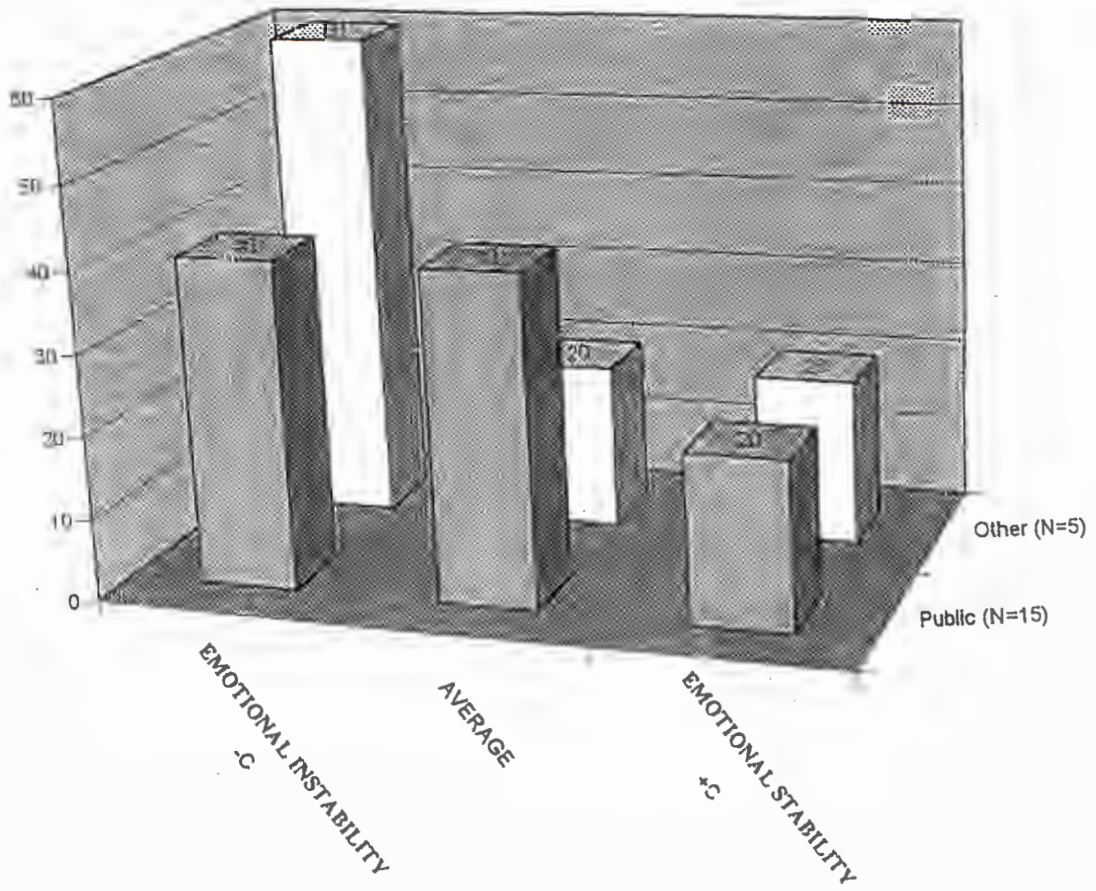
Graph 3.1 displays a significant difference between the upper and the lower adolescents in the scoring of this factor. The majority 61.5% of the upper adolescent scored high on emotional instability while only a minority of 14.3% of the lower adolescent scored with this trait.

GRAPH 3.2 LANGUAGE DISTRIBUTION FACTOR C (EMOTIONAL INSTABILITY/EMOTIONAL STABILITY)



The presentation of graph 3.2 above is almost the same as the previous one. The majority 63.6% of the Zulu speaking respondents scored high on emotional instability and only a minority of 9.1% scored as emotionally stable in the same grouping. Only few respondents 22.2% from other language grouping scored as emotionally unstable.

GRAPH 3.3 SCHOOL DISTRIBUTION FACTOR C (EMOTIONAL INSTABILITY/ EMOTIONAL STABILITY)



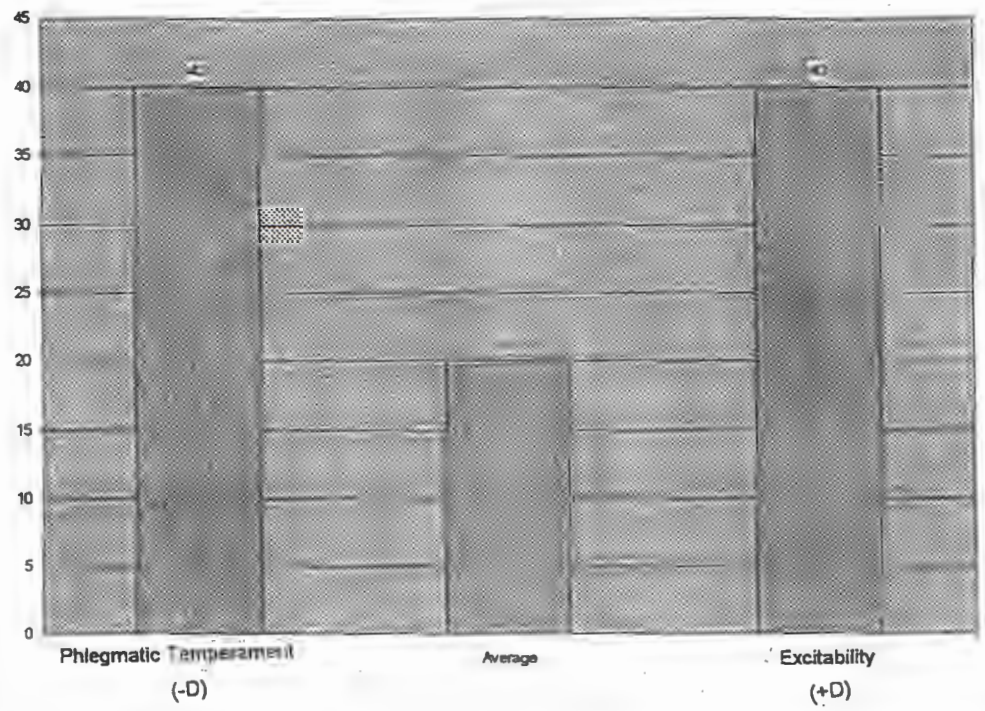
Only 40% from the public schools are emotionally unstable as opposed to 60% from private schools who scored high on this trait. The two groupings scored equally 20% on emotional stability.

(4) FACTOR D

Factor D measures the level of excitability. (+D) is associated with the rebellious adolescent who is easily upset, quick tempered and has an outburst of rage. The (+D) person states that they are restless sleepers, easily distracted from their work by noise or personal problems and that they feel hurt and angry when they are restrained pushed.

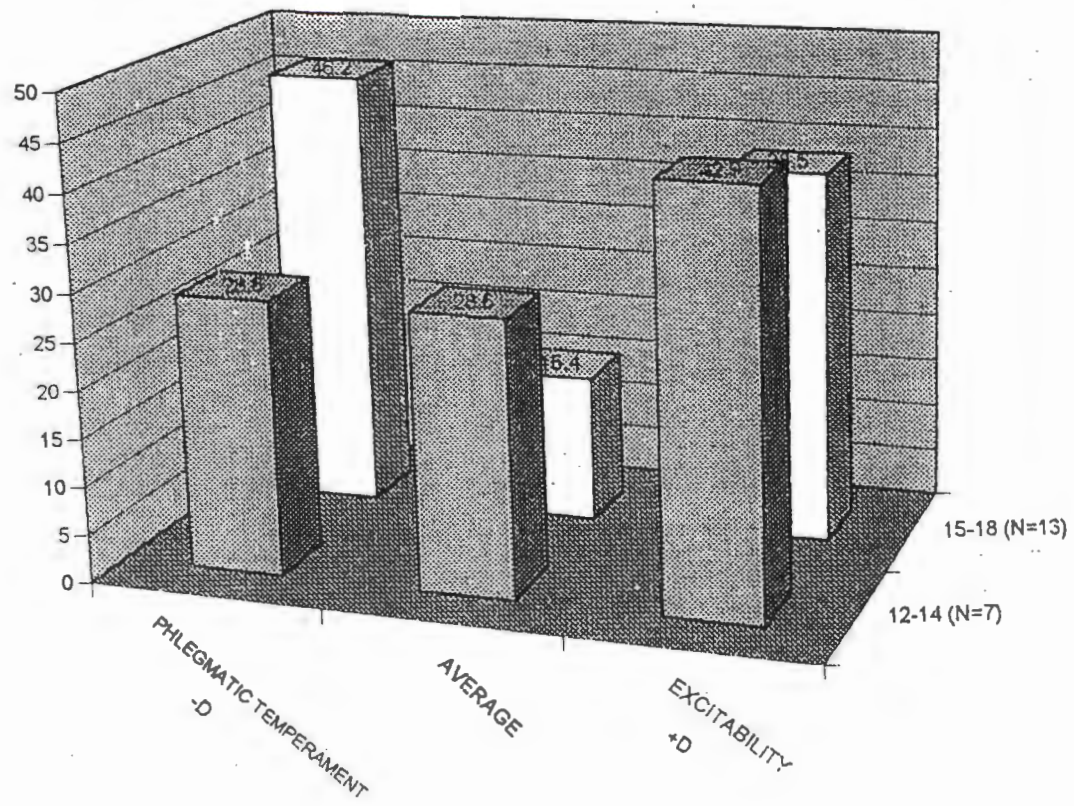
The (-D) persons are calm, complacent, level-headed and reserved. The (+D) factor is distinguished from the (-D) factor by the more "temperamental" quality of excitability, distractibility, unsureness and uncontrolled impulsiveness.

GRAPH 4 OVERALL DISTRIBUTION FACTOR D (PHLEGMATIC TEMPERAMENT/EXCITABILITY)



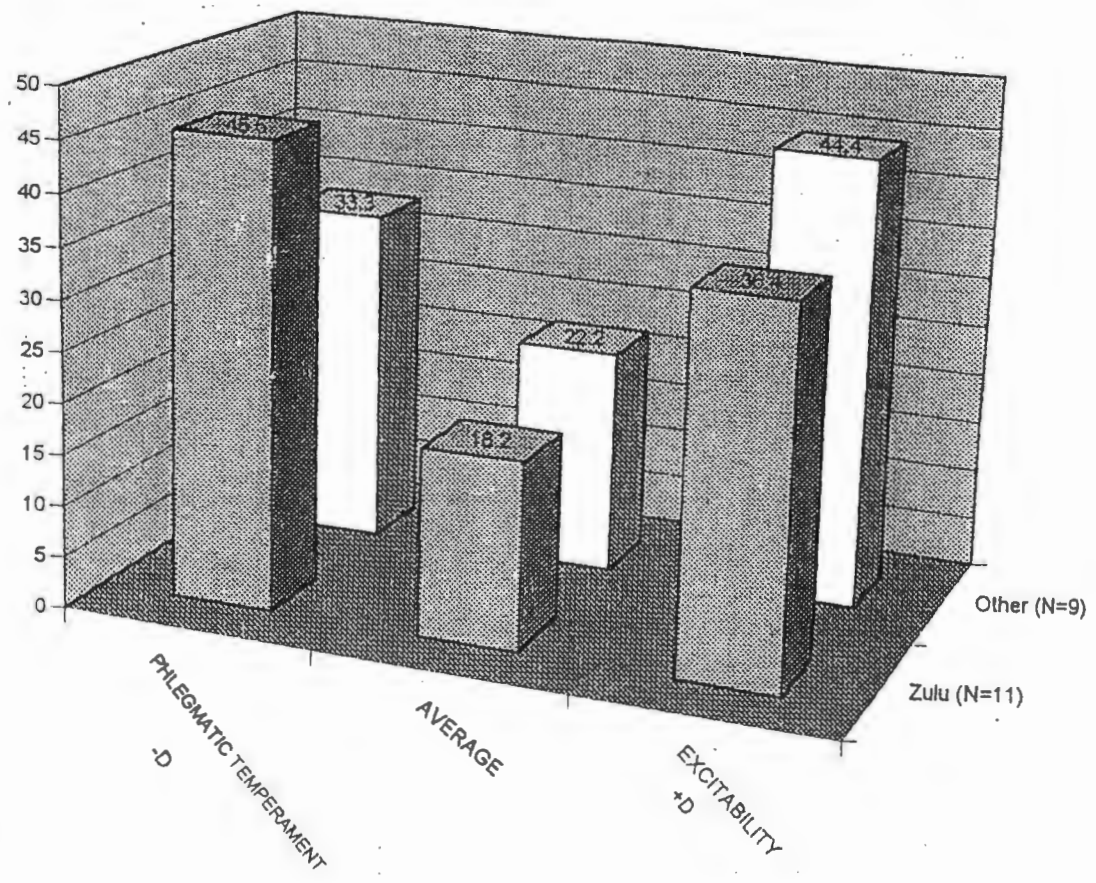
There was an equilibrium in the scoring of this factor: 40% scored with phlegmatic temperament and another 40% scored as excitable. The remaining 20% were average.

GRAPH 4.1 AGE DISTRIBUTION FACTOR D (PHLEGMATIC TEMPERAMENT/EXCITABILITY)



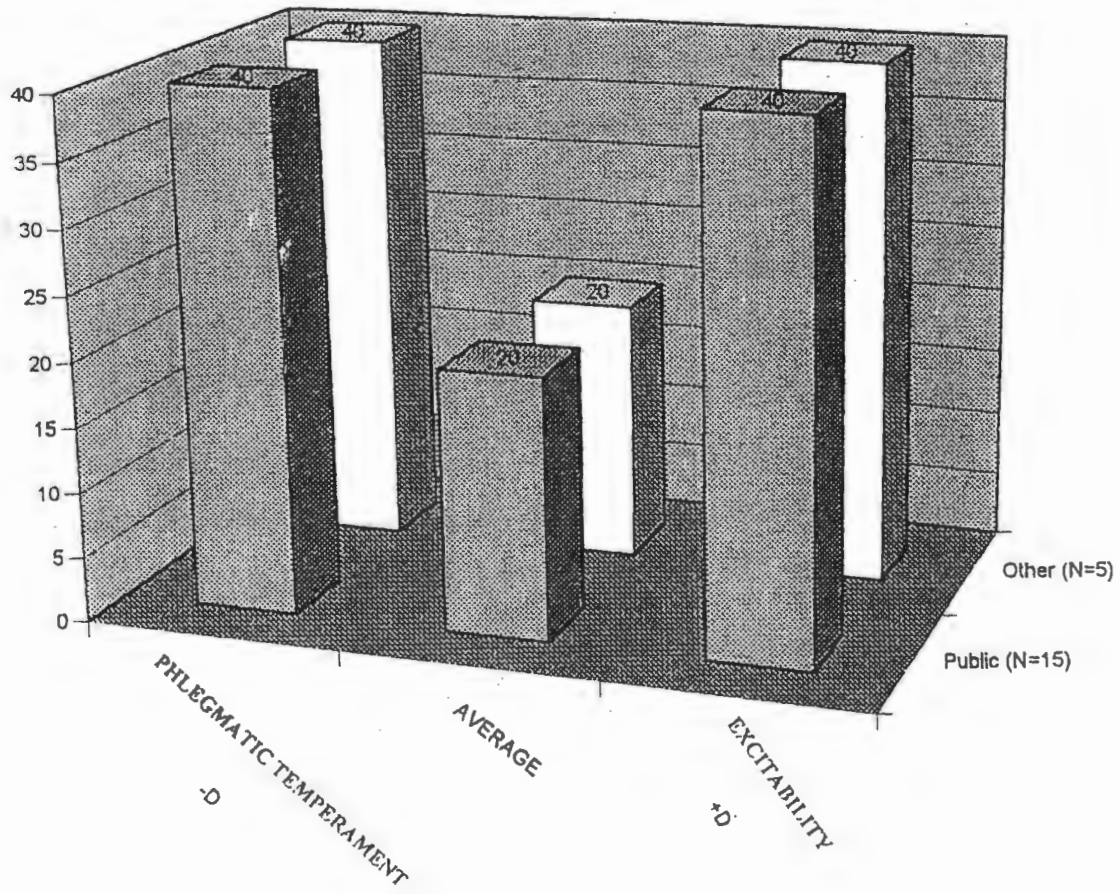
Lower adolescents have excitable personality factor. There is no significant difference between the two groupings in the scouring of phlegmatic temperament as illustrated by graph 4.1. above. 42.9% in the lower adolescents scored with this factor and 38.5% on the upper adolescents.

GRAPH 4.2 LANGUAGE DISTRIBUTION FACTOR D (PHLEGMATIC TEMPERAMENT/EXCITABILITY)



The other language grouping scored lower 33.3% on phlegmatic temperament and a bit higher 44.4% on excitable personality factor. There is no significant difference between the scoring of the two dicotuum of Factor D within the Zulu grouping. 45.5% scored with phlegmatic temperament and 36.4% scored as excitable (see graph 4.2).

GRAPH 4.3 SCHOOL DISTRIBUTION FACTOR D (PHLEGMATIC TEMPERAMENT/EXCITABILITY)

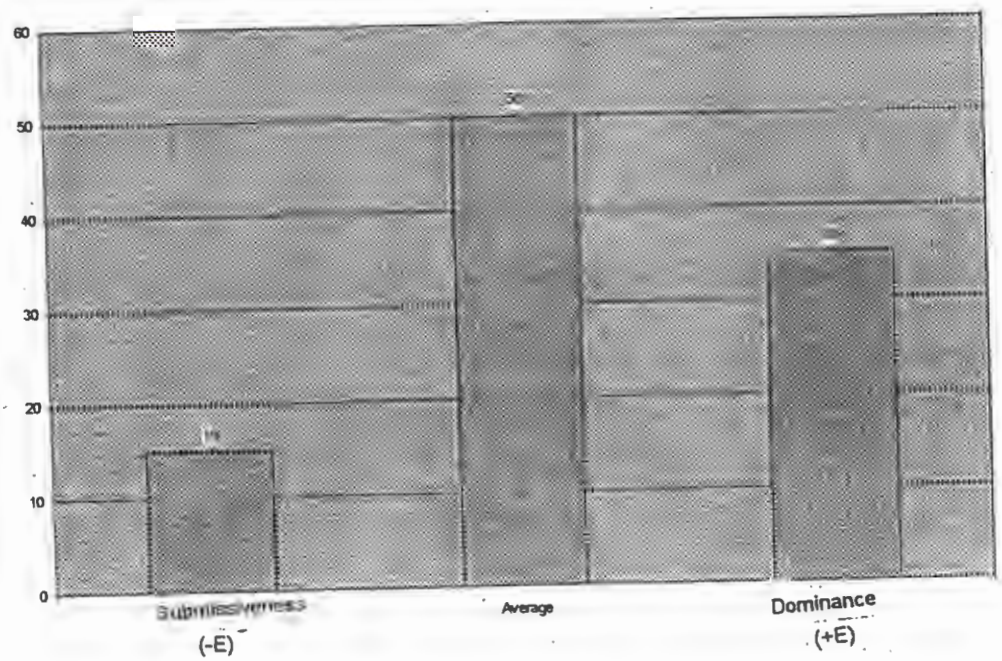


There is an equilibrium in the scoring of Factor D in the two groupings as illustrated by graph 4.3 above. 40% in both categories scored with phlegmatic temperament, 20% in both were average and 40% again in both groupings scored as excitable.

(5) FACTOR E

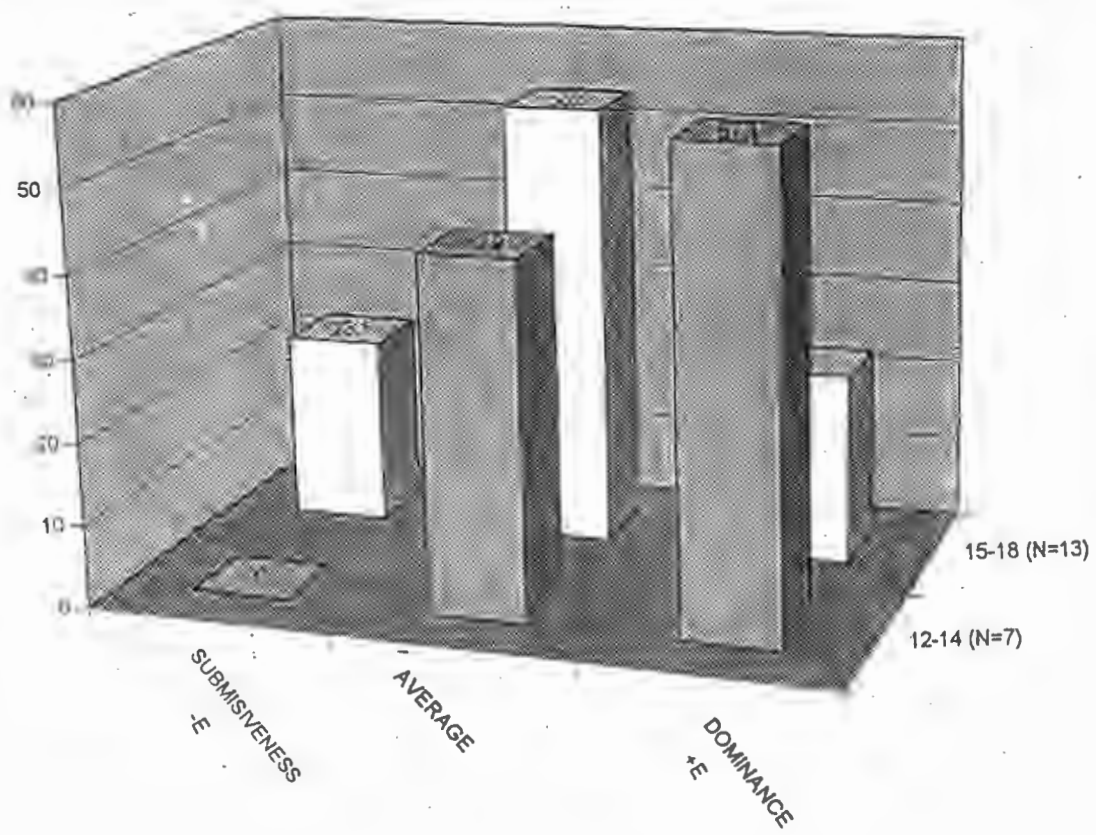
This factor measures dominance. (+E) persons like to dominate situations, have a will of their own, are often disobedient, stubborn and they act independently. They are individualistically oriented, display initiative and creativity, but sometimes also antisocial behavior. They can be aggressive and rebellious. (-E) persons tends to be submissive, to accept the leadership of others and show respect to authority figures. They are easily influenced.

GRAPH 5 OVERALL PICTURE FACTOR E (SUBMISSIVENESS/ DOMINANCE)



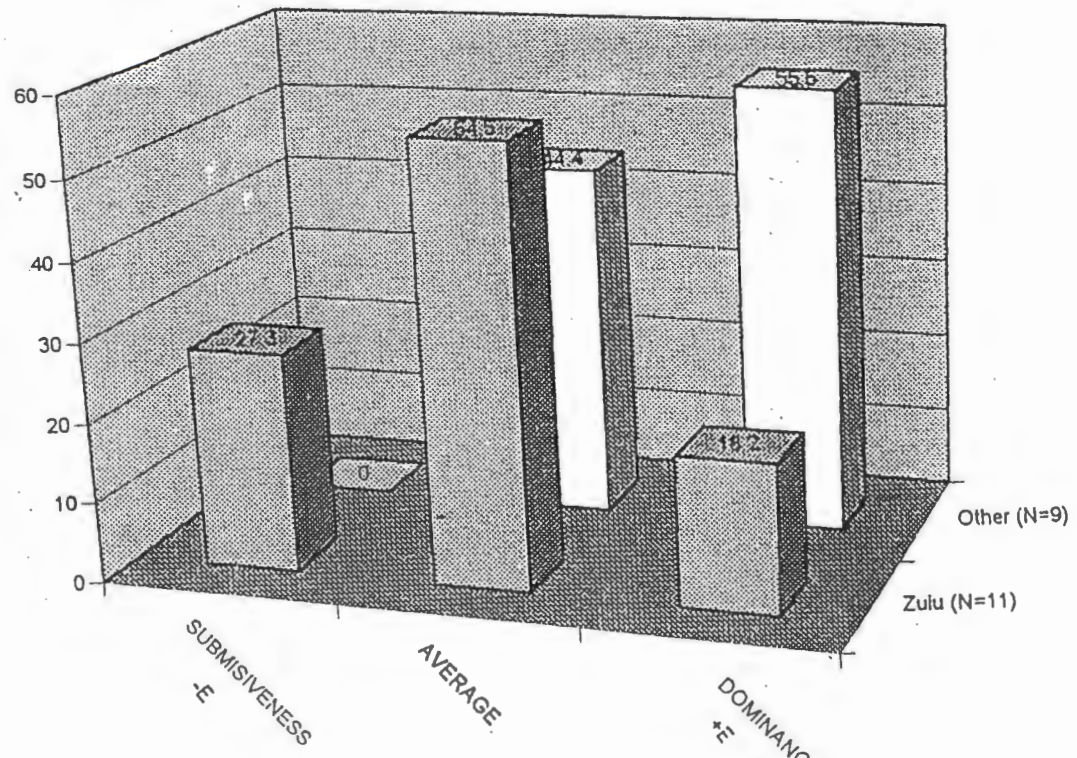
In graph 5, 50% of the respondents were neither dominant nor submissive. 35% were submissive and 15% were dominant.

GRAPH 5.1 AGE DISTRIBUTION FACTOR E (SUBMISSIVENESS/ DOMINANCE)



There were no respondents from the lower adolescents who scored as submissive. Slighter majority of them 57.1% were dominant. In the upper adolescent grouping there was an equal distribution between the dicotuum 23.1% each (see graph 5.1).

GRAPH 5.2 LANGUAGE DISTRIBUTION FACTOR E (SUBMISSIVENESS/ DOMINANCE)



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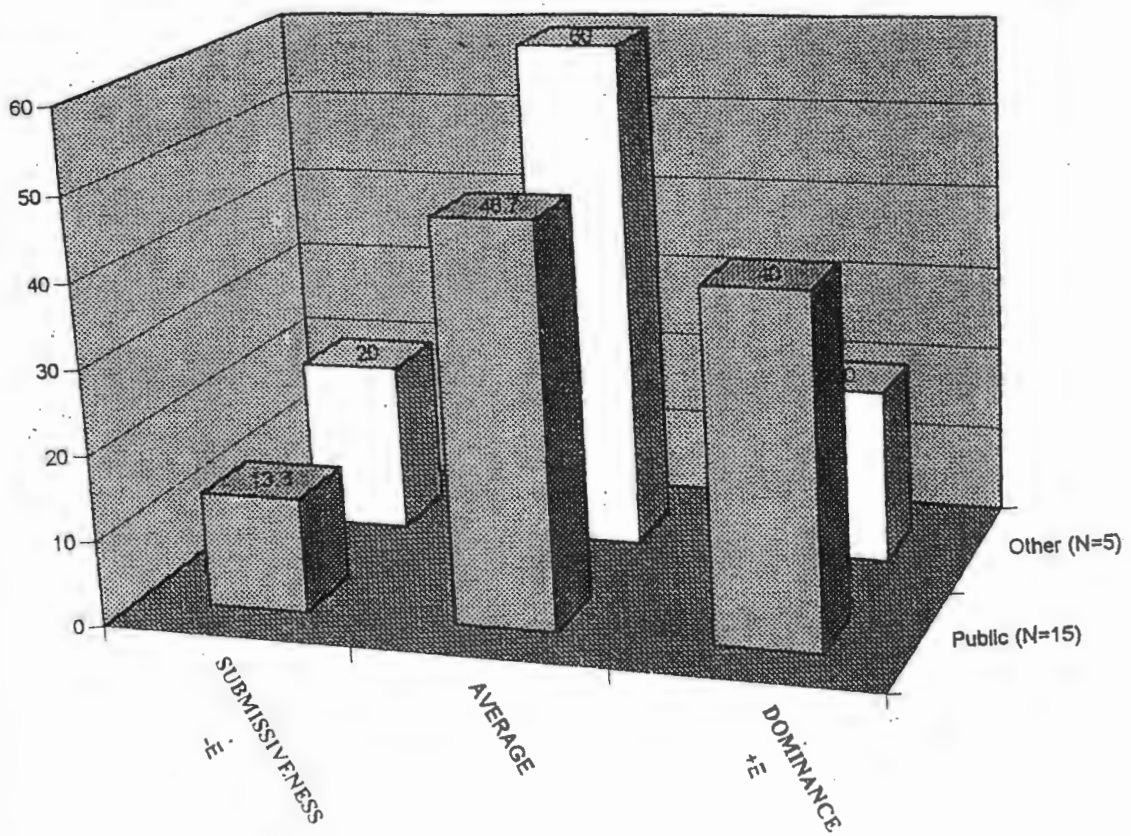
In graph 5.2, 27.3% of the Zulu speaking respondents presented as submissive and 18.2% as dominant. In the other language group category, most of the respondents 55.6% presented as dominant and no respondents were submissive in this group.

GRAPH 5.3 SCHOOL DISTRIBUTION FACTOR E (SUBMISSIVENESS/ DOMINANCE)

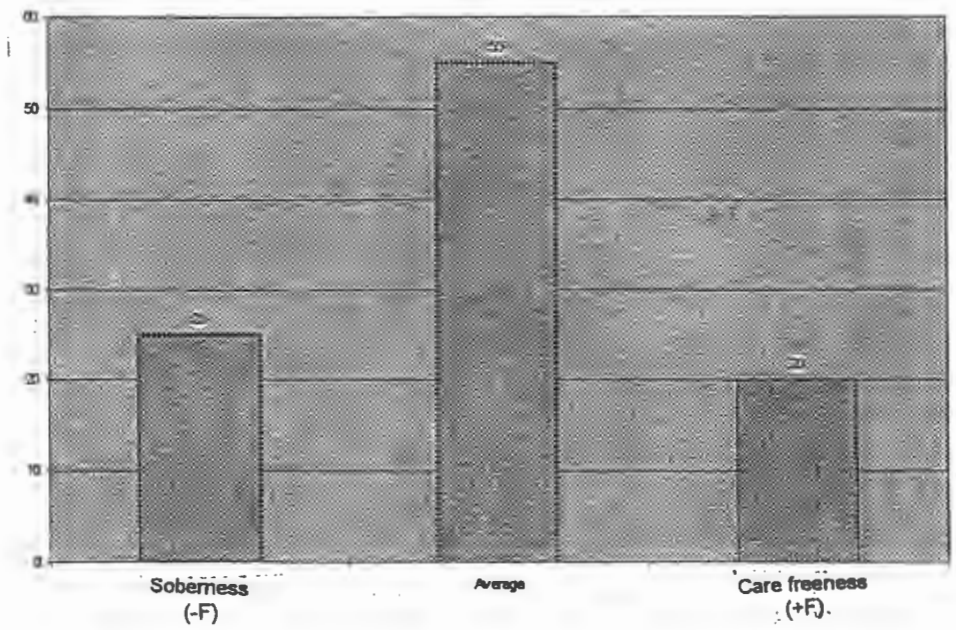


Majority 60% in the non-public schools and not attending category scored as neither dominant nor submissive. Minority of 13.3% in the public schools category scored a submissive and 40% as dominant (see graph 5.3).

(6) FACTOR F

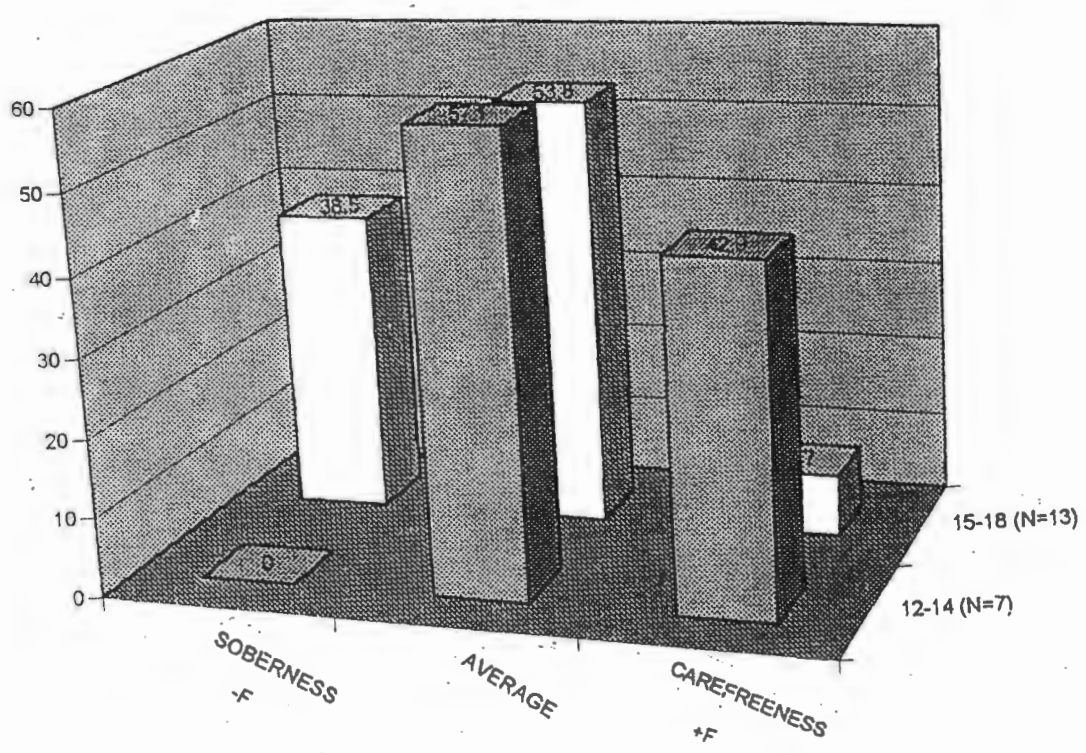
Factor F measures carefreeness. (+F) score is an important component of extroversion. Persons with (+F) are enthusiastic, unthinking and impulsive. They are worried, careless and carefree. They are highly talkative, lively, frank, expressive and alert. Carefree attitudes may have been learned in safe, indulgent families where exciting expectations were made and where the environment inculcated optimism. Persons with (-F) score are introspective and quiet often revealing nervousness, tends to bite their nails and become subdued when tense. They stick to inner values.

GRAPH 6 OVERALL DISTRIBUTION FACTOR F (CAREFREE/ SOBERNESS)



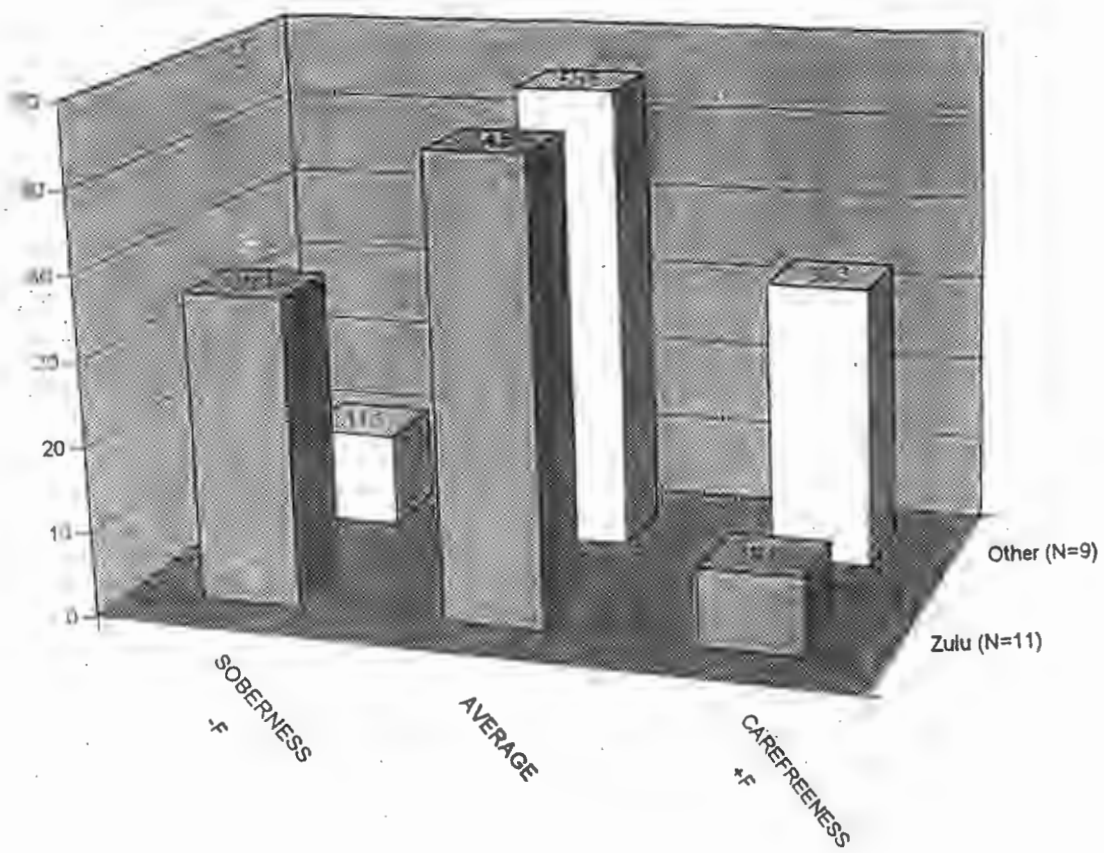
25% of the respondents presented as sober and 20% as carefree. 55% were average.

GRAPH 6.1 AGE DISTRIBUTION FACTOR F (CAREFREE/SOBERNESS)



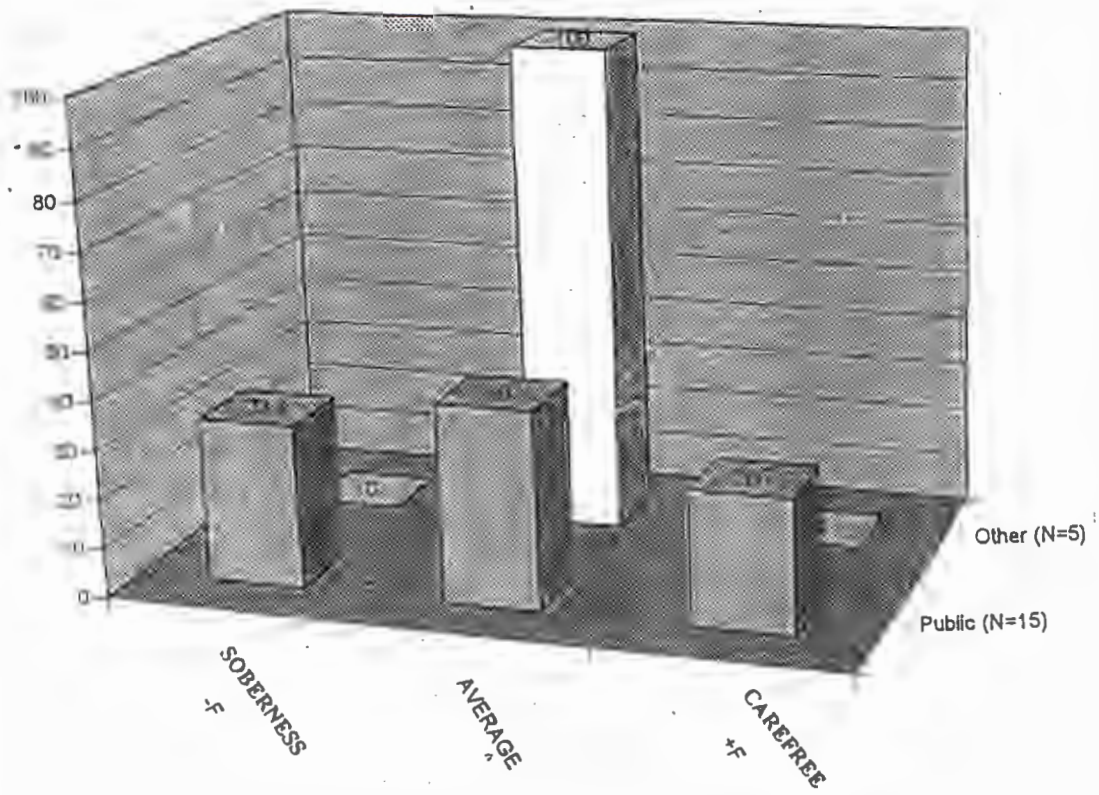
No respondents in the lower adolescent category scored as sober, as opposed to 38.5% in the upper adolescent who scored with this trait. Most of the lower adolescent 42.9% presented as carefree. Only a minority of 7.7% in the upper adolescent presented with this trait (see graph 6.1).

GRAPH 6.2 LANGUAGE DISTRIBUTION FACTOR F (CAREFREE/ SOBERNESS)



Graph 6.2 presents us with an opposition. In the Zulu grouping, the minority of 9.1% were carefree whereas in the other language grouping the minority of 11.1% fell within the sober category.

GRAPH 6.3 SCHOOL DISTRIBUTION FACTOR F (CAREFREE/ SOBERNESS)

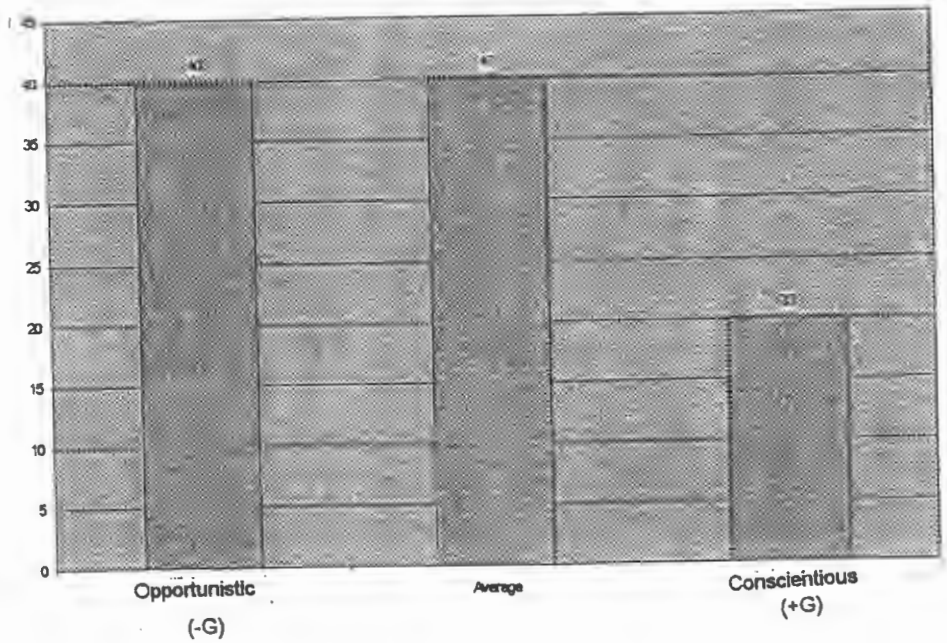


All of the respondents 100% in the private school and not attending category were neither carefree nor sober. In the public school grouping there were no significant difference between those who scored sober and who scored carefree (see graph 6.3).

(7) FACTOR G

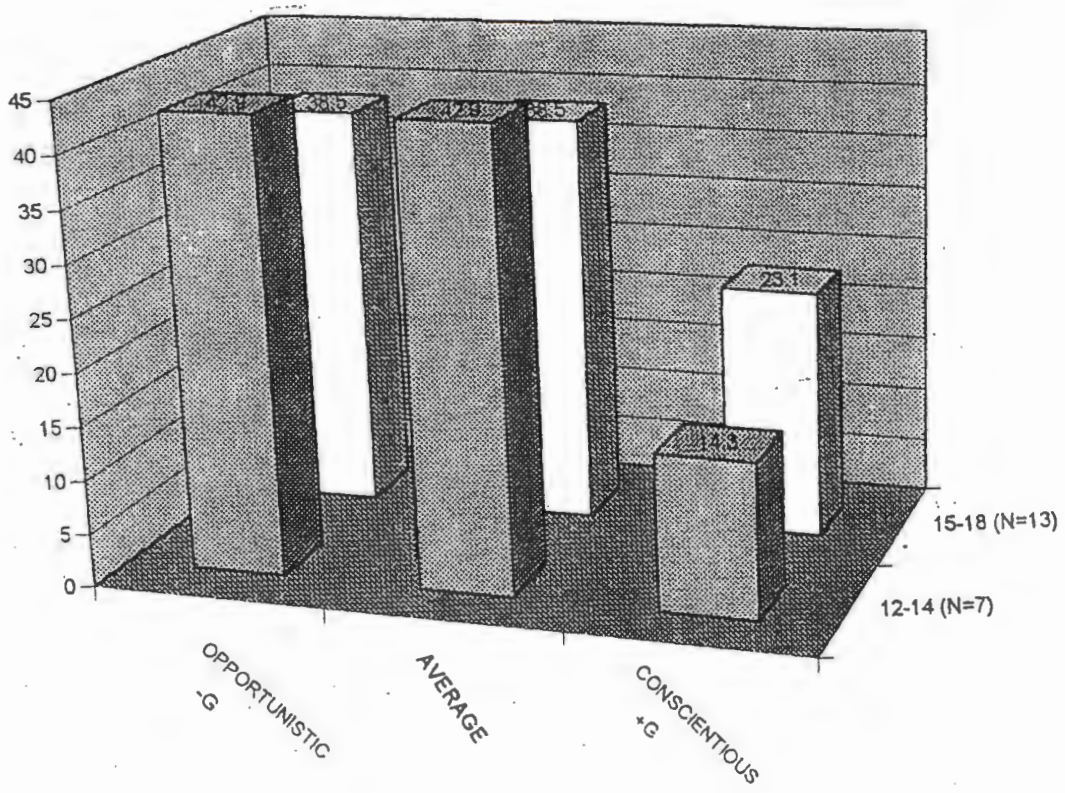
Factor G measures a person's conscientiousness, adjustment to and acceptance of social norms. Conscientious (+G) persons act to accepted standards. They are persevering, plan things, are able to concentrate, think carefully before they act, prefer the company of people they regard as competent, and consider themselves as the guardians of morals and manners. A (-G) score is associated in adolescents with a disregard of set rules, the occurrence of rage outburst, bragging, lying and in serious cases, breaking the law.

GRAPH 7 OVERALL DISTRIBUTION FACTOR G (OPPORTUNISTIC & CONSCIENTIOUS)



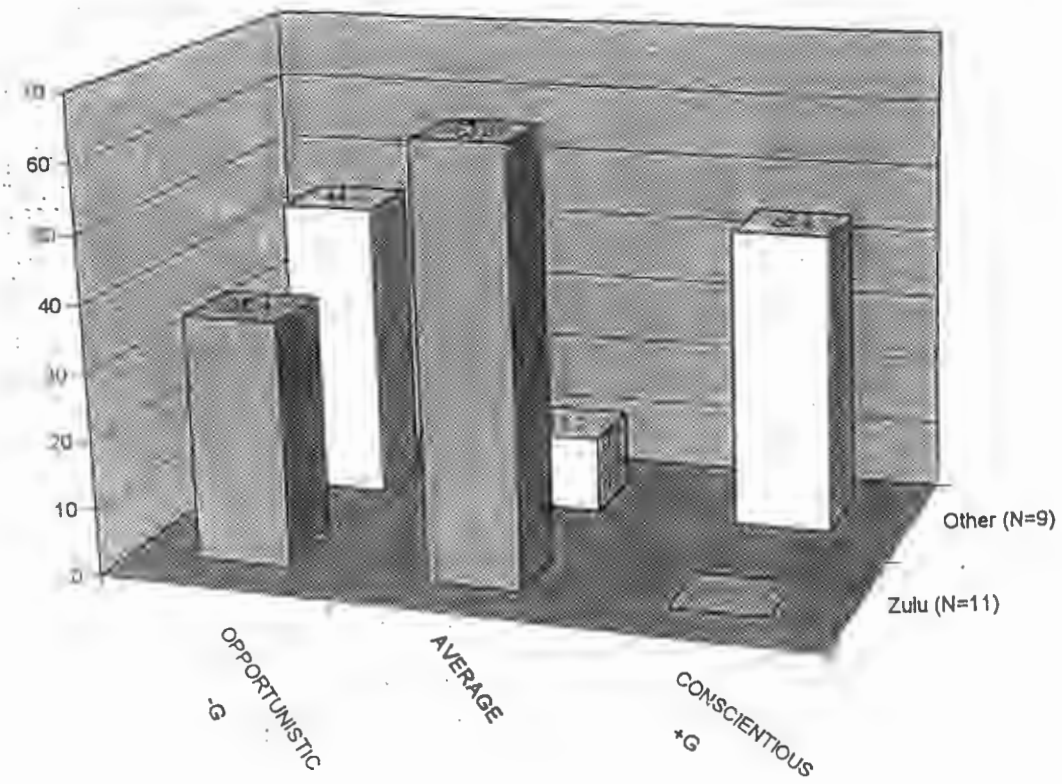
In the overall picture presented by graph, a minority of respondents 20% were conscientious, 40% were opportunistic and the remaining 40% were average.

GRAPH 7.1 AGE DISTRIBUTION FACTOR G (OPPORTUNISTIC/ CONSCIENTIOUS)



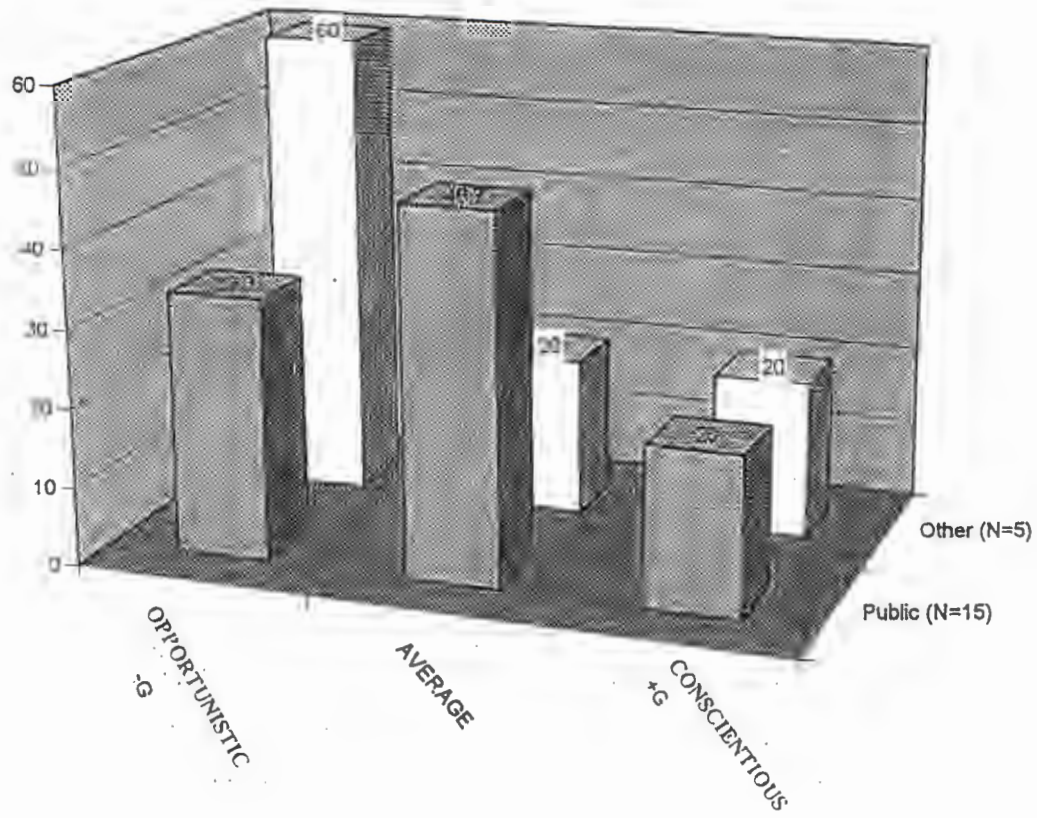
Only a minority of 14.3% in the lower adolescent category scored as conscientious and 23.1% in the upper adolescent. There was an equal distribution of 42.9% in the lower adolescents, in the scoring of opportunism and average. This picture goes for the upper adolescent grouping as well, where 38.5% scored as opportunistic and also38.5% scored average.

GRAPH 7.2 LANGUAGE DISTRIBUTION FACTOR G (OPPORTUNISTIC/ CONSCIENTIOUS)



There we no respondents in the Zulu category who scored as conscientious. 63.3% were average and 36.4% were opportunistic. In the other language groupings there was an equal distribution of 44.4% in the dicotuum (see graph 7.2).

GRAPH 7.3 SCHOOL DISTRIBUTION FACTOR G (OPPORTUNISTIC/ CONSCIENTIOUS)



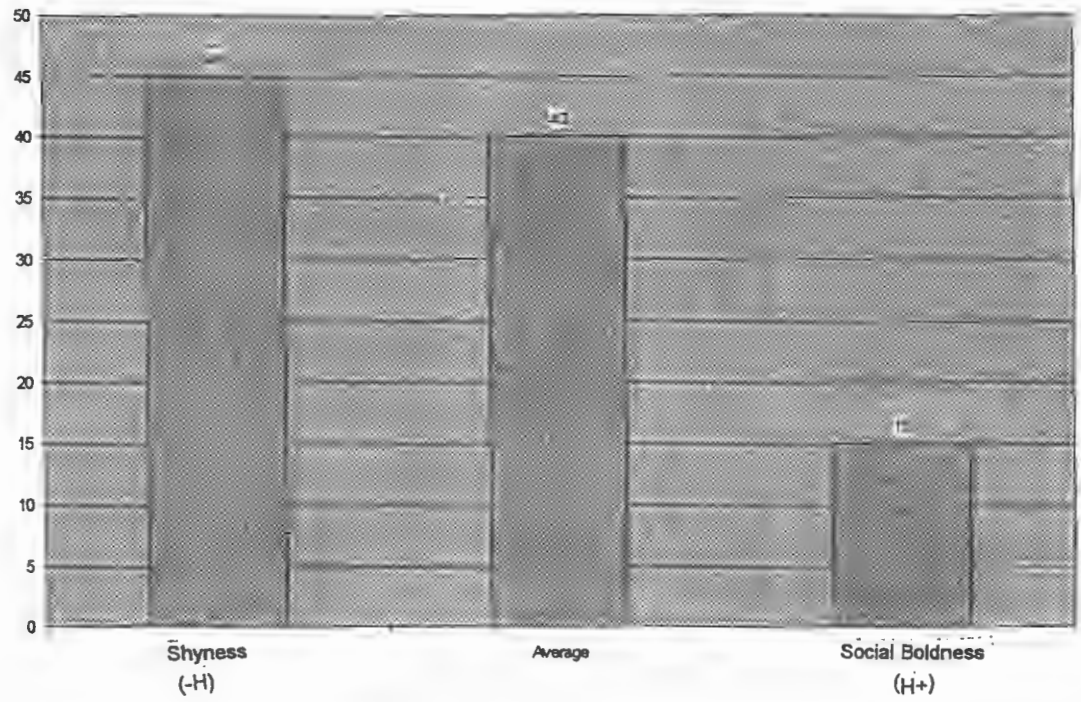
The majority of respondents 60% in the private and not attending school category were opportunistic. A minority of 20% in the same category were conscientious. In the public schools category 33.3% were opportunistic 20% were conscientious.

(8) FACTOR H

This factor measures social boldness. (+H) persons are talkative, jovial and act spontaneously in a group situation. They enjoy the limelight and frequently take the lead during social activities. They are popular, but are not necessarily socially adept and sensitive to other people's feelings. (-H) persons are shy, reserved, careful and do not

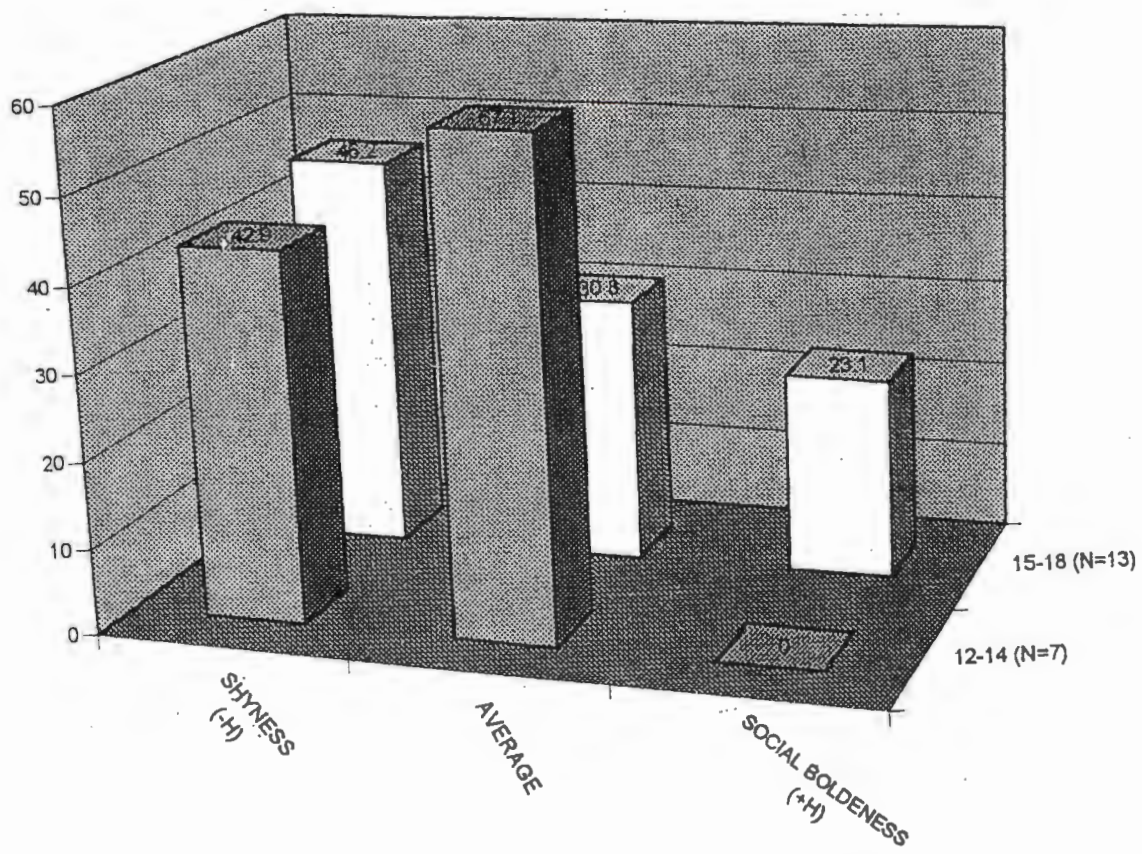
express their emotions easily. They avoid open competition and are afraid of new situations. They are considerate about not hurting other people's feelings.

GRAPH 8 OVERALL PICTURE FACTOR H (SHYNESS/ BOLDNESS)



The illustration of graph 8 shows that 45% of the respondents presented as shy. Only a minority of 15% presented as socially bold.

GRAPH 8.1 AGE DISTRIBUTION FACTOR H (SHYNESS/BOLDNESS)



In the lower adolescent category there were no respondents who were socially bold. 57.1% of them were just average and 42.9% were shy. In the upper adolescence a minority of 23.1% were socially bold, 46.25 were shy and 30.8% were average (see graph 8.1).

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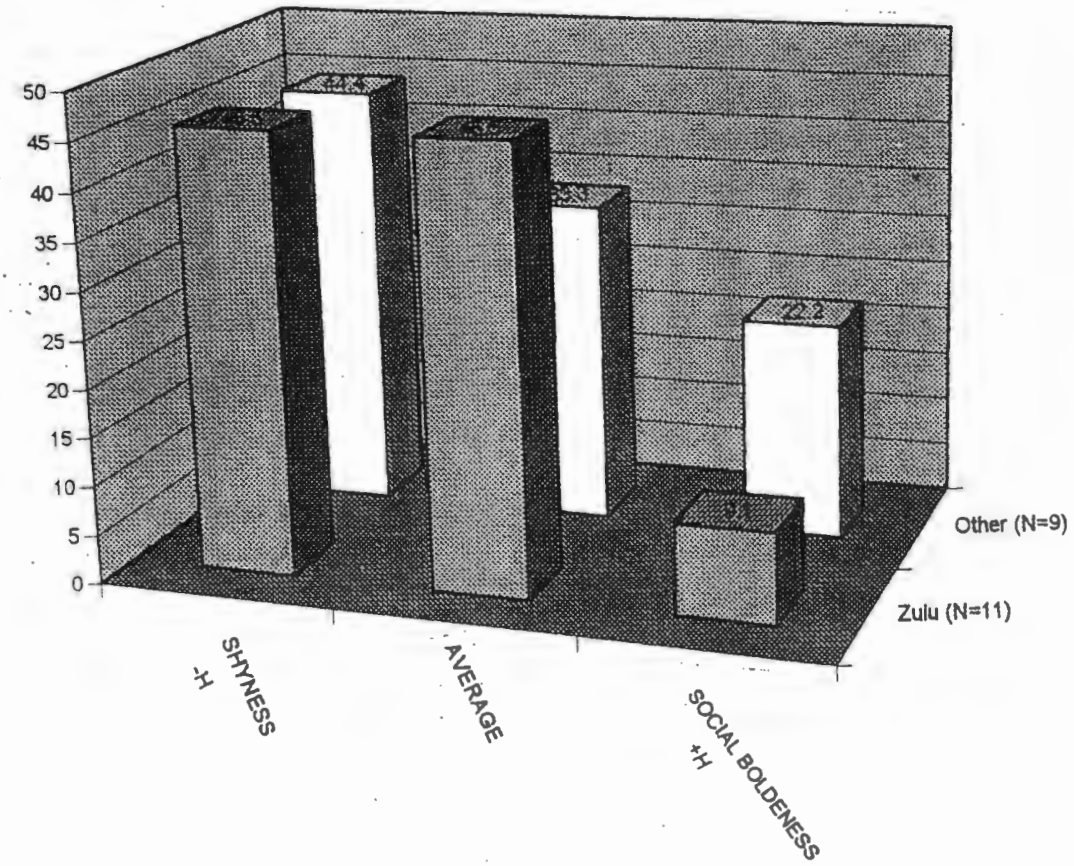
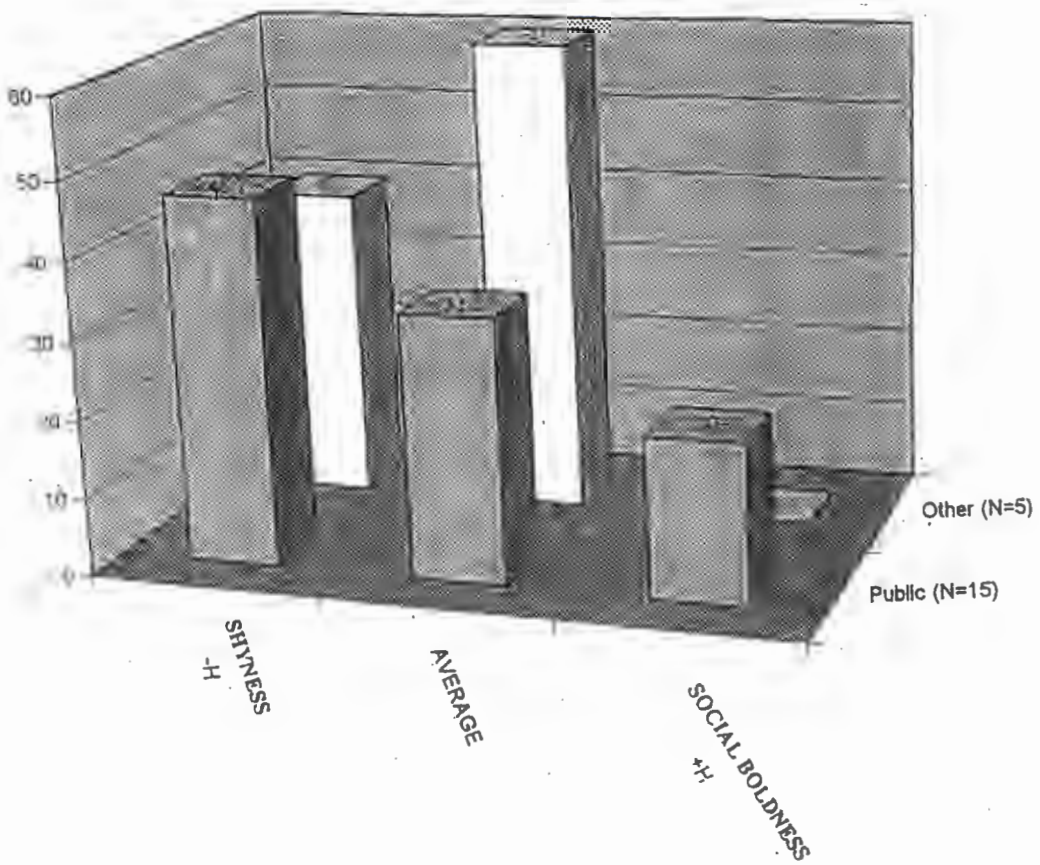
GRAPH 8.2 LANGUAGE DISTRIBUTION FACTOR H (SHYNESS/BOLDNESS)



45.6% of Zulu speaking scored as shy and 44.4% from other language groupings. Only a minority of 9.1% of the Zulu speaking respondents scored as socially bold (see graph 8.2).

GRAPH 8.3 SCHOOL DISTRIBUTION FACTOR H (SHYNESS/BOLDNESS)

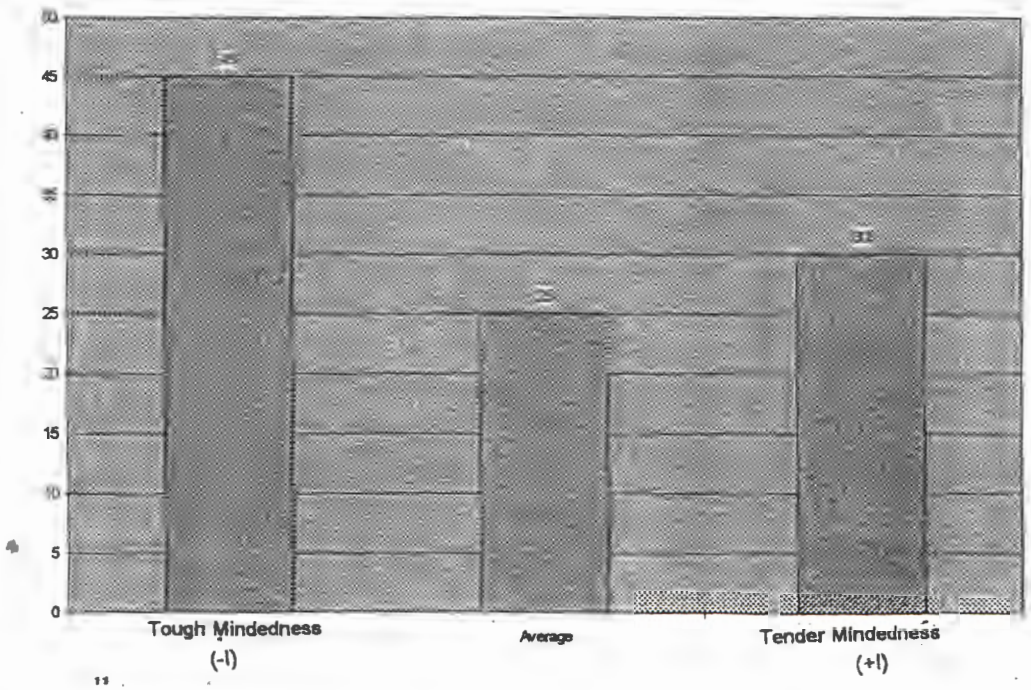


There were no respondents from the private and not attending school category who were socially bold. The majority of them 60% were just average. The remaining 40% were shy. 46.7% of the respondents from public schools were shy. A minority of 20% were socially bold (see graph 8.3).

(9) FACTOR I

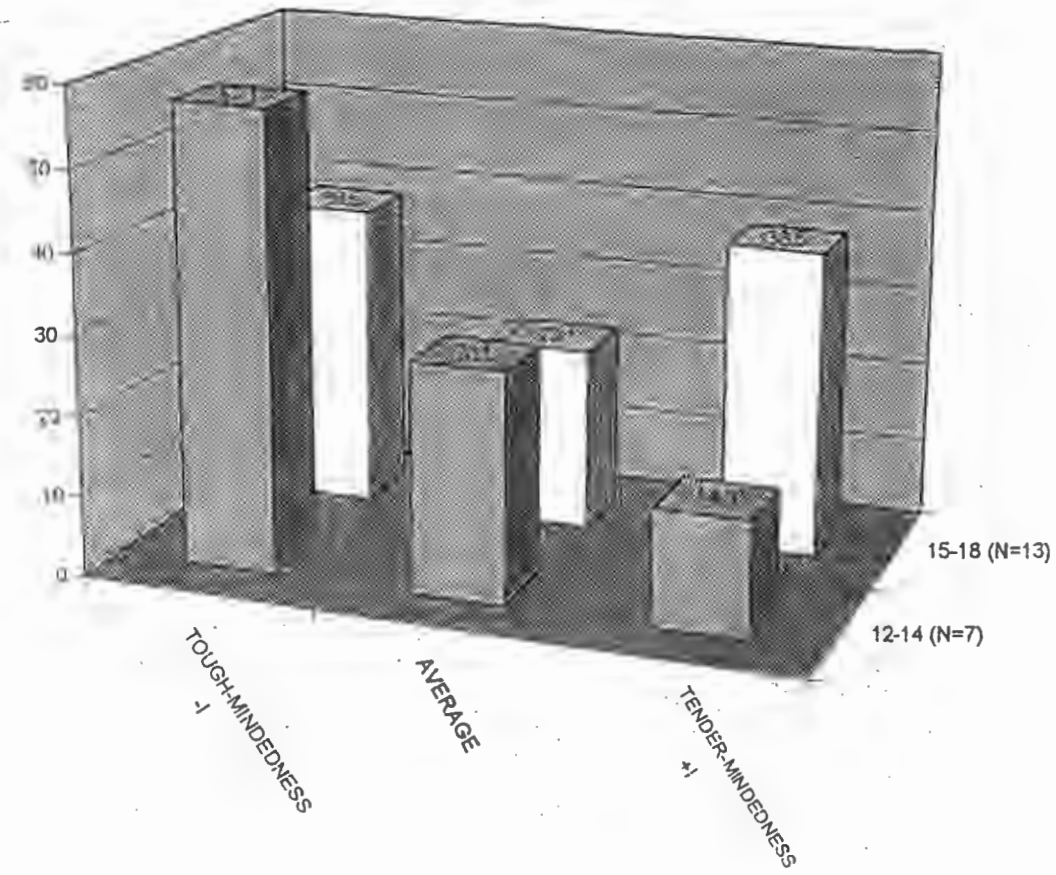
Factor I measure tender-mindedness. (+ I) persons are imaginative and artistic and love dramas. They are impractical and disorganized generally in life. They are regarded as fastidious, dependent, demanding of attention, tale telling, sensitive and nervous. Such people become tired easily and adapt to change with difficulty. In crisis situations, they overreact and make unnecessary fuss about things. Persons with a low (-I) scores are practical, down to earth, with a mature attitude of life. They make decisions on practical, logical grounds and react to the obvious facts rather than relying on their feelings.

GRAPH 9 OVERALL DISTRIBUTION FACTOR I (TOUGH-MINDEDNESS/ TENDER-MINDEDNESS)



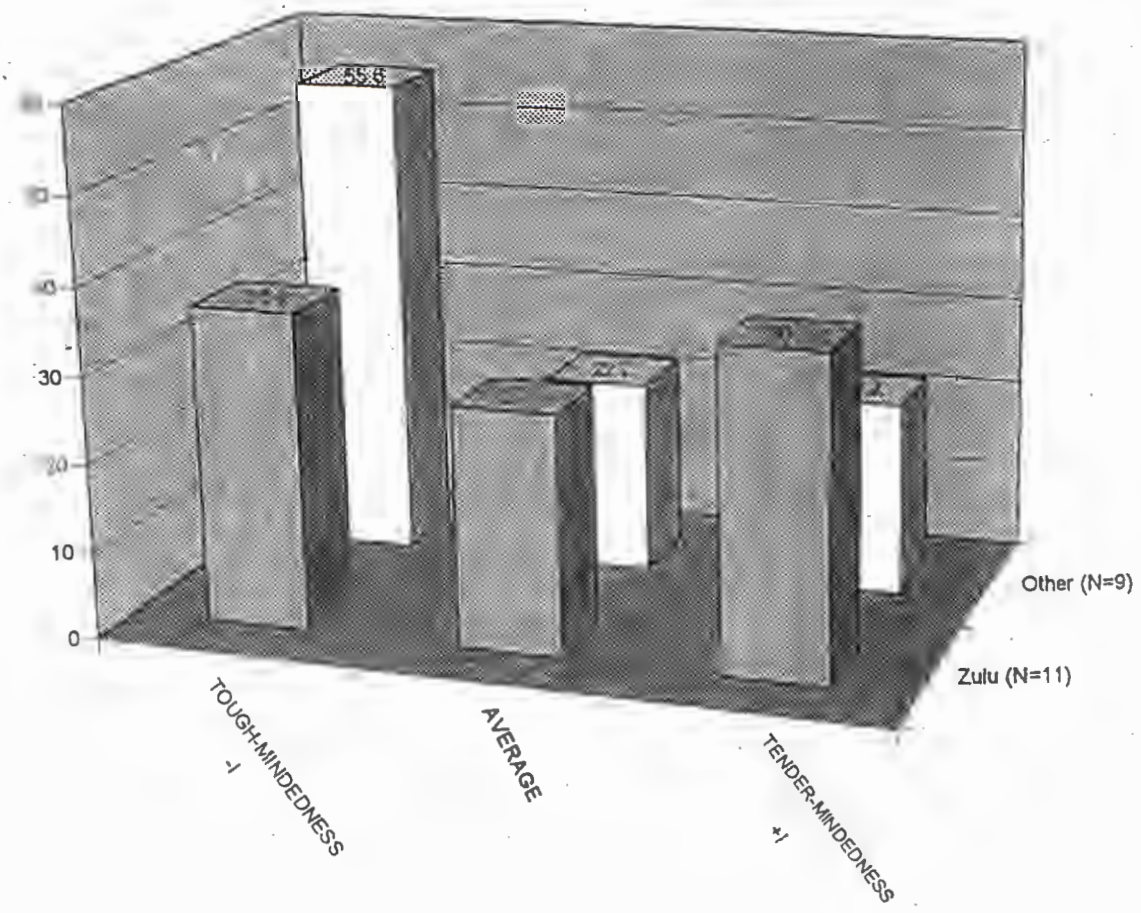
In the overall presentation given by graph 9, 45% of the overall respondents scored as tough-minded, 30% as tender-minded and 25% were average.

GRAPH 9.1 AGE DISTRIBUTION FACTOR I (TOUGH-MINDEDNESS/ TENDER-MINDEDNESS)



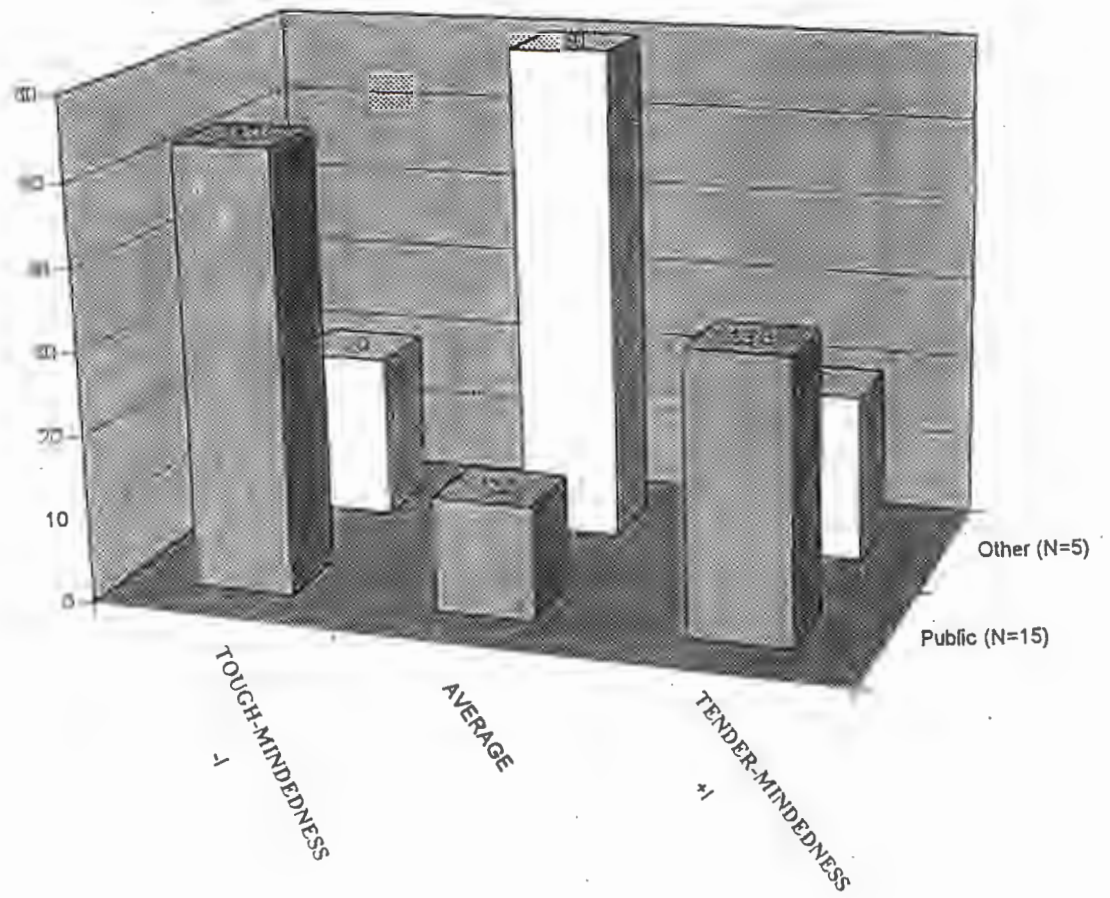
Most of the respondents 57.1% in the lower adolescent category were tough-minded. Only a minority of 14.3% were tender-minded in the same category. There was an equal distribution of 35.5% in both dicotuum in the upper adolescent category (see graph 9.1).

GRAPH 9.2 LANGUAGE DISTRIBUTION FACTOR I (TOUGH-MINDEDNESS/ TENDER-MINDEDNESS)



In graph 9.2 most of the respondents 55.6% from the other language groupings presented as tough-minded. Only 22.2% were tender-minded in this category. Within the Zulu grouping both sides of the dicotuum shared an equal proportion of 36.4%.

GRAPH 9.3 SCHOOL DISTRIBUTION FACTOR I (TOUGH-MINDEDNESS/ TENDER-MINDEDNESS)

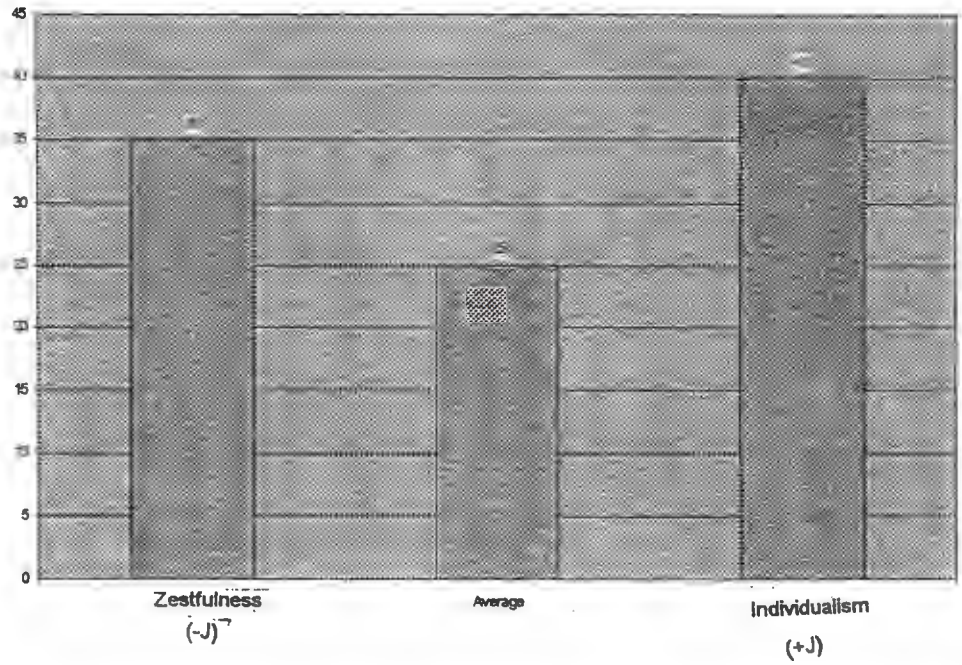


The private and not attending school respondents scored low 20% in both sections of Factor I. 53.3% of the respondents from public schools were tough-minded and 33.3% were tender-minded (see graph 9.3).

(10) FACTOR J

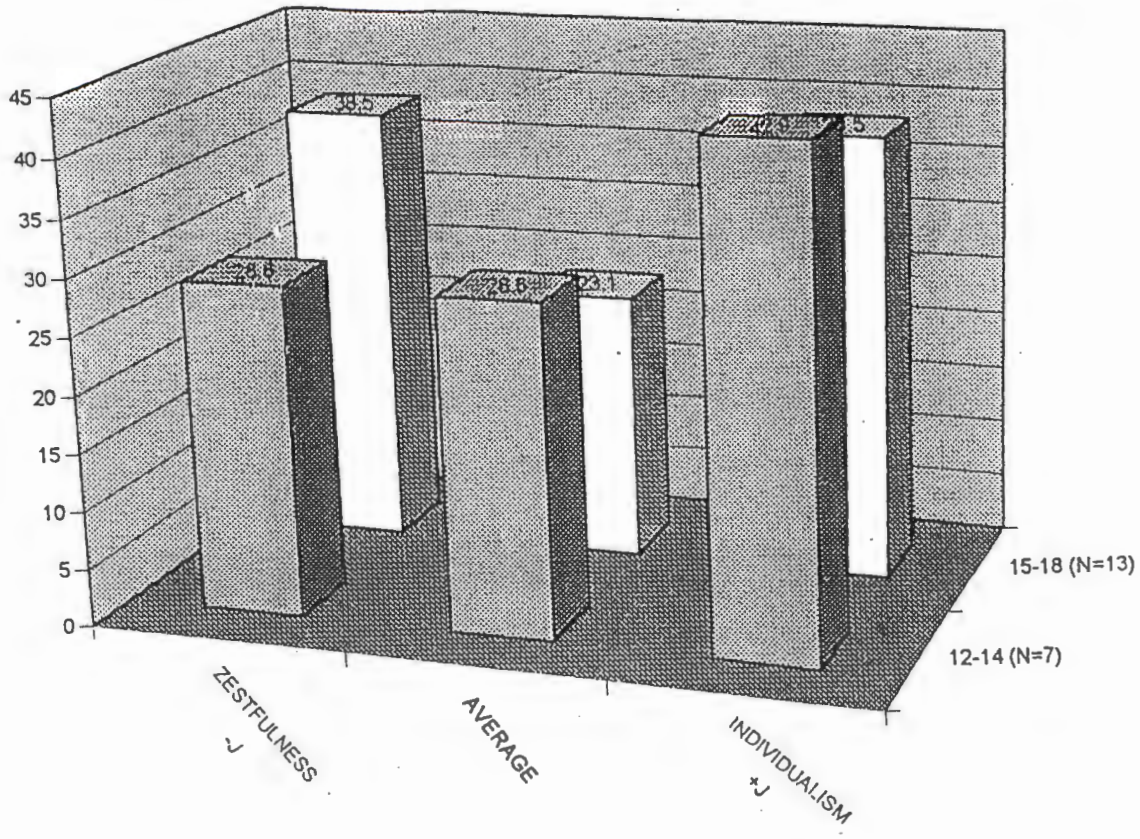
This factor measures individualism. (+J) persons prefer to do things on their own, are meticulous, think over their mistakes and how to avoid them. They tend not to forget an unfair treatment, their options usually differ markedly from those of the rest, they are also unpopular with others. They prefer to avoid arguments by remaining in the background.

GRAPH 10 OVERALL DISTRIBUTION FACTOR J (ZESTFULNESS/ INDIVIDUALISM)



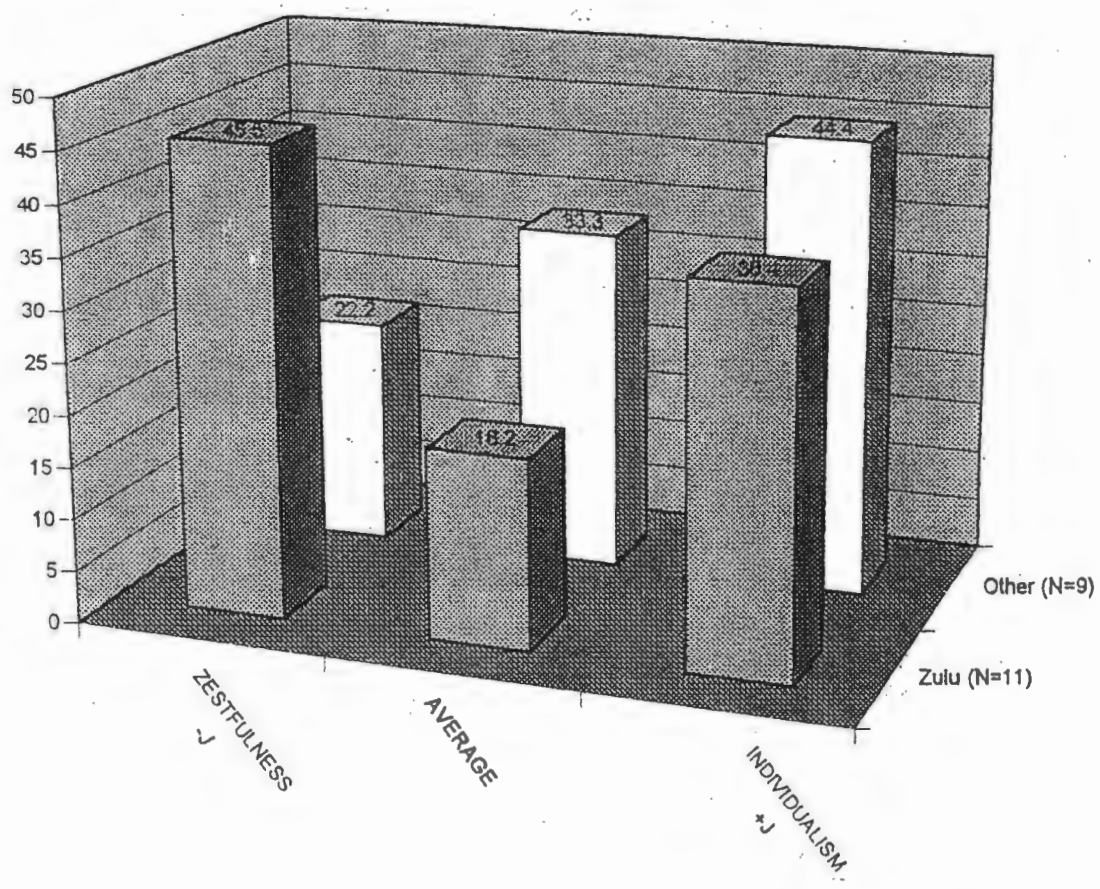
In the overall presentation given by graph 10, it shows that 40% of the respondents were highly individualistic, 35% were had zest for life and 25% were average.

GRAPH 10.1 AGE DISTRIBUTION FACTOR J (ZESTFULNESS/ INDIVIDUALISM)



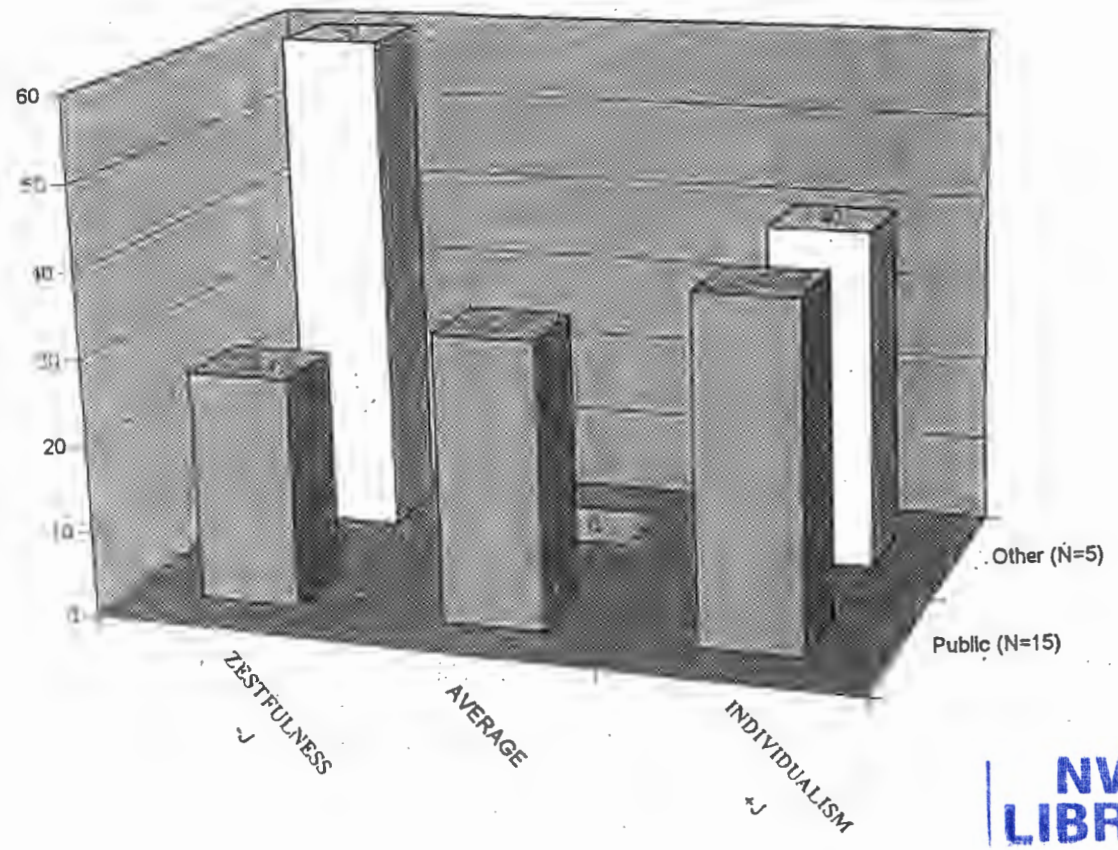
The upper adolescents shared an equal proportion of 38.5% in the scoring of Factor J, that is in both (-J) and (+J). In the lower adolescents most of the respondents 42.9% presented as individualistic(see graph 10.1).

GRAPH 10.2 LANGUAGE DISTRIBUTION FACTOR J (ZESTFULNESS/ INDIVIDUALISM)



As illustrated by graph 10.2, a minority 22.2% of the respondents from other language groupings had zest for life as opposed to 45.5% in the Zulu category. 44.4% were individualistic in the other language groupings and 36.4% in the Zulu speaking grouping.

GRAPH 10.3 SCHOOL DISTRIBUTION FACTOR J (ZESTFULNESS/ INDIVIDUALISM)



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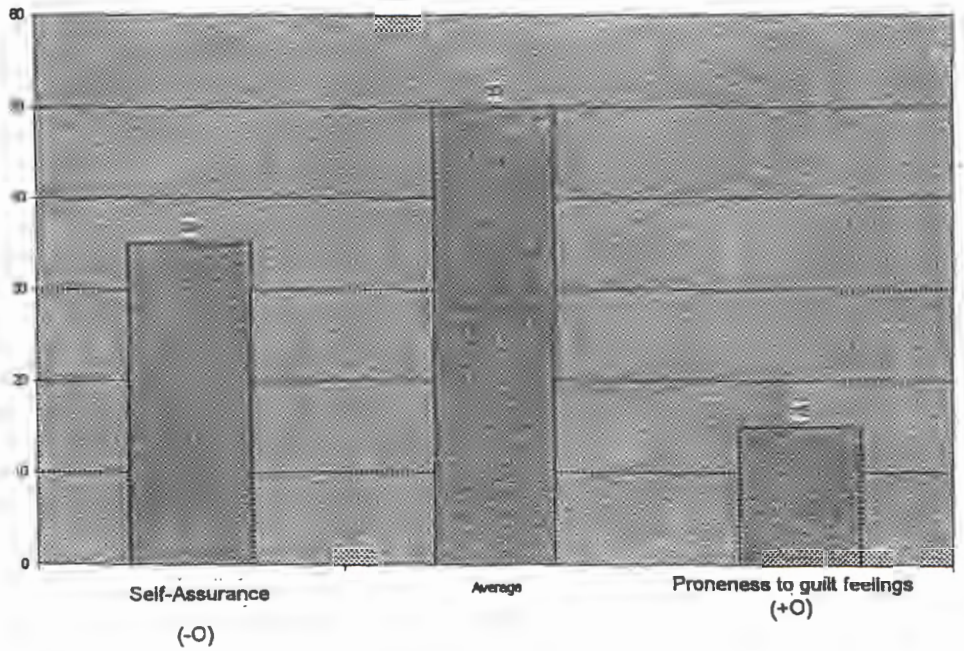
The majority of respondents 60% in the private and not attending school category had zest for life and 40% were individualistic. 40% of the public school respondents were individualistic and 26.7% had zest for life (see graph 10.3).

(11) FACTOR O

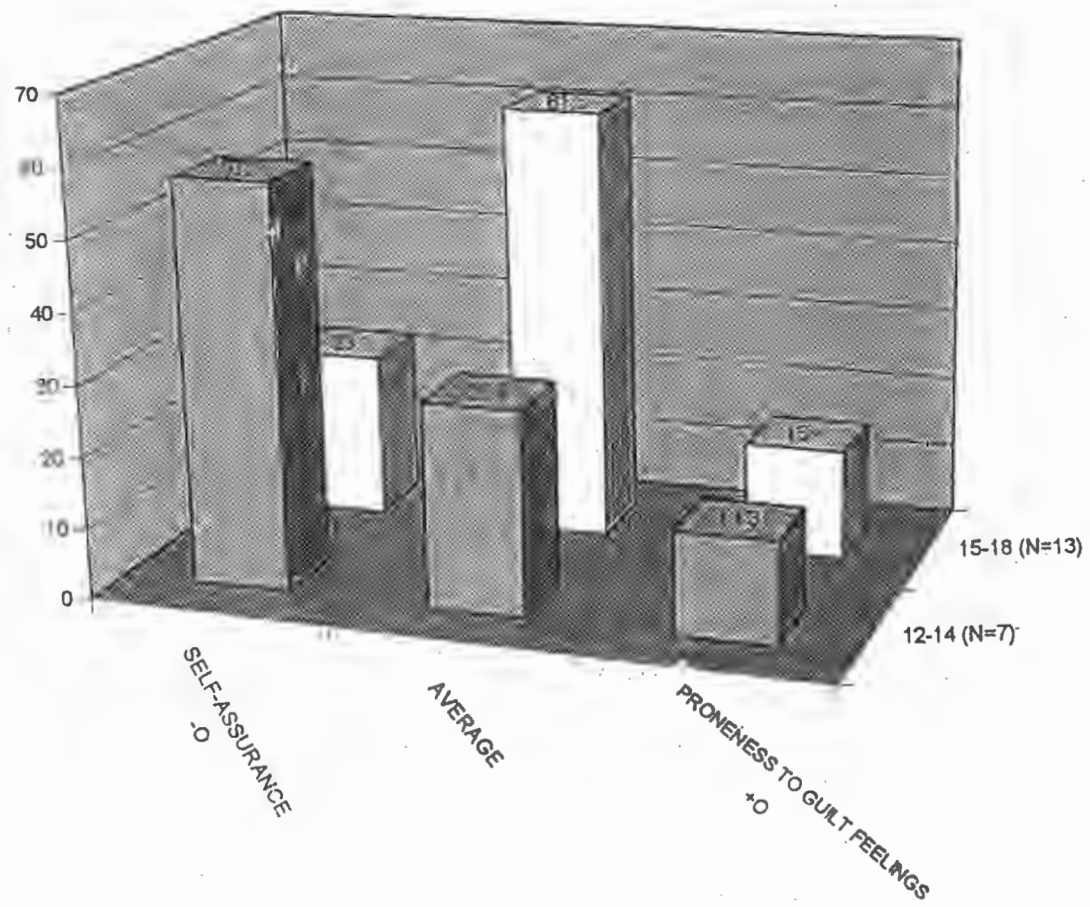
Factor O "measure" proneness to guilt feelings. (+O) is associated with fears and feelings of inadequacy and loneliness.(-O) persons feel inferior and inadequate in meeting the daily demands of life. They become overtired by existing situations, consequently they prefer quiet places to people and noisy conditions. They are easily upset by pressure from authority figures, prone to depression, guilt and remorse if they make mistakes. In contrast,(-O) persons are self-assured, placid and vigorous. They are not very dependent on other people's approval or disapproval and prefer uncomplicated conduct.

GRAPH 11 OVERALL DISTRIBUTION FACTOR O (SELF-ASSURANCE/ PRONE TO GUILT FEELINGS)



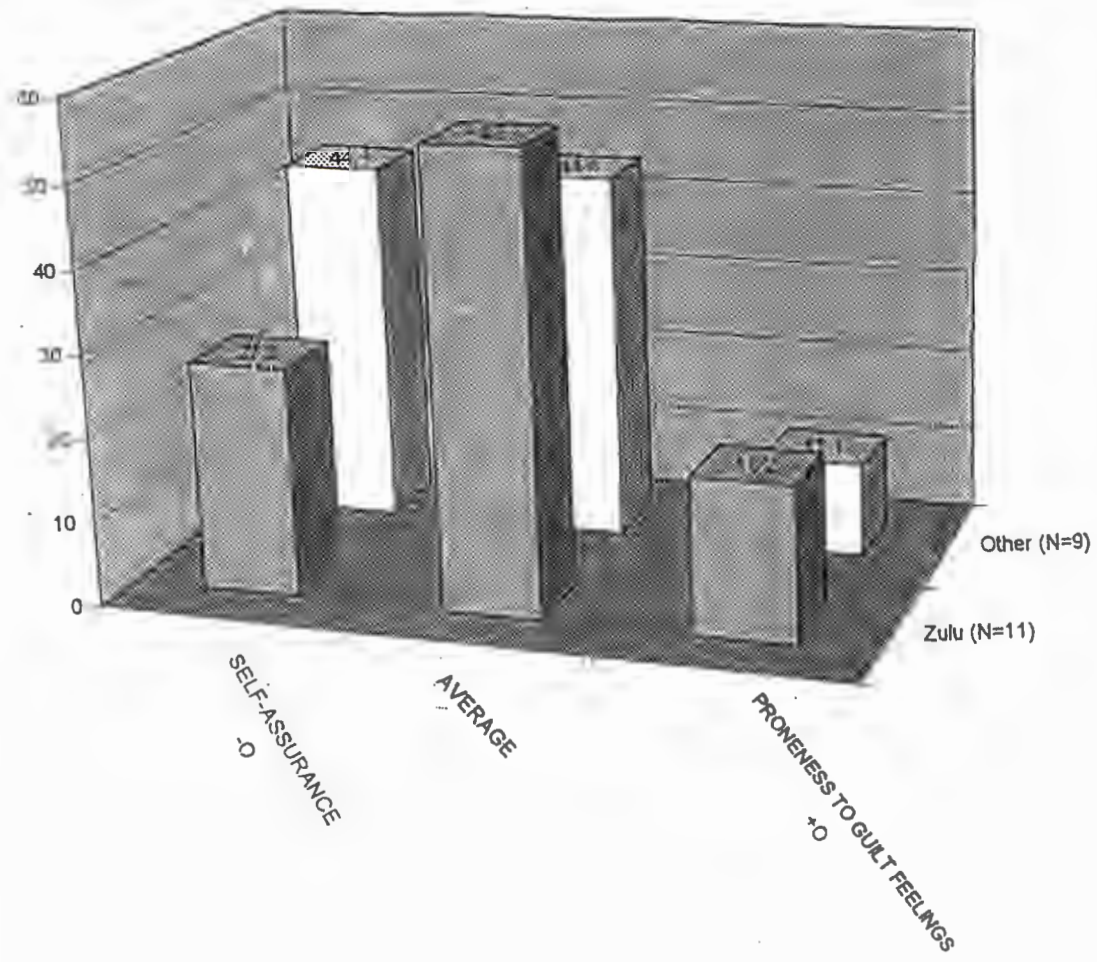
50% of the overall respondents were average, neither prone to guilt feelings nor self assured. Only 15% were prone to feelings of guilt and 35% were self assured (see graph 11).

GRAPH 11.1 AGE DISTRIBUTION FACTOR O (SELF-ASSURANCE/PRONE TO GUILT FEELINGS)



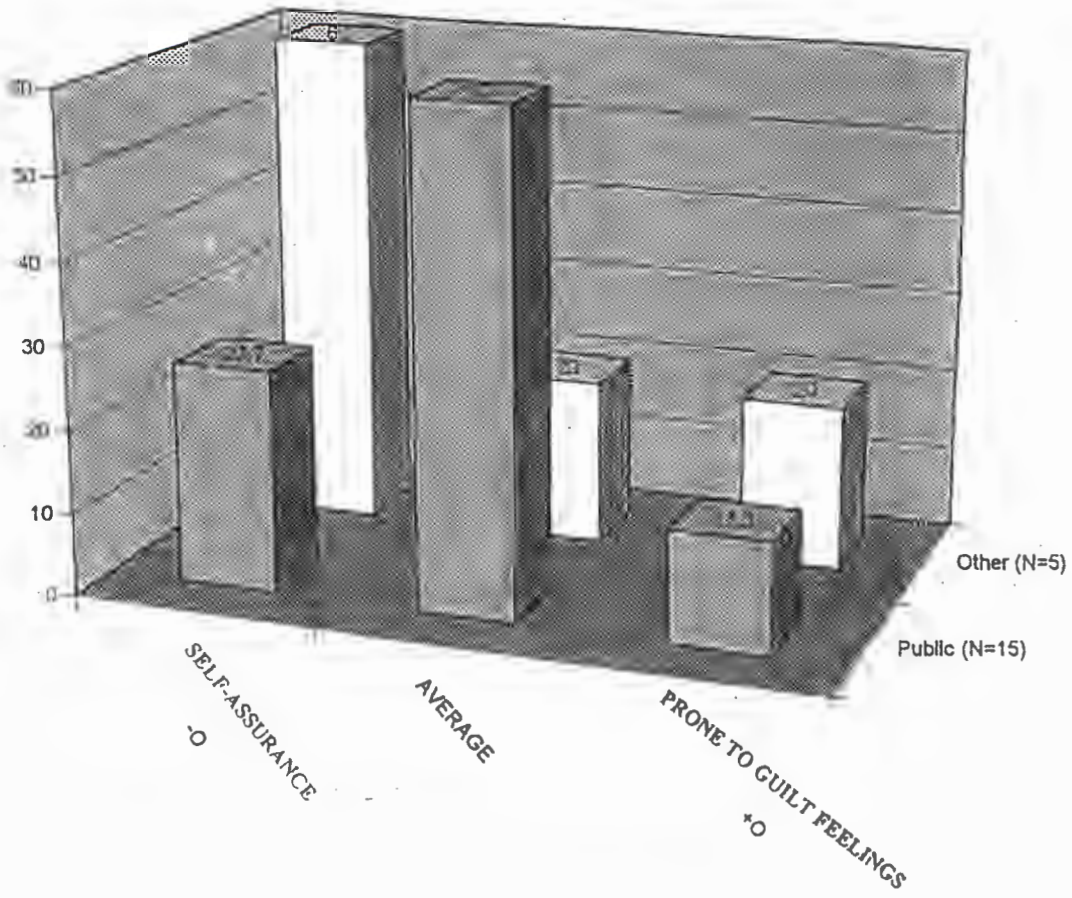
Most of the respondents 57.1% in the lower adolescent were self assured. Only a minority of 14.3% measured as prone to feelings of guilt in the same grouping. In the upper adolescents 61.5% scored as neither prone to guilt feelings nor self assured (see graph 11.1).

GRAPH 11.2 LANGUAGE DISTRIBUTION FACTOR O (SELF-ASSURANCE/ PRONE TO GUILT FEELINGS)



Fewer respondents presented with feelings of guilt, that is 11.1% in the other language groupings and 18.2% in the Zulu speaking group. 40% of the respondents from other language groupings were self assured and only 27.3% in the Zulu grouping (see graph 11.2).

GRAPH 11.3 SCHOOL DISTRIBUTION FACTOR O (SELF-ASSURANCE/ PRONE TO GUILT FEELINGS)

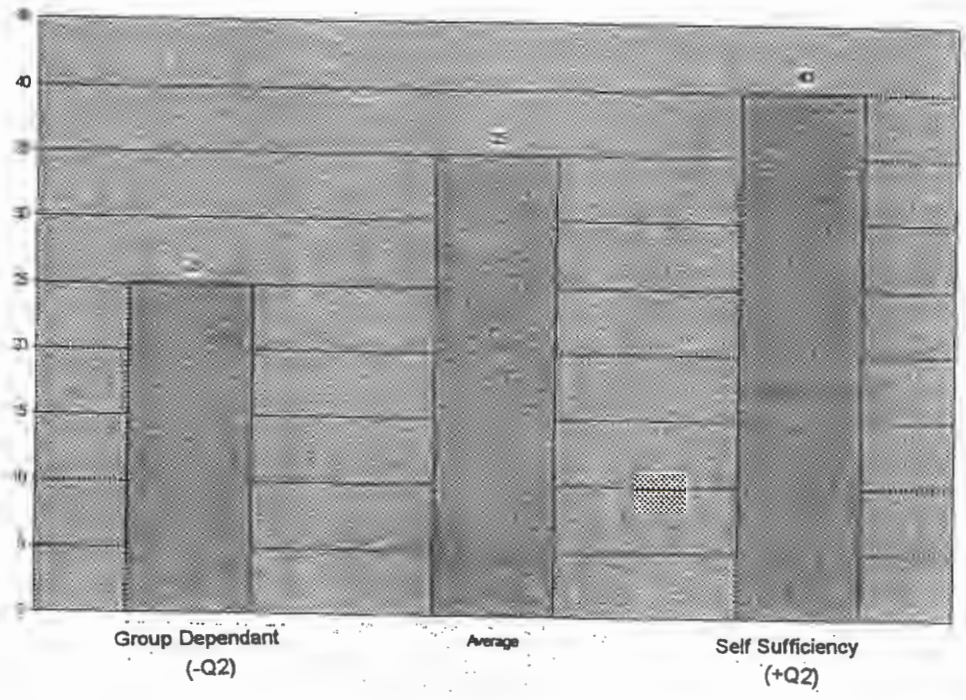


The majority 60% of the respondents in the private and not attending school grouping were self assured as opposed to 26.7% within the public school category. Only 13.3% in the public school respondents were prone to guilt feelings and 20% in the non public school grouping (see graph 11.3).

(12) FACTOR Q2

This factor "measure" self-sufficiency. (+Q2) persons reveal a confident and resourceful self-sufficiency. They are determined and accustomed to making their own decisions. They avoid social contact because they feel it is a waste of time, not because they feel emotionally rejected. (+ Q2) persons frequently are mature for their age. They prefer older friends, they have mature interests and achieve better than average people. (-Q2) persons usually follow the group, attach great value to social approval, are conventional and follow the prevailing fashions.

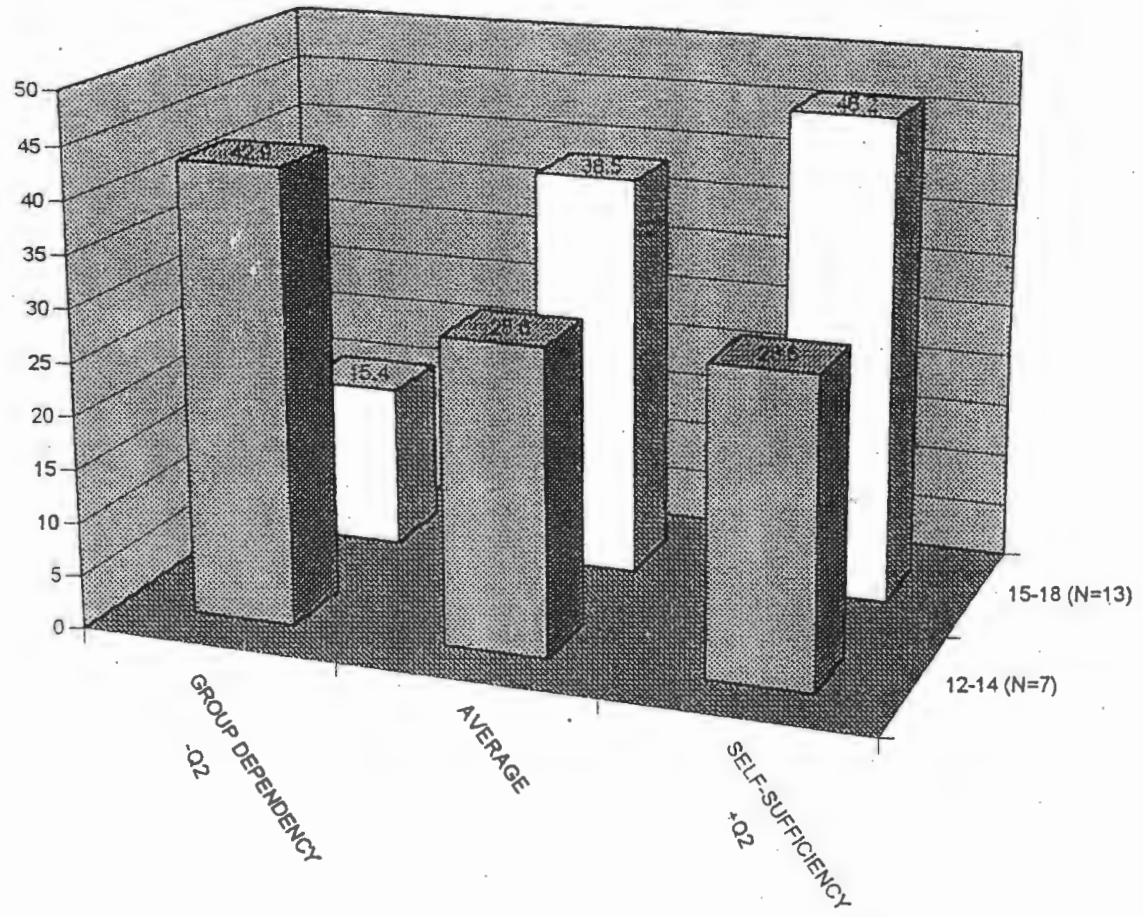
GRAPH 12 OVERALL DISTRIBUTION FACTOR Q2 (GROUP DEPENDENCY/ SELF SUFFICIENCY)



25% of the overall respondents were group dependent, 40% were self sufficient and 35%

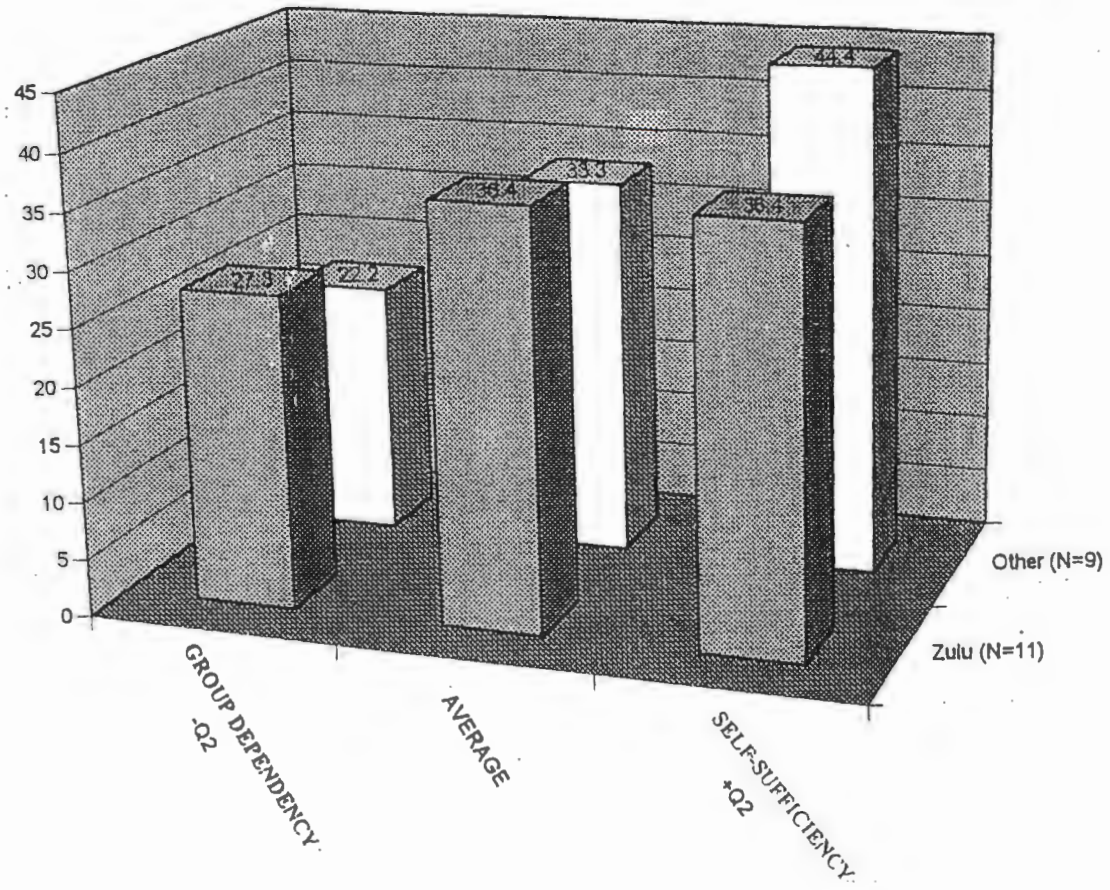
were average (see graph 12).

GRAPH 12.1 AGE DISTRIBUTION FACTOR Q2 (GROUP DEPENDENCY/ SELF SUFFICIENCY)



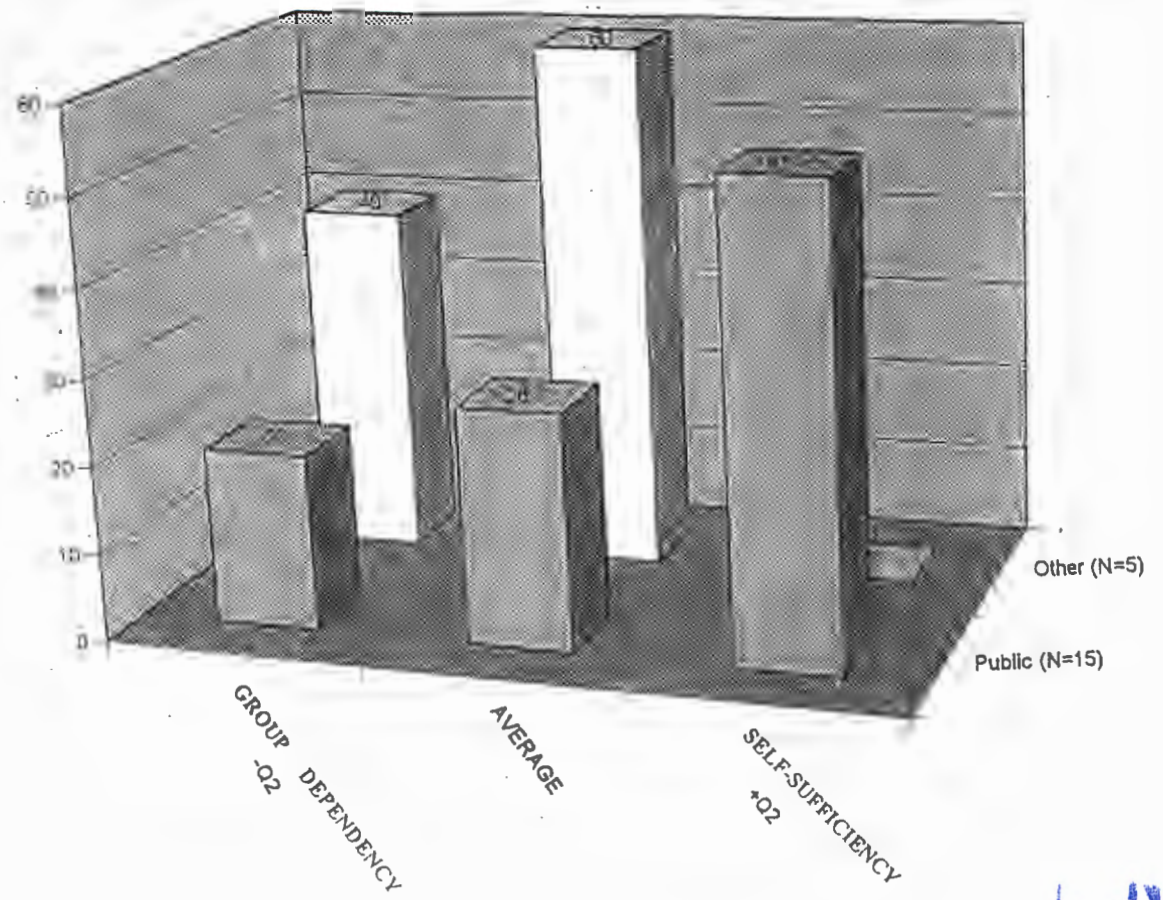
Most of the respondents 46.2% presented by graph 12.1 above in the upper adolescents were self sufficient. In the lower adolescent category most of the 42.9% were more group dependent (see graph 12.1).

GRAPH 12.2 LANGUAGE DISTRIBUTION FACTOR Q2 (GROUP DEPENDENCY/SELF SUFFICIENCY)



In graph 12.2 above most 44.4%, in the other language groupings measured as self sufficient and only 22.2% were group dependent. 36.4% of the Zulu speaking respondents were self sufficient and 27.3 were group dependent.

GRAPH 12.3 SCHOOL DISTRIBUTION FACTOR Q2 (GROUP DEPENDENCY/ SELF SUFFICIENCY)



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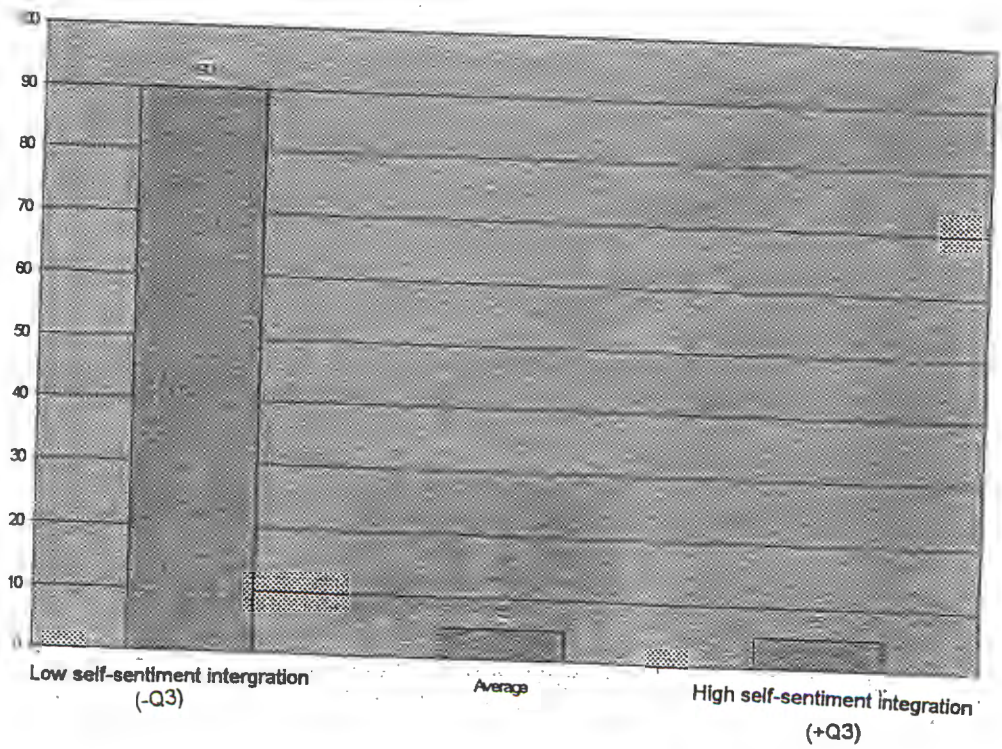
There were no respondents who were self sufficient in the private and not attending school category, whereas in the public school most 53.3% of the respondents measured with this Factor. 40% in the former grouping (private and not attending) were group dependent and 20% in the public schools (see graph 12.3).

(13) FACTOR Q3

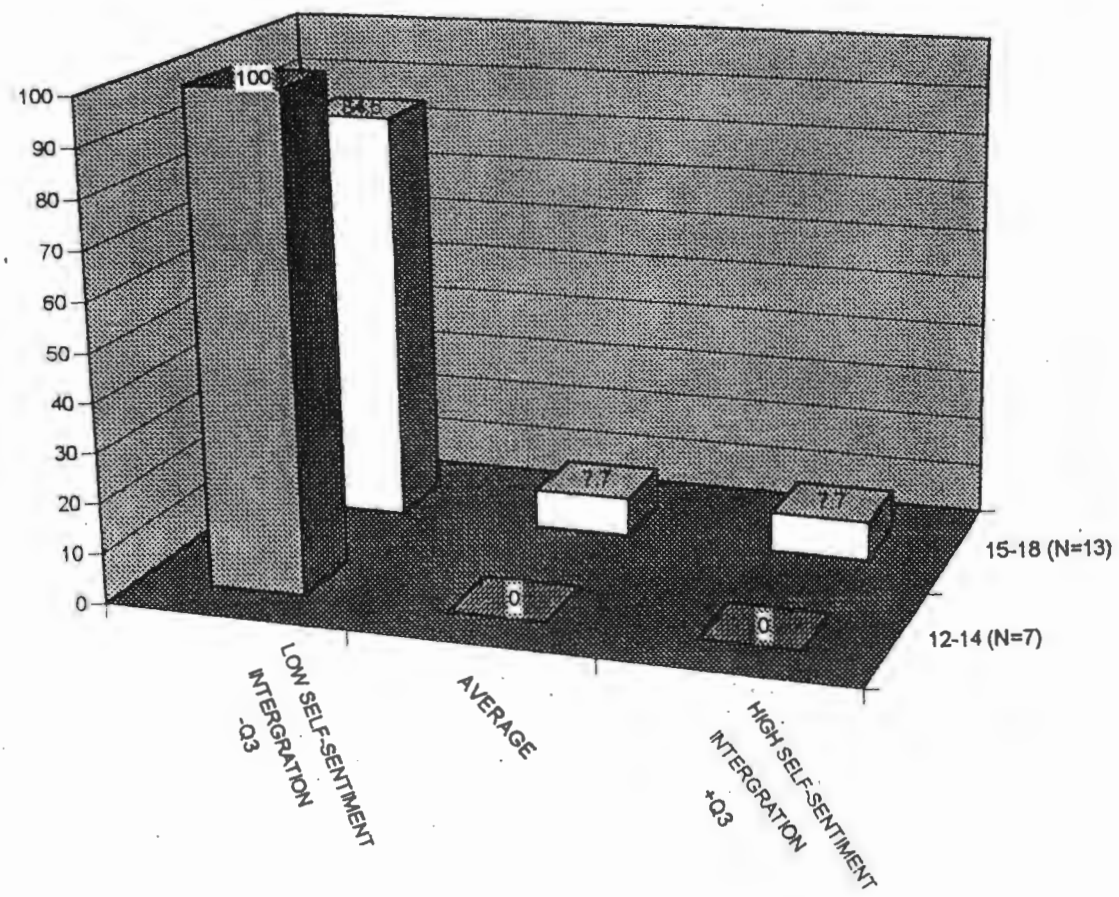
Factor Q3 measures self control this factor indicates the measure in which the individual experiences self sentiment, has an integrated self-image and leave according to internalized societal rules. (+Q3) score displays self control and are ambitious and conscientious, value the generally accepted social standards, consider others, plan ahead, are conscientious of their social image, critical of they own conduct and control of their own emotions. Persons with a (- Q3) rating display an uncontrolled, impulsive emotionality and they reject cultural values for their own interest. They show uncontrolled emotionality, anxious, uncertainty and irritability.

GRAPH 13 OVERALL DISTRIBUTION FACTOR Q3 (LOW SELF-SENTIMENT INTERGRATION/HIGH SELF-SENTIMENT INTERGRATION)



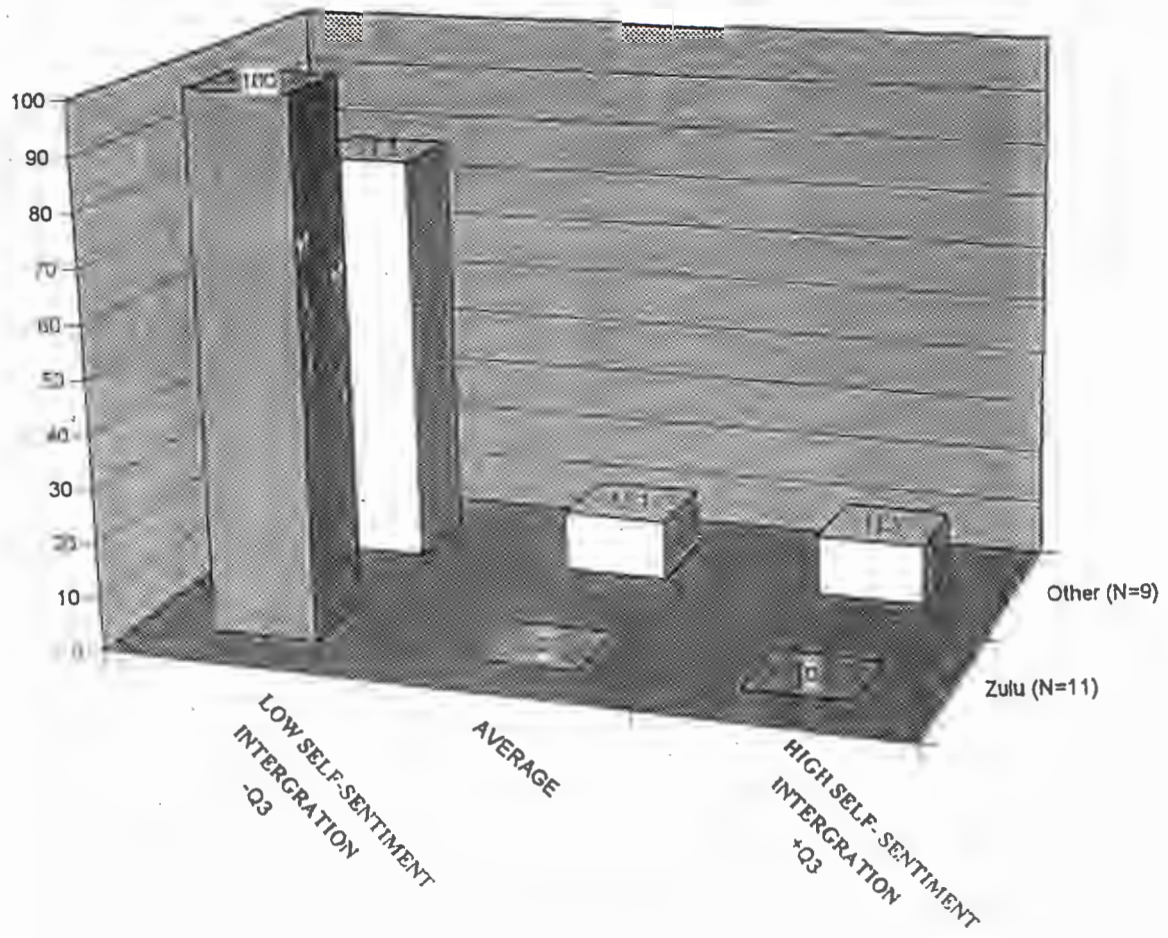
A very significant majority 90% of the respondents had low self-sentiment integration. Only a minority of 5% had high self-sentiment integration . 5% fell in the average Category (see graph 13).

GRAPH 13.1 AGE DISTRIBUTION FACTOR Q3 (LOW SELF-SENTIMENT INTERGRATION/HIGH SELF-SENTIMENT INTERGRATION)



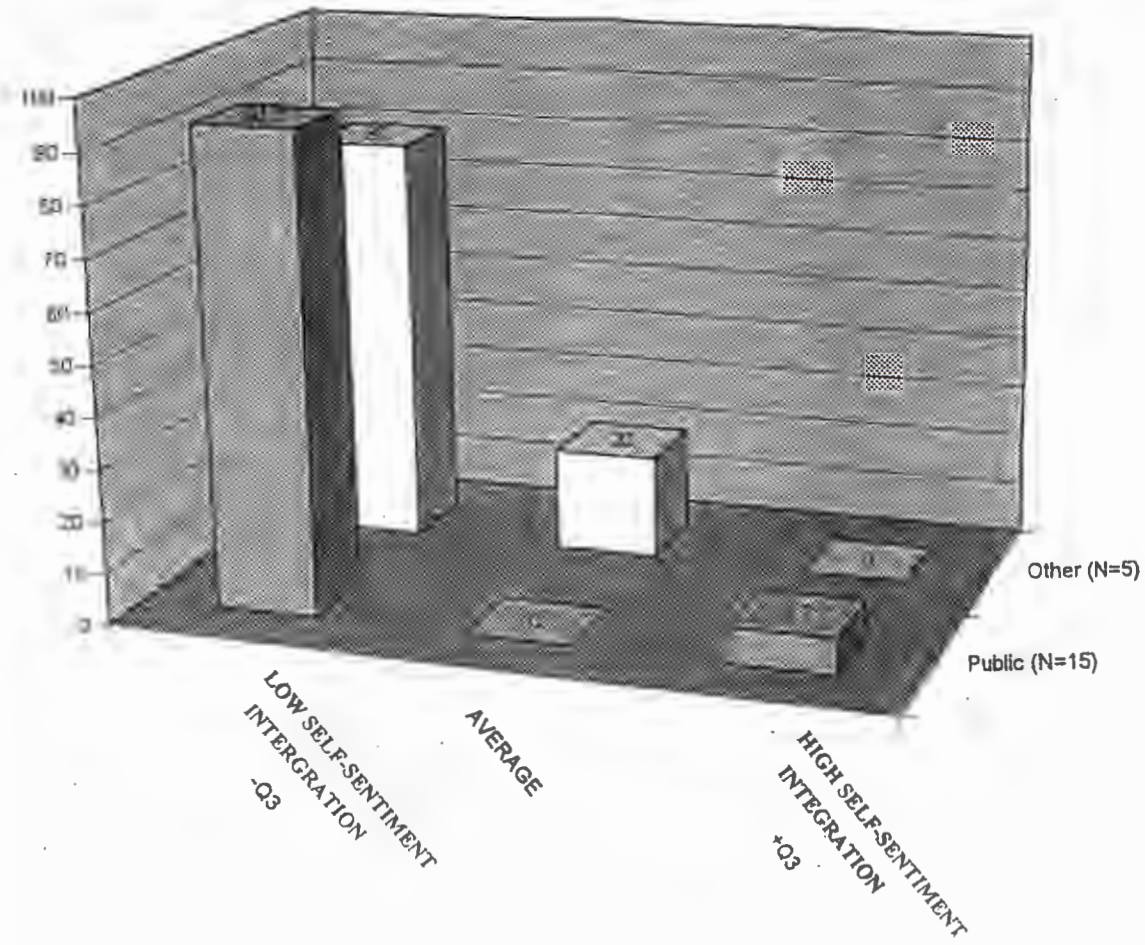
The presentation of graph 13.1 showed that all the respondents from the lower adolescents 100% had low self-sentiment. None of them had high self-sentiment. Only 7.7% in the upper adolescents had high sentiments about themselves, the majority of 84.6% had low self-sentiments.

GRAPH 13.2 LANGUAGE DISTRIBUTION FACTOR Q3 (LOW SELF-SENTIMENT INTERGRATION/HIGH SELF-SENTIMENT INTERGRATION)



All of the Zulu respondents as presented by graph 13.2 had low self-sentiment including 77.8% in the other languages' category. 11.1% in the latter category (other languages' group) had high self sentiments.

GRAPH 13.3 SCHOOL DISTRIBUTION FACTOR Q3 (LOW SELF-SENTIMENT INTERGRATION/HIGH SELF-SENTIMENT INTERGRATION)

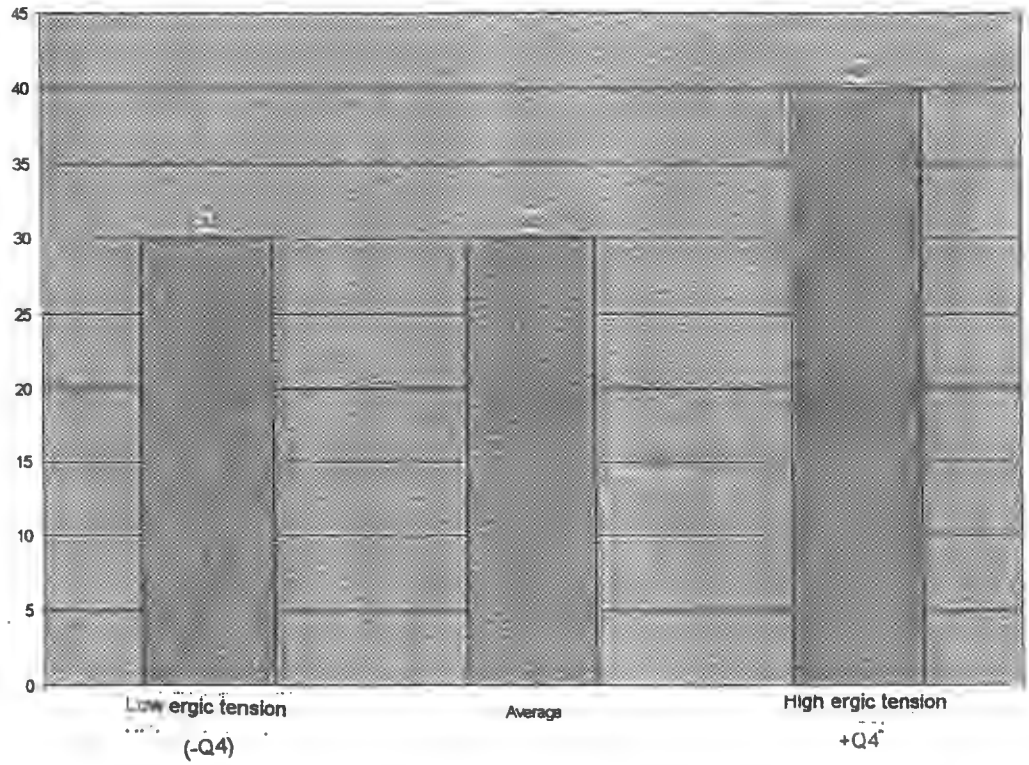


The majority of respondents in the public 93.3% and private and not attending school category 80% had low self-sentiment integration. Only 6.7% in the public schools had high self-sentiment integration.

(14) FACTOR Q4

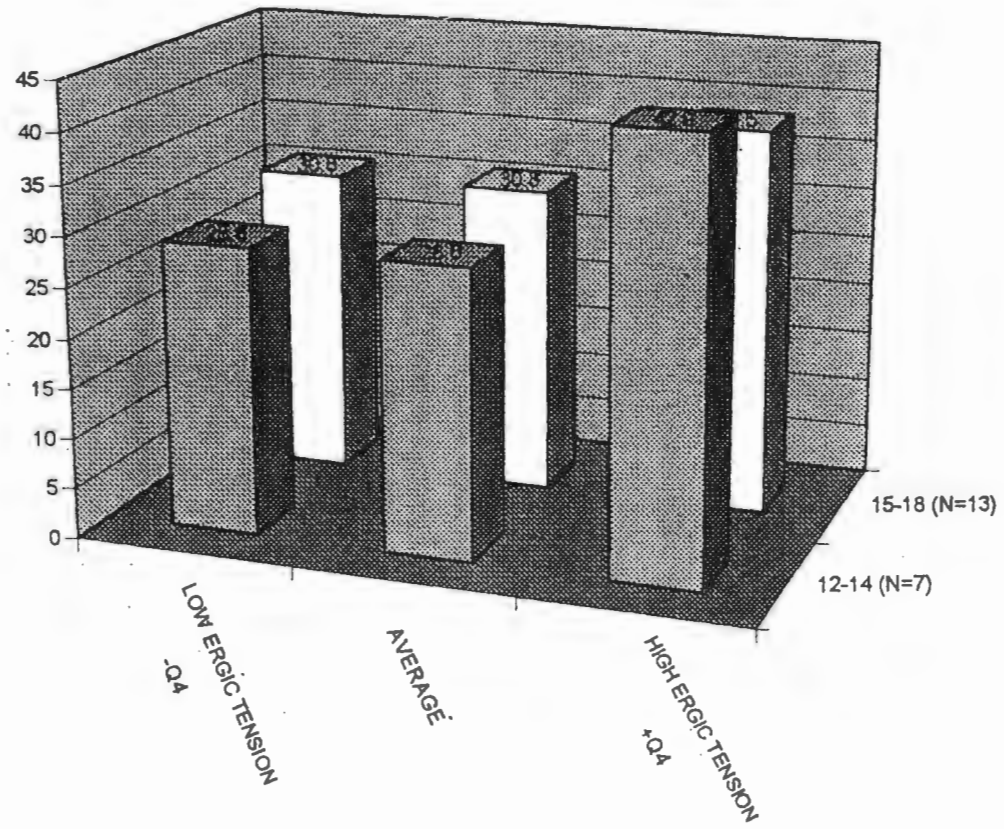
Factor Q4 measure tension. (+Q4) indicates frustrated needs. (+Q4) persons describe themselves as frustrated, unnecessarily worried, continually tense and irritable. They are sensitive to and aware of criticism and show lack of positive goals. (-Q4) score indicates that the person does not experience a high level of tension and anxiety.

GRAPH 14 OVERALL DISTRIBUTION FACTOR Q4 (LOW ERGIC TENSION/ HIGH ERGIC TENSION)



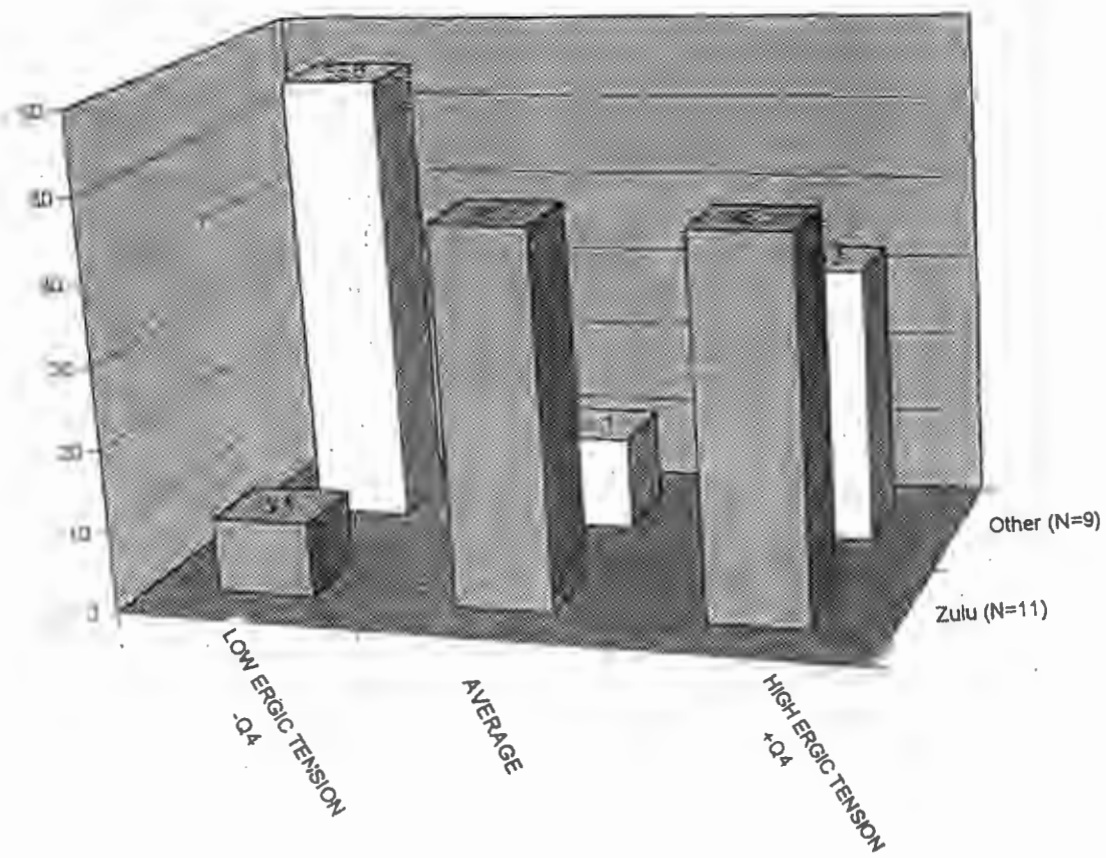
40% of the respondents had high tension and 30% had low levels of tension. 30% were average.

GRAPH 14.1 AGE DISTRIBUTION FACTOR Q4 (LOW ERGIC TENSION/ HIGH ERGIC TENSION)



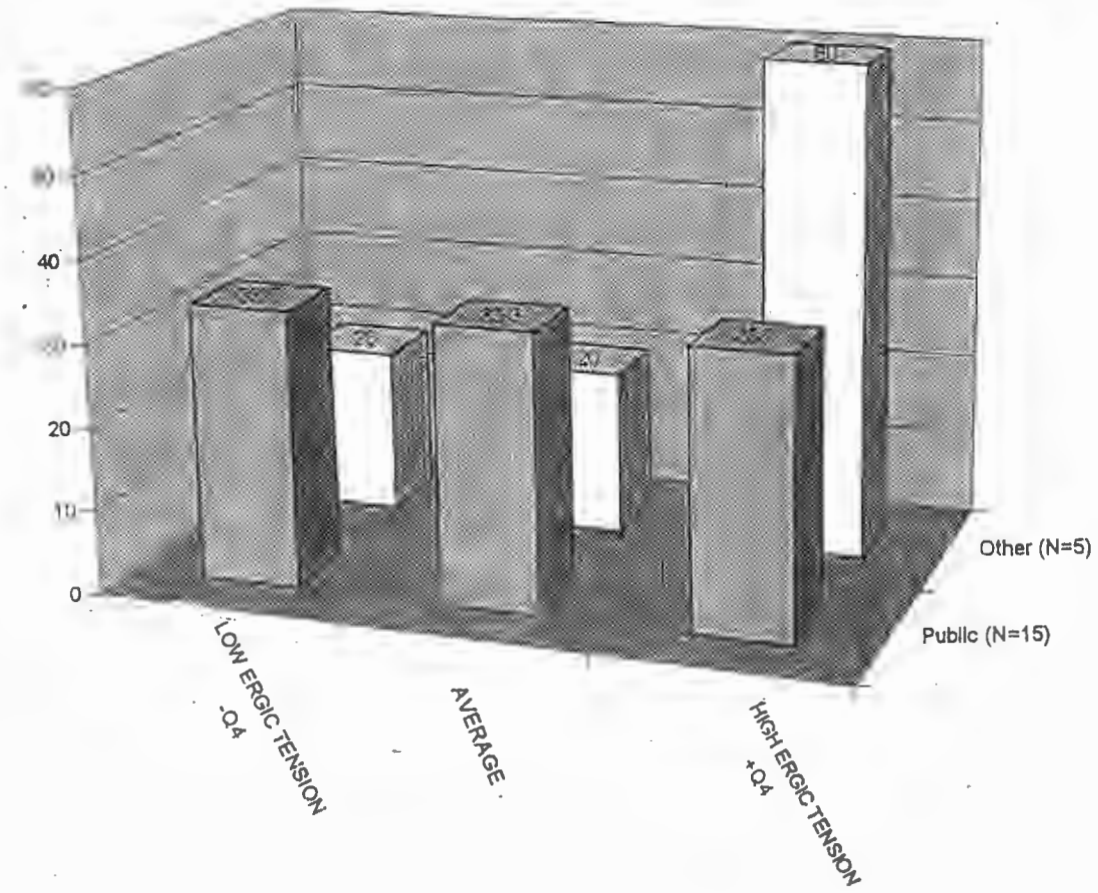
38.5% of the lower adolescent and 42.9% of the upper adolescent had high tension levels. 28.6% in the lower adolescent category and 30.8% in the upper adolescent category had low tension.

GRAPH 14.2 LANGUAGE DISTRIBUTION FACTOR Q4 (LOW ERGIC TENSION/HIGH ERGIC TENSION)



There was a contrasting presentation in graph 14.2. Most of the respondents 55.6% in the other language grouping had low tension whereas it was only a minority 9.1% in the Zulu speaking category sharing this trade.

GRAPH 14.3 SCHOOL DISTRIBUTION FACTOR Q4 (LOW ERGIC TENSION/ HIGH ERGIC TENSION)



60% of the private had non attending school category had high tension levels. Only 20% in the same category had low tension. In the public school category there is an equal distribution of points 33.3%, in all the sectors of Factor Q4, that is in the (-Q4), (+Q4), and average sector.

4.2. CONCLUSION

The preceding section focused on the results. In the following chapter, the researcher will discuss the findings and conclusion of the study.

CHAPTER 5

DISCUSSION OF RESEARCH FINDINGS AND CONCLUSIONS

5.1. DISCUSSIONS OF RESEARCH FINDINGS

The findings of the study are in accordance with the hypothesis. One hypothesis of the study by the researcher, was that adolescent suicide attemptors were impulsive and angry. The findings supported this view. This was revealed in the findings by the high scoring on Factor Q3, which measured self-control. The overwhelming majority of respondents (90%) in the overall distribution lacked self-control. They came across as people with high levels of irritability who would follow their own urges, especially when angry, without prior thinking of the consequences. Only five percent of the respondents in the overall distribution could control their impulses.

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The other hypothesis held was that there were common personality factors in adolescent suicide attemptors. Findings showed that the most common personality factors appeared to be lack of self-control followed by low intelligence. Seventy percent of the respondents in the overall distribution scored with this factor (low intelligence). The implication of this is that they are most likely to encounter difficulties with their school work. As a result, this might lead them to a situation where they repeat the same grade again, leading them to feelings of diminished self-esteem which in turn, escalates feelings of hopelessness, discouragement and pre-disposition towards suicide. This picture portrayed by the results explains why the suicidal attempts in Chris Hani Baragwanath escalates around examination time. Ten percent of the respondents in the over all distribution were of high intellectual functioning.

In descending order, the next common personality factors scored were around the 40 percentiles. Those factors will be discussed hereunder:

In the overall distribution picture, 45% of the respondents were emotionally unstable. In relation to language distribution, most (63.3%) respondents presented with this trait and only a minority of (22.2%) in the other language groupings were unstable. Forty percent of the respondents in the overall distribution presented with high levels of tension. According to Catell & Catell (1975) the above pattern indicates that the respondents suffer from frustrated needs that are not met, either by their families, parents, or even significant others in their lives.

According to the findings of the study, some of the respondents presented as tough-minded people who were highly individualistic and self-sufficient. This group tended to rely on themselves, and did not usually seek help from other people. Forty percent of the respondents in the overall distribution presentation were rather reserved and shy. They encountered difficulties in expressing their emotions freely and therefore, had to bottle up their emotions. Forty percent of the respondents had an excitable temperament. This factor is associated with the rebellious adolescent who is easily upset, quick tempered and has outbursts of rage. Forty-two percent of the lower adolescents presented with this trait. The picture display showed that the older the adolescent got, the more controlled, level-headed and calmer they are likely to be. Forty-six in the upper adolescent category had phlegmatic temperament. Furthermore, only 23.1% of the upper adolescents were dominant which went hand in hand with stubbornness, aggressiveness and hostility, as opposed to 57.1% in the lower adolescent category. Therefore, the picture that emerged showed that the rebellion, aggression and stubbornness in adolescents started at an early

age and the older they got, the more calm and controlled they became.

One other important finding was that, even though all participants had attempted suicide, 35% of them in the overall distribution had zest for life (see Appendix B). This showed that they still had an interest in living. Therefore this suggested that their act might have been a cry for help, or that they found themselves in a very desperate situation and could not think of any other solution to solve it.

A remarkable 40% of the respondents were warm-hearted and good natured people. Another 20% were conscientious and responsible.

According to the HSPQ manual (High School Personality Questionnaire), a possibility of suicidal tendencies was expected amongst people with the following personality profile: submissiveness, emotional instability, reserved, proneness to guilt feelings and high levels of tension (Visser, Garber – Strauss, 1992). The findings of the study however presented us with a different profile. The high risk personality factors were low intelligence and lack of self control. Other personality factors suggested in the manual were present in the respondents but were not in the majority.

Apart from personality issues indicated above, the participants also reported social problems they experienced that served as contributory factors to the attempted suicide. These included home environment characterized by violence, poor communication between them and their parents, peer pressure, truancy, experimenting with alcohol and a case of broken romance.

In summary, the study supports the view that personality factors such as lack of self-control (impulsivity) which is highly prevalent in the study group and other personality traits play a very important role in the mentality of suicidal behavior. Social problems also play an important role since the adolescent does not exist in isolation but with other people.

5.2. RECOMMENDATIONS

In view of the research findings, the following recommendations are made:

5.2.1. LIFE SKILLS PROGRAMMES

Life skills programmes, which entail self assertiveness training, conflict management and basic communication skills, should be introduced towards the end of the lower primary school years to equip adolescents with these skills. This is suggested since 95% of the sample are attending school.

During this time the children are on a pre-adolescent stage. This could better equip them with the necessary life skills for the coming trying stage of adolescence. They should be taught to speak out their problems regardless of how difficult the problem is. This will prevent them from bottling up and internalizing their anger.

Adolescents should be taught to think before they act. This will prevent impulsive actions which may result in bruises around the neck, burn marks or even stab wounds, on their bodies to serve as life time reminders. They should be taught to love themselves. This should start at the home front level, which is the primary area of socialization and in

therapy sessions.

5.2.2. ACADEMIC PERFORMANCE ASSESSMENT

For the therapist working with adolescents who have attempted suicide, the following is recommended. If the attemptor comes around examination time, the therapist should enquire further on the history of his academic progress. Should they find that the child has failed frequently, then an intelligence test should be performed on the child. The findings will show if the child is properly placed or needs specialized education. If the latter (specialized education) is the case, relevant recommendations and referrals should be made. They can be referred to remedial schools, special schools or even training centres.

5.2.3. UNCONDITIONAL LOVE AND ACCEPTANCE

One other important aspect that needs to be driven home to parents as pointed out in the findings is the topic of unconditional love and acceptance. All parents expect the best from their children, and they mean well. However, not all children will produce good results, given their intellectual level. Parents need to provide love, support and unconditional acceptance, especially to those children who find it difficult academically. Active participation in the academic progress of their children will facilitate communication and show them the apparent interest behind it. This will significantly decrease the numbers of suicide rates coming to the psychiatric clinic, especially around examination time.

In conclusion, suicide is not a solution to the problem, it is symptomatic of a larger social

problem. That stated, let us try to be supportive of one another as a society, especially to the adolescents, in finding an amicable way of dealing with daily problems. This will help them to grow up as healthy self-contained individuals.

5.3. LIMITATIONS OF THE STUDY

This study was limited since it was a small scale study, which was not sufficient enough to give indepth information about the study at hand.

5.4. IMPLICATIONS FOR FURTHER RESEARCH

For further research, it is suggested that a similar study be conducted using a larger sample. This could provide in depth information about the topic under study.

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APPENDIX A

CHRI HANI BARAGWANATH HOSPITAL DEPARTMENT OF PSYCHIATRY

CHILD, ADOLESCENT & FAMILY UNIT

CONSENT FOR PSYCHOLOGICAL ASSESSMENT

I, ... hereby give consent for the

administration of psychological tests for research purposes to my child.....

....., date of birth : .....

I understand that full confidentiality is assured and that no publication of name

or other identifying details will be made.

I understand that I will be entitled to receive test results, should I wish to do so.

SIGNED :.....

RELATIONSHIP TO CHILD : .....

WITNESS : .....

DATE : .....

APPENDIX B

SUMMARY TABLE PRESENTING ALL FACTORS

FACTOR A		PERCENTAGE
WARMHEARTEDNESS	Reserved	40%
	Outgoing	30%
FACTOR B		
INTELLIGENCE	Concreteness	70%
	Abstract Thinking	10%
FACTOR C		
EMOTIONAL STABILITY	Emotional Instability	45%
	Emotional Stability	20%
FACTOR D		
EXCITABILITY	Phlegmatic Temperament	40%
	Excitability	40%
FACTOR E		
DOMINANCE	Submissiveness	15%
	Dominance	35%
FACTOR F		
CAREFREENESS	Soberness	25%
	Care freeness	20%
FACTOR G		
CONSCIENTIOUSNESS	Opportunistic	40%
	Conscientious	20%
FACTOR H		
SOCIAL BOLDNESS	Shyness	45%
	Social Boldness	15%
FACTOR I		
TENDERMINDEDNESS	Tough Mindedness	45%
	Tender Mindedness	30%
FACTOR J		
INDIVIDUALISM	Zestfulness	35%
	Individualism	30%
FACTOR O		
GUILT PRONESS	Self-Assurance	35%
	Proneness to guilt feelings	15%
FACTOR Q2		
SELF-SUFFICIENCY	Group Dependant	25%
	Self Sufficiency	40%
FACTOR Q3		
SELF CONTROL	Low self-sentiment intergration	90%
	High self-sentiment integration	5%
FACTOR Q4		
TENSION	Low ergic tension	30%
	High ergic tension	40%