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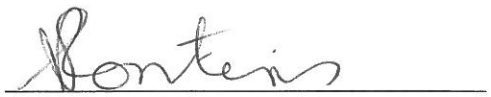
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A research project submitted in partial fulfilment of the requirements for the degree MA in Community-Based Counselling Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg.

DECLARATION

Under the supervision of Dr. Vinitha Jithoo,

I, Anastasia Rontiris hereby declare that this research is my own original work and all external sources have been accurately reported and acknowledged. This work has not previously, in its entirety, or in part been submitted to any other university in the interest of an academic qualification.



Anastasia Rontiris

26/03/2014

Date

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ABSTRACT

Suicidal behaviour is a serious public health problem. Globally and in South Africa prevalence rates are increasing particularly amongst young adults, highlighting a need for preventative measures. One way to assist with these efforts is to enhance our understanding of suicide by investigating young adult's views towards suicidal behaviour. To date, limited research exists in the South African context on views towards suicide. The purpose of this study was to explore young adult's views about suicidal behaviour within the context of culture and religion. A qualitative research design was adopted using semi-structured individual interviews. The participants were ten students from the University of the Witwatersrand between the ages of twenty and twenty-five. The results were analysed using thematic content analysis. The results revealed that participants predominantly identified psychological, social and cultural risk factors for suicidal behaviour, ignoring the influence of psychopathology. The participants also highlighted the influence of the social and cultural context on shaping not only their own views, but those of their family, culture and community. The results indicated that unlike their families, religions and communities, the participants did not hold negative views towards suicide. Instead they appeared to have a great deal of sympathy towards those who had attempted or committed suicide and seemed to denounce the negative views of those around them. Lastly, the results illustrated that role of gender was central to explanations gender differences in suicidal behaviour. Implications of the findings for future research and prevention are discussed.

TABLE OF CONTENTS

DECLARATION i
ACKNOWLEDGEMENTS ii
ABSTRACT iii
1 CHAPTER ONE 1
1.1 Introduction 1
1.2 Key Terminology 4
1.3 Theoretical Framework 5
1.4 Rationale 8
1.5 Outline of the research report 10
2 CHAPTER TWO 11
2.1 Literature Review 11
2.2 Risk factors associated with suicidal behaviour: A South African perspective 11
2.2.1 Individual characteristics 11
2.2.2 The micro-system 16
2.2.3 The exo-system 19
2.2.4 The macro-system 23
2.3 Views towards suicidal behaviour 27
2.3.1 Gender 27
2.3.2 Religion 31
2.3.3 Cultural Context 34
2.4 Conclusion 36
3 CHAPTER THREE 37
3.1 Methodology 37
3.2 Research Design 37
3.3 Procedure 37
3.4 Participants 38
3.5 Instrument 38
3.6 Method of data analysis 39
3.7 Ethical Considerations 40
4 CHAPTER 4 41
4.1 Results 41
4.2 Perceived risk factors 41
4.2.1 Psychological risk factors 42
4.2.2 Social and cultural risk factors 47
4.3 The influence of the socio-cultural context 51

4.3.1 "It's a sin" 52
4.3.2 Breaking the cultural dilemma 56
4.4 The role of gender 58
4.5 Conclusion 65
5 CHAPTER 5 67
5.1 Discussion 67
5.2 Implications of findings for suicide prevention 76
6 CHAPTER 6 79
6.1 Conclusion 79
6.2 Limitations 80
6.3 Implications for future research 80
7 REFERENCES 82
APPENDIX A: ETHICS APPROVAL 94
APPENDIX B: INTERVIEW GUIDE 95
APPENDIX C: PARTICIPANT INFORMATION SHEET 96
APPENDIX D: PARTICIPANT CONSENT FORM 98
APPENDIX E: CONSENT TO RECORD AND TRANSCRIBE INTERVIEW 99
APPENDIX F: CONSENT TO USE DIRECT QUOTES 100

CHAPTER ONE

1.1 Introduction

Suicide is a serious and ever increasing public health problem worldwide; one which cannot be ignored. Most people are unaware of how serious the problem is and this lack of awareness is partly due to a number of different attitudes globally. In these instances suicidal behaviour is either viewed as a social taboo or is construed as self-harm used to manipulate others or to escape from reality (Schlebusch, 2005). Therefore, suicidal behaviour is often not given the attention that it deserves. This is coupled with the social stigma that is often attached to those who engage in suicidal behaviour; making it difficult for such individuals to openly discuss their emotions or suicidal thoughts. Consequently, this leads to difficulties in recovery for those who survive either their own suicidal behaviour or that of a loved one (Schlebusch, 2005).

Globally, it is estimated that approximately one million people worldwide die by suicide each year, with an overall yearly rate of 16 per 100 000 suicides within the general population. This translates to one death every 40 seconds (Schlebusch, 2005). In general, these statistics indicate that more people in the world are dying annually from suicide than from war, homicides and traffic accidents (Schlebusch, 2005). While this illustrates the severity of the problem globally, reports indicate that there has been an increase in suicide rates in recent years in both high-income and low-income countries. Figures show that globally an increase in suicide rates of approximately 60% was observed from 1950 to 1995 (Bertolote, 2001). This rapid increase in suicide rates has led the World Health Organisation to estimate that by 2020, 1.5 million people across the globe will die by suicide each year; translating to one death every twenty seconds. Worldwide, the most at risk group has been established as the 15 to 24 year age group, meaning that in many countries, suicide is one of the leading causes of death among the youth (Bridge, Goldstein & Brent, 2006).

In the African context, published studies on suicidal behaviour are limited partly because there has been an underlying assumption that suicidal behaviour occurs less frequently in these communities (Schlebusch, 2005). However, recent studies have shown that suicidal behaviour amongst the youth has increased significantly in parts of Africa. For example, Kinyanda, Nakku, Oboke, Oyok, Ndyanabangi, and Olushayo (2009) reported suicide rates of 15 to 20 per 100 000 for the period of 2005 to 2007 in northern Uganda. This is not always acknowledged largely due to methodological difficulties including data

compilation with a lack of standardised research designs and assessment instruments as well as poor research infrastructure or collaboration. Furthermore, divergent cultural and religious perceptions of suicidal behaviour have also influenced the assumption that suicidal behaviour is not a significant problem in parts of Africa (Schlebusch, 2012). Therefore, not only do the statistics underreport the true burden of the problem, but the literature from African countries is generally scarce.

Despite this, recent research illustrates that contrary to early beliefs that suicidal behaviour in Africa is low, suicidal trends are in many instances the same as across the globe (Kinyanda et al., 2009). Despite an increase in research investigating suicidal behaviour in Africa, the rates are still likely to be underreported and a good understanding of the full burden of suicidal behaviour is limited. This is largely due to a lack of research infrastructure and funds, a lack of expertise in suicide research and inadequate inter-African research collaboration. Furthermore, limited and outdated studies as well as a lack of standardised research designs and assessment instruments also contribute to the under reporting of data (Palmier, 2011). Suicidal behaviour in most parts of Africa also still carries negative cultural sanctions therefore perpetuating non-reporting (Palmier, 2011).

Following the pattern of suicide research in Africa, South Africa also faces a major issue relating to the trustworthiness of statistics regarding suicidal behaviour. Due to a lack of research, an incomplete representation of suicidal behaviour is often presented, and therefore the problem could be more serious than often thought (Schlebusch, 2005). Recently however, there has been an increase in research surrounding suicidal behaviour, in order to establish a clearer understanding of the severity of the problem in South Africa. For example, the South African Stress and Health (SASH) survey conducted between 2002 and 2003 amongst the general population, found that the lifetime prevalence estimate of attempted suicide among South Africans is 2.9% and individuals between the ages of 18 and 34 are at a significantly higher risk for engaging in attempted suicide (Joe, Stein, Seedat, Herman, & Williams, 2008). The tenth National Injury Mortality Surveillance System (NIMSS) report provides further evidence of the seriousness of suicidal behaviour in South Africa (Donson, 2009). The results showed that overall, suicide was the fourth leading cause of death in the country indicating that suicide accounts for approximately 10% of all non-natural deaths in South Africa. The study also found that nearly 70% of all suicide victims were aged between 15 and 44 years of age and that suicide was highest among the youth aged 15 to 29 years of age (Donson, 2009). Therefore, the results indicate the severity of the problem in South Africa particularly amongst young adults.

While, there may still be shortcomings with research investigating suicidal behaviour in South Africa, there does appear to have been an increase in the overall suicide rates reported. For example, in 1988 it was reported that suicides accounted for less than 1% of non-natural South African deaths whereas by 1994 this had risen to 7%. Nationwide in 1999, fatal suicidal behaviour accounted for 8% of all non-natural deaths in South Africa (Schlebusch, 2005) with the most recent NIMSS figures indicating that about 10% of all non-natural deaths in South Africa are suicides (Donson, 2009). While research has reported that the overall suicide rate in South Africa has been steadily increasing, perhaps more disconcerting is the increase in prevalence amongst South Africa's youth. Known rates of fatal suicidal behaviour in young people are a cause for great concern. Studies indicate that in South Africa, suicide is the third leading cause of death amongst the youth and on average 9.5% of non-natural deaths in young people in South Africa are due to suicides (Schlebusch, 2012). These high prevalence rates illustrate that young adults in South Africa are a particular concern and there is an ongoing need for greater accuracy and more knowledge in this area.

One approach to advancing our understanding in this area is to explore the views and beliefs that people hold about suicidal behaviour. Hjelmeland and Knizek (2004) support this approach arguing that certain views and beliefs held about suicidal behaviour can hinder people from reading or acting upon the subtle signals suicidal people send out. Furthermore, signals may be underestimated and not taken seriously. Boldt (1988, p.95) writes "suicidologists use the term 'suicide' as though there is no need to understand its meaning. This neglects the fact that meaning precedes ideation and action and that individuals who commit suicide do so with reference to cultural-normative specific values and attitudes" (Boldt, 1988, p. 95). This comment highlights the important role that culture plays when understanding suicidal behaviour. Colucci (2006) emphasised that suicide has different meanings to people belonging to different socio-cultural backgrounds. Therefore, it is vital that research is context and culture specific in order for us to obtain a comprehensive and accurate understanding of suicide. The concept of culture is probably one of the most debated aspects and in general there is little agreement on its definition. Broadly speaking however, culture is a term used to define the shared learned behaviour of individuals which includes rules, values, practices and customs of a group of people. This is often reflected in the artefacts, roles, languages, consciousness and attitudes of people (American Psychological Association, 2003). Hjelmeland, Akotia, Owens, Knizek, Nordvik, Schroeder and Kinyanda (2008) suggest that when it comes to understanding suicidal behaviour, there is a need to obtain a broader view of human behaviour and this requires a shift from the prevailing

universal definition of suicide to culture-specific meanings of suicide. Suicide can be considered a cultural artefact because no suicidal behaviour is committed without reference to the prevailing normative standards and attitudes of a cultural community. Therefore, there is a need to move away from international research which cannot readily be transposed from one country to another (Hjelmeland et al., 2008).

According to Colucci (2006), an understanding of what suicidal behaviour means to people is regarded as essential. However, despite the number of scholars who have underlined the relevance of this, investigating young adult's views is a missing area in suicide research (Colucci, 2006). Therefore this study aimed to explore young adult's views towards suicidal behaviour in the South African context. This aim was accomplished by exploring what young adults understood about suicide, what they believed motivated suicide and the common ways in which suicide is attempted or completed. Furthermore, the influence of religion, culture and gender on views towards suicide will also be explored. In this chapter key terminology utilised throughout the research report will be clarified. This is followed by a description of the theoretical framework of the study and thereafter the rationale of the study will be presented.

1.2 Key Terminology

For this research, it is important to firstly clarify concepts and definitions related to suicidology and suicidal behaviour. A great deal of research has been conducted however both internationally and locally in order to improve the clarity of these definitions. This has resulted in an ongoing debate highlighting the complex, wide-ranging, multifactorial and multidimensional nature of suicidal behaviour globally. Based on the work of many experts in suicidology, Schlebusch (2005) has proposed a number of definitions related to suicidology and suicidal behaviour. To begin with, suicidal behaviour denotes "a wide range of self-destructive or self-damaging acts in which people engage, owing to varying degrees of levels of distress, psychopathology, motive lethal intent, awareness and expectations of the deleterious consequences or outcome of the behaviour" Schlebusch (2005, p.6). This definition of suicidal behaviour not only emphasises that suicide is a form of behaviour with a suicidal connotation, but it also takes into account all the different factors that can influence suicidal behaviour as well as an acknowledgement of the consequences of an individual's actions. Suicidal behaviour can also be divided into fatal and non-fatal suicidal behaviours. Fatal suicidal behaviour refers to "self-committed, completed suicidal behaviour that embodied the victim's intent or aim to die and where that person managed to achieve that

predetermined goal" (Schlebusch, 2005, p.6). This definition illustrates the finality of an act of fatal suicidal behaviour but more importantly also emphasised an individual's intent. Furthermore, there is also suicidal ideation which can be described as a person's thoughts about killing themselves as well as a person writing, talking about or planning their suicidal behaviour (Schlebusch, 2005).

Non-fatal suicidal behaviour refers to self-inflicted suicidal behaviour that did not succeed in ending the victim's life and which embodies several manifestations. Furthermore, non-fatal suicide can be divided into attempted suicide and parasuicide. According to Silverman (2006), there is a great deal of ambiguity around the term attempted suicide since a definition for attempted suicide can include a wide range of behaviours spanning the entire range of suicide intent and medical lethality. The problem with this ambiguity is that often linguistic, operational, theoretical and clinical confusion is created (Silverman, 2006). For example, Schlebusch (2005, p.6) defines attempted suicide as "non-fatal suicidal behaviour where there is a fortuitous survival of the intended suicide". From a different perspective, Bryan and Rudd (2006) define attempted suicide in terms of whether an injury occurred or not. They define a suicide attempt with injuries as "an action resulting in nonfatal injury, poisoning or suffocation where there is evidence that the injury was self-inflicted and that he or she intended at some level to kill himself or herself" (Bryan & Rudd, 2006, p.186). On the other hand they define attempted suicide without injuries as "a potentially self-injurious behaviour with a nonfatal outcome for which there is evidence that the person intended at some level to kill himself/herself" (Bryan & Rudd, 2006, p. 186).

Parasuicide on the other hand refers to non-fatal suicidal behaviour without the intention to die; it is more a cry for help where it is used as an inappropriate problem-solving skill in the form of self-harm. Therefore, the main difference between attempted suicide and parasuicide is the intent to die or not but both have non-fatal outcomes (Schlebusch, 2005). Despite the difference in definitions, there appear to be three main factors common to all definitions: 1) self-initiated, potentially injurious behaviour, 2) the presence of the intent to die and 3) a non-fatal outcome. Therefore it is clear, that the definitions pertaining to suicidal behaviour are complex, multifactorial and multidimensional in nature. For the purpose of this study however, the definitions proposed by Schlebusch (2005) will be utilised.

1.3 Theoretical Framework

In order to better understand suicidal behaviour in the South African context, an ecological lens developed by Bronfenbrenner (1979) has been adopted in this study. This

allowed for a move beyond an individualistic frame and instead allowed for a consideration of the complex relationships between personal, interpersonal and sociocultural factors which may influence young adults' views on suicidal behaviour. According to Bronfenbrenner (1977, p. 514) "the ecology of human development is the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives". This means that development and socialisation are influenced by the different circles of the environment with which a person is in active inter-relation. This includes three significant assumptions: 1) a person is an active player, exerting influence on his/her environment; 2) the environment compels a person to adapt to its conditions and restrictions, and 3) the environment is understood to consist of different size entities that are placed one inside another (Bronfenbrenner, 1979). These entities or systems can be distinguished as micro-, meso-, exo- and macro-systems (Figure 1).

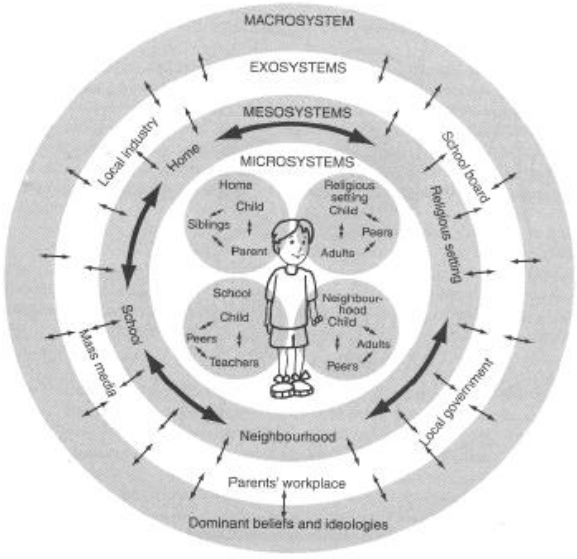


Figure 1. Bronfenbrenners ecological systems theory (Taken from Harkonen, 2007).

The micro-system is the complex of interrelations within an individual's immediate setting containing that person (home, school, workplace etc). Here, Bronfenbrenner (1977) argues that a setting can be defined as a place with certain physical features in which the participants engage in particular activities in particular roles for specific periods of time. Therefore, the factors of place, time, physical features, activity, participant and role constitute the elements of a setting. The micro-system is the closest environment for an individual and includes the structures with which the individual maintains direct contacts. Harkonen (2007) argues that at this level the relations between individuals can happen in two ways-from the

individual and towards the individual. For example, an individual's parents have an influence over his/her beliefs and behaviour but the individual can also influence their parent's beliefs. The fact that parents can influence an individual's beliefs is perhaps the most important factor as this means that an individual's beliefs and attitudes towards suicidal behaviour will be affected by their immediate environment. This was referred to as bi-directional influence and he argued that this was strongest at the micro-system (Harkonen, 2007).

Furthermore, an individual's beliefs can also be influenced by their school environment and at a tertiary level by their university experience. This is because in this environment, a developing individual is an active participant with multiple factors including teachers, peers and other school governing officials. Peers are also a particularly strong influence on an individual's views and beliefs, especially when individuals are going through the transition of adolescence and are trying to establish their identity. Therefore within their direct environment, they are influenced in multiple ways and this influences their views, beliefs and attitudes.

A system of micro-systems can form a meso-system, which comprises the interrelations among two or more settings in which the developing person actively participates. For example, at an individual level this can include the relations between home and school, school and peers. The meso-system is formed or extended whenever the developing person moves into a new setting and interconnections can take on a number of additional forms. For example, intermediate links in a social network or formal communications among other settings (Bronfenbrenner, 1979). It is important to observe here when considering the development of an individual's views, whether the influencing factors have coinciding directions, therefore supporting each other, or whether they have opposing directions and therefore different opinions or views (Harkonen, 2007). Therefore, an individual may have been influenced by consistent and similar views or may have been influenced by opposing views in their immediate environment.

The next setting is the exo-system which refers to a setting where the individual person does not actually participate and never enters but in which events occur that affect what happens in the person's immediate environment. This system encompasses the world of work, the neighbourhood, the mass media, agencies of government and informal social networks (Bronfenbrenner, 1977). This means that as an individual interacts with their community, their neighbourhood, their church or religion, the media and social networks like Facebook and Twitter, they are continuously bombarded and exposed to a variety of information. In addition they are also influenced by a large number of other views, opinions

and attitudes therefore influencing their own view. In the South African context, where an individual is exposed to multiple cultures, religions and traditions, they are exposed to a multitude of beliefs and views; which is an important point to consider when researching individual's views in the South African context.

Finally, the macro-system refers to the overarching patterns of ideology and organisation of the social institutions, common to a particular culture or subculture such as the economic, social, educational, legal and political systems as well as attitudes, beliefs, values and ideologies inherent in a community and culture which consequently impact the micro- meso- and exo- systems (Bronfenbrenner, 1977). Therefore, in the South African context, research has shown that a number of stigmatising attitudes are held against individuals with mental health conditions. Kakuma, Kleintjes, Lund, Drew, Green and Flisher (2010) for example, outlined a number of studies amongst communities which have found high levels of stigmatising attitudes towards individuals with mental health conditions. This illustrates that if there is an overarching ideology focusing on holding negative stigmatised attitudes towards mental health, the individuals who live within that country will therefore be influenced by this ideology and by the negative views held towards mental health.

1.4 Rationale

The rates of suicide mentioned previously indicate that suicide is not only a South African problem but a global one too and one that cannot be ignored. The fact that suicide rates are increasing worldwide and in South Africa especially, illustrates the importance of investigating suicidal behaviour. Given that there is a lack of research in the South African context, there is a need to understand the discourse of suicidal behaviour in order to enhance our understanding and knowledge of suicidology.

Research on the prevalence of suicidal behaviour among young adults has identified this as a particularly vulnerable period in their life for suicidal behaviour. This could be due to the fact that at this life stage, individuals face a developmental crisis. At this developmental stage young adults are most engaged in developing a healthy identity as noted by Erik Erikson's eight stages of the life cycle. According to Erikson, individuals attempt to resolve the issues of identity versus role confusion during this time and often experiencing considerable stress in a variety of contexts as they attempt to forge an identity (Portes, Sandhu, & Longwell-Grice, 2002). Erikson argued that particularly when entering tertiary education, individuals are no longer children but are not yet equipped to be adults. This leads to individuals being concerned about how they are viewed in the eyes of others rather than

focusing on how they feel. This transition into young adulthood is a difficult developmental period during which an individual must deal with physical changes, sexuality and maturation and move toward economic independence and separation from parents (Burrows & Laflamme, 2008). Furthermore, this life stage is often accompanied by low self-esteem, confusion and uncertainty, depressed mood and substance abuse; factors which may increase the risk of engaging in suicidal behaviour (Burrows & Laflamme, 2008).

Young adults in South Africa however, face additional challenges when it comes to developing their identity as more young adults than ever are becoming exposed not only to their local culture, but also the beliefs and practices of other people. A cultural identity includes key areas of Erikson's formation of an adolescent's identity including ideology (beliefs and values), love (personal relationships) and work. In order to form a cultural identity, choices need to be made about the culture with which one identifies. Given South Africa's heterogeneous society, individuals may face cultural conflicts when forming their identity. Erikson's identity formation task centres on the process of developing an individual identity within one's cultural community. However, when an individual is exposed to multiple cultures, they need to decide with which cultural community they affiliate themselves with and this can lead to conflict and further identity confusion (Jensen, 2011). Therefore, young adults in South Africa who are trying to establish their identity are met with two different world views which at times conflict; a traditional one embedded in certain beliefs, ideals and values and a Western world with all the promises of a first world country. This has a profound influence on young adult's cultural identity development. This means that there is a need to obtain a greater understanding of the phenomena of suicide amongst the youth in South Africa.

Currently, the largest proportion of published research in the field of suicidology employs quantitative methodology such as questionnaires. This results in the explanation of suicidal behaviour in linear cause and effect terms. Hjelmeland and Knizek (2010) argue that in order to enhance the study of suicide and suicide prevention, a qualitative approach should be utilised to allow for the capture of rich data through interpretation and understating. This can allow for the uncovering of beliefs, values and perceptions of individuals towards suicidal behaviour. Investigating views on suicidal behaviour is important because they affect the willingness of health care staff and the willingness of people in general to intervene in a suicidal crisis or help those who deliberately self-harm themselves. Furthermore, this can assist with understanding suicide as well as the content and efficiency of the intervention (Hjelmeland et al., 2008). While a number of studies have been conducted globally

investigating views on suicidal behaviour (e.g. Beautrais, Horwood & Fergusson, 2004) as well as in other African countries (e.g. Hjelmeland et al., 2008; Knizek, Akotia & Hjelmeland, 2011), limited research has been conducted in the South African context investigating this. This highlights a pressing need to fill this gap in the literature.

Investigating young adult's views on suicidal behaviour and understanding this discourse is necessary in order to assist with the implementation of preventative measures. Prevention of suicide is particularly important as it has remained a neglected area in mental health despite the issue of health education and disease prevention having received considerable attention in recent years. There is a growing need to educate professional health-care workers and the general public on preventing suicide as the price of neglecting such a need is too high to pay (Schlebusch, 2005).

Currently, research in the South African context focusing on young adult's views on suicidal behaviour is lacking, despite suicide rates being high in this population group. By embarking on qualitative research with young adults, the proposed study contributes to addressing this gap in the literature.

1.5 Outline of the research report

Following the brief introduction of research on suicidal behaviour presented above, Chapter 2 expands on the suicidology literature. Chapter 2 provides an overview of the risk factors of suicidal behaviour in South Africa as well as the current literature on views towards suicidal behaviour. The literature review is followed by a detailed description of the research design, procedure, participant characteristics, analysis method and ethical considerations presented in Chapter 3. The study's findings are then presented in Chapter 4 which describes the main themes identified from the views expressed by the participants. Chapter 5 discusses the results of the findings, the limitations of the present study and the implications of the findings. In the final chapter, Chapter 6, conclusions of the study and its findings are drawn.

CHAPTER TWO

2.1 Literature Review

The present chapter begins by providing a detailed overview of the current literature on risk factors of suicidal behaviour in South Africa. This theoretical and empirical perspective on suicidal behaviour serves as a backdrop to understanding suicide in the South African context. This section will then be followed by an overview of the current international literature focusing on views towards suicidal behaviour. Religion, culture and gender will be the focus of this section. This will also serve as a backdrop to understanding the specific views that the participants of the present study hold about suicidal behaviour.

2.2 Risk factors associated with suicidal behaviour: A South African perspective

When it comes to researching suicidal behaviour, understanding the aetiology behind suicide is necessary in order to fully conceptualise the field of study. Despite researchers' knowledge of certain risk factors associated with young adults suicidal behaviour, little attempt has been made to integrate findings and to advance the theoretical understanding of its aetiology (Ayyash-Abdo, 2002). This means that a great deal of research has focused on individualistic or isolated factors of suicide, failing to adopt a holistic view when understanding its aetiology. Suicidal behaviour is not simple but instead it is a complex phenomenon with multifactorial and multidimensional risk factors and causes (Schlebusch, 2005). A number of factors can play a significant role in the development of suicidal behaviour. However, the best way to understand their influence is to examine their interactional dynamics. Therefore, the next sections will consider the risk factors of suicidal behaviour using Bronfenbrenner's ecological systems theory. Firstly, an individual's personal characteristics will be considered followed by risk factors at the micro-, exo- and macro-systems.

2.2.1 Individual characteristics

Firstly, at the individual level, there are a number of risk factors associated with suicidal behaviour which shape an individual's response to the micro- and exo-systems. These include: 1) demographic characteristics including gender and race, 2) medical characteristics including the presence of a mental disorder, and the presence of a medical

illness such as HIV/AIDS 3) psychological characteristics such as hopelessness, impulsivity, poor problem solving skills, and coping style.

1) Demographic Characteristics

Beginning with gender, research in South Africa has been found to be in line with international research as the suicide rate has been found to be significantly higher amongst men than women (Burrows & Laflamme, 2006). Recent rates of 24.5 per 100 000 for males and 6.9 per 100 000 for females have been reported in South Africa (Matzopoulos, Norman & Bradshaw, 2004). On the other hand, both internationally and in South Africa, women have been shown to attempt suicide more often than men. Burrows, Vaez and Laflamme (2007) support this by arguing that females tend to use less violent methods compared with males. Furthermore, they reported that there is an excess of violent suicide in males and this is because males are more aggressive, have greater knowledge regarding violent methods and are less concerned with bodily disfigurement. Therefore this explains why males are more likely to commit suicide whereas females are more likely to attempt suicide.

When it comes to race, research in South Africa has often been conflicting. For example, some research has identified the highest suicide rates among Whites followed by Asians and then Africans (Burrows & Laflamme, 2006; Burrows, et al., 2007) Contradicting this however, a study conducted by Stark, Joubert, Struwig, Pretorius, Van der Merwe, Botha, Kotze and Krynauw (2010) investigated 469 suicide cases in Bloemfontein between 2003 and 2007. They found that 72.1% of the victims were African, 26% were White, 1.1% were Coloured and 0.6% were Indian. Furthermore, for attempted suicide, the SASH study found that the highest prevalence rates were amongst Coloureds followed by Africans and Whites together and then by Indians (Joe et al., 2008). However, the research is not as simple and clear cut as there is a great deal of evidence to suggest that gender and race are interrelated. For example Burrows and Laflamme (2006) found that the size of the differences between male and female rates varied by race group both within and around cities. They found that for Coloureds in Tshwane there were no significant differences in suicide rates for males and females but that the rate of female suicides in Cape Town exceeds that of males. Similarly, Burrows et al., (2007) found that specifically White males were more likely to commit suicide. These studies illustrate that gender, race and perhaps geographical location are often interrelated as risk factors for suicidal behaviour and therefore must be considered as such.

2) Medical Characteristics

In terms of medical characteristics, the association of suicide and mental disorders has been widely investigated locally. Research has illustrated that about 61% of South Africans who consider killing themselves and 70% who actually made a suicide attempt were found to have a prior mental disorder (Khasakhala, Sorsdahl, Harder, Williams, Stein & Ndetei, 2011). Furthermore, the SASH study found that the lifetime prevalence of any disorder was 30.3% with 11.2% of respondents having two and 3.5% having three or more disorders (Stein, Seedat, Herman, Moomal, Heeringa, Kessler, & Williams, 2008). Research in South Africa has identified the most common co-morbid risk factors as substance abuse and mood disorder, especially major depression (Schlebusch, Vawda & Bosch, 2003). For example recent NIMSS figures show that alcohol was a factor in about one-third of all suicides (Donson, 2009). Research regarding the effect of mood disorders and depression in particular on suicidal behaviour has been extensively documented. For example, in a study conducted by Shilubane, Ruiter, Bos, van den Borne, James and Reddy (2012), investigating suicide amongst Black South African young adults, they found that their participants experienced a number of negative emotions and feelings of depression. This was especially true on the day they attempted suicide as they experienced a depressed mood, loneliness and hopelessness ultimately leading them to engage in suicidal behaviour.

Research has also identified the presence of a physical illness as a risk factor for suicidal behaviour. In the South African context research has extensively focused on HIV and AIDS as a risk factor for suicidal behaviour. Approximately 5.7 million people are living with HIV and AIDS in South Africa; the largest epidemic worldwide (Schlebusch & Vawda, 2010). This means that the impact of HIV and AIDS on households and individuals is profound. Schlebusch and Noor Mahomed (2004, as cited in Schlebusch, 2005) argued that a diagnosis of HIV can lead to suicidal behaviour because of an individual's lack of social support, an individual's inability to cope and inadequate emotional resources including anxiety and depression at the time of testing. This means that being infected with HIV and AIDS can lead to engagement in suicidal behaviour.

For example, Schlebusch and Vawda (2010) found that all their participants attributed their recent suicide attempts to their recent HIV diagnosis. A diagnosis of HIV however is also often accompanied by a host of other challenges and co-morbid stressors including depression, substance abuse, cognitive deficits and relationship problems (Schlebusch & Vawda, 2010). Rochat, Bland, Tomlinson and Stein (2013) found that out of their sample of HIV infected women almost half experienced depression and this tended to be chronic.

Furthermore, over half of the depressed women were suicidal. It is clear that a diagnosis of HIV and AIDS is not simple as a complex interrelationship exists between the illness and co-morbid mental diagnoses or life stressors.

3) Psychological Characteristics

An individual's psychological characteristics have also been found to be risk factors for suicide. Hopelessness, which refers to a system of pervasive negative expectations, has been associated with suicidality in young adults (Ayyash-Abdo, 2002; Bridge et al., 2006). Indicators of hopelessness include uncertainty about the future, the expectation of future unhappiness and low expectations about reaching one's goals. Furthermore, this system of pervasive negative expectations about the future may be tied to the individual's social environment and life experiences (Durant, Mercy, Kresnow, Simon, Potter, & Hammond, 2006). Hopelessness is related to feeling overwhelmed, helpless and a burden to others. These concepts form part of the interpersonal theory of suicide as a way of understanding why individuals are driven to engage in suicidal behaviour. The basic assumption of this theory is that people die by suicide because they can and because they want to (Van Orden, Witte, Cukrowicz, Braithwaite, Selby, & Joiner, 2010). Within the framework of this theory, three constructs have been identified as central to suicidal behaviour. Two of these constructs are related to suicidal desire-thwarted belongingness and perceived burdensomeness, and one construct is related to the acquired capability for suicide.

Thwarted belongingness refers to a need to be socially connected to others in ways that are observable, forming a fundamental human psychological need which when unmet results in a desire for death (Van Orden et al., 2010). Perceived burdensomeness however, is likely to develop when individuals experience factors such as family conflict, unemployment and physical illness therefore seeing themselves as a burden on others. Lastly, according to the theory, it is possible to acquire the capability for suicide when physical pain tolerance is increased and when fear of death is reduced (Van Orden et al., 2010). The relation between these constructs can be explained by four hypotheses. These hypotheses present a causal pathway for the development of the desire for suicide and the capability to engage in serious suicidal behaviour. These hypotheses are: 1) thwarted belongingness and perceived burdensomeness are proximal and sufficient causes of passive suicidal ideation, 2) the simultaneous presence of thwarted belongingness and perceived burdensomeness when perceived as stable and unchanging is a proximal and sufficient cause of active suicidal desire, 3) the simultaneous presence of suicidal desire and lowered fear of death serves as the

condition under which suicidal desire will transform into suicidal intent, 4) the outcome of serious suicidal behaviour is most likely to occur in the context of thwarted belongingness, perceived burdensomeness (and hopelessness regarding both), reduced fear of suicide and elevated physical pain tolerance (Van Orden et al., 2010).

Another psychological characteristic which research has established as a risk factor for suicidal behaviour is impulsivity. A study conducted by McGirr, Renaud, Bureau, Seguin, Lesage, & Turecki (2008) for example, found that higher levels of impulsive-aggressive traits were associated with suicidal behaviour and this was particularly the case amongst young adults. In the South African context impulsivity and aggression are often linked to both suicide and violence and the link between the two has been well researched and will be discussed below. However, it is important to note that research has shown that increased impulsiveness, emotional lability, disinhibition, decision-making and reasoning problems could result in increased aggressiveness and ultimately to increased suicidal behaviour (Schlebusch, 2005).

Research has also identified poor problem solving skills as a risk factor for suicidal behaviour. According to Schlebusch (2005), suicidal individuals exhibit poor problem solving. In the South African context suicidal behaviour has been viewed as a method of communication when individuals feel unable to express their distress in a conventional manner. Therefore, suicidal behaviour is used as an inappropriate problem-solving strategy (Schlebusch, 2005). Associated with poor problem solving, is an ineffective coping style. Coping can be considered a combination of individual and environmental factors but at the most general level coping includes all responses to stressful events (Meehan, Peirson & Fridjhon, 2007). Meehan et al., (2007) found that when young South African adults had a functional coping strategy they had a positive outlook on life and no suicidal ideation. On the other hand, they found that a dysfunctional coping strategy was linked with a negative outlook on life and negative suicidal ideation. George and van den Berg (2012) also found that avoidant coping strategies contributed to high levels of suicidal ideation amongst South African young adults. Moreover, adaptive coping including acceptance seeking social support for instrumental reasons was found to reduce levels of suicidal ideation.

The characteristics of an individual which may predispose an individual to engaging in suicidal behaviour have been presented above. However, these factors cannot be considered sole causes for suicidal behaviour as an individual's immediate environment is important as well. This will be explored in the next section.

2.2.2 The micro-system

The micro-system consists of an individual's immediate environment including their family, their peers and their environment of education. Within this environment traumatic events and stressors that an individual is exposed to can also influence their likelihood to engage in suicidal behaviour. It is also important to remember that individual characteristics are interrelated with an individual's immediate environment and can influence the way they respond to trauma and stressors ultimately affecting whether they engage in suicidal behaviour or not.

At the family level, conflict in the family has been found to be an important correlate for suicidal behaviour in young adults (Schlebusch, 2005). For example, a study conducted by Madu and Matla (2003) found that family cohesion in particular was linked to suicidal behaviour amongst South African young adults. They argued that this is because such families discourage independence so they facilitate disengagement between members. Furthermore, young adults from such families are subject to a high degree of parental restriction and are frequently prohibited from engaging in social activities without adult supervision (Madu & Matla, 2003). The authors also found that a lack of organisation in a family may lead to increased family stress, rigidity, chaos and dysfunctionality leading to increased levels of suicidal behaviour. Schlebusch (2005) has further stated that rigid problem-solving behaviour, over-controlling parenting styles and a lack of tolerance for role changes are characteristic of the family functioning of suicidal young adults.

Pillay and Wassenaar (1997) have also identified family conflict as a risk factor for suicidal behaviour amongst young adults in South Africa but have argued that when family conflict is an ongoing stressor, suicidal behaviour occurs after a build up in such a conflict ridden environment, indicating the young adult's inability to continue living in it. In these instances family conflict may be influenced by the process of globalisation. According to Jensen (2011), globalisation involves a multidirectional flow of people, goods and ideas which means that young adults are exposed not only to their local culture but also to the beliefs and practices of other people from other cultures as is the case in South Africa. What this means though is that there is a widening gap opening up between young adults and their parents in terms of views of parental authority and youth autonomy. Often in traditional cultures where young adults spend the majority of their time with parents and are integrated into adult groups, young adults tend to share common views with their parents (Jensen, 2011). However, when young adults are exposed to more modern cultures they begin

developing different views from their parents resulting in family conflict as they attempt to establish more autonomy.

Relationships outside the family such as peer relationships can also influence suicidal behaviour. Peer relationships can either be seen as a risk factor or a protective factor given that positive peer relationships provide greater opportunities for social interaction as well as experiences of greater personal satisfaction. On the other hand poor peer connectedness can predispose a young adult to an environment of social isolation as well as the development of emotional and social problems (George & van den Berg, 2012). As young adulthood is a period characterised by crucial needs for close friendships, emotional fulfilment and emotional independence, during this time young adults may turn to their peers for emotional support often sharing secrets, plans and feelings (Ayyash-Abdo, 2002). Therefore loneliness can become a big problem during this developmental stage often leading to suicidal behaviour. For example, research in South Africa has shown that individuals who engage in suicidal behaviour felt they did not have friends they trusted enough. Even though at times they shared problems with them due to limited communication with their family, they still felt as though they could not trust their friends (Shilubane et al., 2012).

Educational environments such as universities have also been linked to suicidal behaviour. Young adults often face a period of transition between high school and university and often this transition can be extremely challenging causing a great deal of stress. For example, many students in South Africa experience difficulty in managing the academic workload at university particularly since often the university curricula and demands are new and more challenging than their previous high schooling careers (Pillay & Ngcobo, 2010). Furthermore, research has shown that financial problems and accommodation difficulties are significant issues for university students in South Africa often increasing their stress levels which affect their levels of functioning as well as their academic performance (Pillay & Ngcobo, 2010). This can often then lead to mental health problems including suicide.

One key point made above, was the presence of stress as a risk factor for suicidal behaviour. Research has shown that in the South African context, young adults face a great deal of stress. For example, Schlebusch, et al., (2003) have emphasised the role acculturation, socio-economic pressures, high crime and violence rates and a history of human rights violations can have on individuals all of which create high stress levels that can act as suicidal triggers. Furthermore, particularly in young adults, stress can be precipitated by conflict in young adult's lives who come from more traditional backgrounds in a

multicultural South African society but who also have to cope with new roles and a more international culture ultimately leading to suicidal behaviour (Schlebusch, 2005).

While it seems as though stress is a key risk factor for suicidal behaviour, research has also shown that an association exists between traumatic events and suicidal behaviour. Trauma is deeply rooted in South Africa's society with South Africa often considered as one of the most violent countries in the world (Kaminer, Grimsrud, Myer, Stein & Williams, 2008). Therefore, given the high rates of violence in the country, experiencing traumatic events are found to be fairly common amongst the South African population. Data from the SASH study has revealed that approximately 75% of South Africans experience some traumatic event during their life time and perhaps more disconcertingly, that most South Africans have experienced more than one traumatic event in their lifetime (Williams, Williams, Stein, Seedat, Jackson, Moomal, 2007). Furthermore, a link has been established between traumatic events and psychological distress including for example suicide. Sorsdahl, Stein, Williams and Nock (2011) reported that traumatic events were common among South Africans with lifetime suicidal ideation and attempts. Furthermore the authors found the most commonly reported trauma to be the death of a loved one followed by witnessing violence and interpersonal violence.

Other research in South Africa has also established the link between traumatic events and suicide albeit through a different causal pathway. In a review by Edwards (2005), he discussed the epidemiological evidence showing that traumatising events are associated with post-traumatic stress disorder (PTSD) in the South African context. He concluded that the research conducted so far illustrates that a large number of South African adults and children develop PTSD as a result of exposure to traumatic events and stress. Therefore, research has found that PTSD is the strongest predictor of suicidal ideation and attempts in South Africa especially after controlling for comorbid mental disorders (Khasakhala, et al., 2011). In particular the most common form of trauma to be associated with PTSD is violence and this includes political violence, intimate partner violence and sexual abuse (Kaminer et al., 2008). South Africa has been found to have the highest murder and armed robbery rates globally estimating the murder rate to be 41 per 100 000 which approximates into fifty murders a day. This means that every day there are hundreds of South Africans who are traumatised by the death of a loved one (Kaminer & Eagle, 2010). Therefore the continuous exposure to criminal violence either directly or indirectly has a big impact on mental health.

This is evident by the results of the SASH study which revealed that women who had been raped had the strongest association with PTSD. Furthermore, at a population level,

criminal assault and childhood abuse were associated with the greatest number of PTSD cases among men, while intimate partner violence was associated with the greatest number of PTSD cases amongst women (Kaminer et al., 2008). Childhood sexual and physical abuse has also been found to be associated with PTSD. For example, a study assessing a group of teenagers and children found that 53% reported sexual abuse and 63.8% of these abused children presented with PTSD (Carey, Walker, Rossouw, Seedat, & Stein, 2008). Clearly exposure to a traumatic event is a risk factor for suicidal behaviour and in South Africa where there are high levels of violence this is especially the case.

The ways in which an individual's immediate environment could influence suicidal behaviour have been presented above. The interrelation between individual characteristics and the micro-system is now clear. However, these two systems are found in a bigger system which influences both of them. The influence of the exo-system will be explored in the next section.

2.2.3 The exo-system

The exo-system consists of the media, social factors and religion. These are factors that are found in an individual's broader environment; one which they may not always be in direct contact with.

At the exo-systemic level research has focused on the mass media as a risk factor for suicidal behaviour. An immense quantity of information on the topic of suicide is available on the Internet and via social media including chat rooms, blogging, video sites and social networking sites. This means that there is a large amount of information available to anyone who looks for it. This includes information on lethal means to commit suicide, sharing of ideas as well as the formation and influence of online groups who promote and provide support for behaviour normally unacceptable by the social mainstream (Luxton, June, & Fairall, 2012). As a country in transformation and with greater exposure to technology, South Africa's internet and cell phone use is continuing to blossom particularly amongst its youth. This means that the role of the mass media is more prominent than ever now and while previously this may have not been considered a risk factor for suicidal behaviour, the ever increasing presence of the media means that it needs to be considered one now.

Research has established that there are several specific ways that social media can increase the risk for suicidal behaviour. For example, one concern is the way suicidal transmission can occur through media contagion. This has been termed the Werther effect, a term used when referring to the phenomenon whereby there is an increased rate of completed

or attempted suicide following the depiction of an individual's suicide in the media (Pirkis, 2009). Modern communication methods are increasing young adult's exposure to suicidal behaviour and the amount of information they learn through mass media publicity. This means that suicidal transmission is now taking place in this manner increasing its effect on vulnerable individuals. Furthermore, there are websites that graphically describe suicide methods and media development is continuously expanding opportunities to influence young adults, therefore enhancing the contagious effects of suicidal behaviour (Schlebusch, 2012).

Another concern relates to social media platforms such as chat rooms and discussion forums which may also pose a risk for vulnerable groups by influencing their decision to die by suicide. In particular, interactions via chat rooms or discussion forums may foster peer pressure to die by suicide encourage users to idolise those who have completed suicide or even facilitate suicide pacts (Luxton et al., 2012). Furthermore, individuals may also use social media to leave suicide notes and share with the public instantaneous message which may influence the decision of other vulnerable people who encounter them. Overall, the interactions through social media can reduce doubts or fears of those who are ambivalent about suicide increasing the risk of them engaging in suicidal behaviour (Luxton et al., 2012).

A third way that social media can increase the risk for suicidal behaviour is through cyber bullying. Cyber bullying includes acts involving bullying and harassment through the use of electronic devices or technology (Badenhorst, 2011). Especially in South Africa as internet and cellular telephone use continues to grow especially amongst the youth, cyber bullying is becoming a severe problem. For example, the Centre for Justice and Crime Prevention study in South Africa found that almost half of the participants reported experiencing some form of cyber bullying (Burton & Mutongwizo, 2009). The biggest issue with cyber bullying is the psychological impact that it can have on the victim. Often this is more traumatising than physical bullying because of the extreme public nature of the bullying. Since technology and social mediums are so easily accessible to individuals, cyber bullying can happen 24 hours a day meaning that there is no escape for the individual. The psychological impact of cyber bullying is therefore present at all times and often results in anxiety, depression and suicide (Badenhorst, 2011).

While the mass media has been found to be a risk factor for suicidal behaviour, recently movements have been made to introduce rules and legislations in order to prevent suicide. Schlebusch (2005) argues that prevention can be achieved if the media and press play a proactive role by not sensationalising coverage on suicidal behaviour, but by providing information about available help to the population. Numerous government and

nongovernment organisations in many countries have developed guidelines for media professionals in an effort to promote more sensitive coverage of suicide. These recommendations primarily encourage journalists to reduce the prominence, detail and sensationalism of suicide reports and to educate the public about suicide and treatment options (Bohanna & Wang, 2012). Social networking sites for suicide prevention can also facilitate social connections among peers with similar experiences and increase awareness of prevention programmes, crisis help lines and additional support and resources (Luxton et al., 2012). Therefore, the mass media can be considered both a risk and a protective factor.

At the exo-systemic level, research has also focused on the social risk factors of suicidal behaviour. In particular, Durkheim's explanation of social risk factors is the most well known. Durkheim contended that suicide rates depended on two social conditions these being social integration and social regulation. Integration refers to the manner in which an individual becomes a part of their society and culture. Well integrated groups enjoy stable, durable and cohesive social ties. They are supported in their lives particularly during times of personal crisis thereby reducing their vulnerability to suicide (Wray, Colen & Pescosolido, 2011). On the other hand social regulation refers to how the person acknowledges and abides by society's rules. For Durkheim, these individuals require moral guidance and external restraint because without them their desires and expectations will exceed their grasp with the resulting failures and frustrations leading to continuous states of despair (Wray et al., 2011). Durkheim argued that these two dimensions influence behaviour and when they are either too strong or too weak they may account for suicidal behaviour. Only when these forces are balanced does the suicide rate diminish (Wray et al., 2011).

Durkheim however, formed his four typology of suicide and argued that suicide arises in social structures characterised by extremes (Wray et al., 2011). When there are high levels of integration, altruistic suicide occurs. Here, the person is seen as of little or no consequence; rather the goal of the group is more important. Just like suicide bombers or soldiers, the integration of the person with the groups becomes so strong that the cause becomes the focus not the individual (Holmes & Holmes, 2005). On the other hand when there is low integration, egoistic suicide occurs. When people are unmarried or alone a great deal of the time, interaction is limited and their dedication is to themselves rather than to those in a group (Johnson, 1956). High rates of suicide are evident here because life has no meaning for these individuals. According to Durkheim when there is low regulation anomic suicide occurs. Businessmen for example fall into this category because they often experience rapid decreases in stations, statuses, finances or even increases in power and glory. Often the

pressures are too great and suicide is their only method of escape (Holmes & Holmes, 2005). Lastly, when there is a high degree of regulation fatalistic suicide occurs. Slaves for example fall in this group as they face an incredibly oppressive discipline and regime leading them to commit suicide (Johnson, 1956).

Durkheim's work on social risk factors has also been used to examine the relationship between religion and suicide. Durkheim based a great deal of his research on religious integration and argued that lower suicide rates were found in individuals who practiced Catholicism due to higher levels of integration and regulation. On the other hand he found that in Protestantism there were fewer shared beliefs and practices as well as little allowance for free inquiry therefore leading to higher suicide rates in this group (Colucci & Martin, 2008). He thus argued that people who were integrated in a religious group, where less likely to engage in suicidal behaviour.

While Durkheim's theory in this respect has come under scrutiny and criticism in recent years, the link between religious integration and suicide still holds some merit. For example, in a study conducted by Ryle (2007), exploring data from the South African Social Attitudes Survey of 2004, a significant correlation was found between religiosity (including religious denomination, frequency of attending religious meetings and doctrinal orthodoxy) and satisfaction with life (modern conveniences, life satisfaction and level of satisfaction with government institutions). The protective role of religion has also been documented by the association between religion and mental and physical health outcomes. For many people it is also an important coping resource in times of stress. This is because engagement in religious activities may counteract the deleterious effects of stress. A study conducted by Copeland-Linder (2006) examining the protective function of religiosity among Black women in a South African township, found that engagement in formal religion buffered the aggregate effects of cumulative stress. The stressors the women faced ranged from crime to family difficulties, financial stress, work stress, intimate stress, and health problems. However, practicing religion allowed them to cope with these stressors.

While it is clear that religion can be seen as a protective factor for suicidal behaviour, it can also be documented as a risk factor. There are a number of situations when this can occur, for example if an individual feels that they need to live up to the standards of their faith. Furthermore, religion can also put individuals at risk for suicidal behaviour if devotion to a religion prompts disapproval or rejection from others who hold different beliefs (Colucci & Martin, 2008). In addition, when religion is not accepting of certain individuals, ways of life or beliefs this can lead to poor psychosocial adjustment. For example, many religions are

outspoken about their intolerance of homosexuality. Individuals who are homosexual face additional challenges from their heterosexual peers as their identities are multifaceted and complex. Furthermore, these young adults face a host of other psychosocial problems including difficulty getting along with their family, being misunderstood by others and harassment from peers. This can then lead to depression, feelings of low self-esteem and low self confidence (Page, Lindahl & Malik, 2013). On top of these stressors conflict may exist between religion and sexual orientation in these young adults. For example, Ream and Savin-Willian (2005) asked a sample of lesbian, gay and bisexual young adults with a Christian background how they reconciled their religious beliefs and sexual orientation. The results indicated that young adults who felt compelled to leave Christianity in order to deal with the conflict reported higher depression and low self-esteem. Therefore religion can be detrimental when it becomes a source of conflict for young adults.

The influence of an individual's exo-system on suicidal behaviour has been presented above further exploring the complexity of risk factors on suicidal behaviour. This last section will now consider the influence of the macro-system on an individual and on all the other systems which may increase an individual's likelihood to engage in suicidal behaviour.

2.2.4 The macro-system

At the macro-systemic level, the economic, social, educational, legal and political systems which provide the overarching patterns of ideology and organisation of a society can be a risk factor for suicidal behaviour.

Many developing countries across the globe are struggling with a number of challenges including poverty, low literacy levels and communicable diseases (Khan, 2005). Therefore mental health is often a low priority in these situations. Perhaps more importantly, many of these countries do not have established political processes that underpin progress in the social and health sectors and only a small fraction of the national budget is received by these sectors. Furthermore, any money that is available is further reduced by massive corruption, poor governance and gross mismanagement (Khan, 2005). In developing countries public funded healthcare facilities are often not very well established lacking resources, poorly staffed and poorly run. In this instance, South Africa is no exception. The end of apartheid in 1994 brought with it the election of a new democratic government who inherited a highly fragmented, inequitable health system. The aim of the government was not only to create an equitable health system at improve access to care for all South Africans, but also to improve principles of service delivery throughout the health system (Deumert, 2010).

Despite the optimistic feeling that the end of apartheid brought for the health system and the progress that has been made in the health care system since then, little has changed in health system expenditure patterns meaning that uneven expenditure across sectors relative to the population served remains a central problem in the South African health system (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). A systematic review conducted by Petersen and Lund (2011) found that due to the constraints of the current health system, common mental disorders remain largely undetected and untreated in primary healthcare in South Africa. This means that the current policies which govern South Africa's health and social systems can lead to an increased likelihood that an individual at a high risk for suicide or with any other mental disorder which is linked with suicide may go undetected. With that, they may never receive the appropriate treatment or intervention and this could increase their risk of engaging in suicidal behaviour.

Other challenges at a macroeconomic level include difficulties with the implementation of social policies. Despite the political freedoms and Human Rights advances brought about by the democratically elected government, there has been a growing trend of increased economic inequality, poverty and unemployment which has marked the social, economic and political landscape in South Africa (Lund, Kleintjies, Kakuma, & Flisher, 2010). One of the achievements of the post-1994 government has been the improvement in access to basic services with government policy providing poor households with free water and electricity to meet the most basic needs. However, there have been huge difficulties with implementation (Coovadia et al., 2009). Preoccupations with cost recovery at a municipal level have resulted in many illegal household disconnections and many people have been unable to access their entitlement. This means that levels of poverty and social inequality are still high in South Africa and perhaps more disconcerting is the evidence that suggests that mental ill-health is strongly associated with poverty and many aspects of social deprivation associated with poverty (Lund et al., 2010). Therefore ineffective government policies can consequently increase poverty ultimately increasing suicidal behaviour.

The macro-system also includes attitudes, beliefs, values and ideologies inherent in a community and culture. Research has shown for example, that societies which are collectivistic as opposed to individualistic have lower levels of suicidal behaviour (Lee, Hong & Espelage, 2010). In a collectivistic society, the basic unit of the society consists of groups and where inter-dependency or in group harmony is emphasised. It is assumed that the emphasis on interconnectedness or responsibility to the family might serve as a protective factor for suicidal behaviour (Lee et al., 2010). In South Africa, the collective consciousness

of the society is termed Ubuntu which is the principle of caring for each other's well being and providing a spirit of mutual support (Netshiombo & Mashamba, 2012). Ubuntu is a philosophy and way of life that constitutes the roots of African belief systems and culture. Ubuntu means that people are people through other people and that individual's humanity is expressed through their relationship with others. Therefore, all of humanity has a common origin and ipso facto belongs together thereby creating a common bond and destiny for humanity. The individual is absorbed into the collective, yet remains an identity as an empirical being (Nkondo, 2007).

Perhaps more importantly, Ubuntu principles can be used to promote a strong sense of national identity. South Africans feel a certain moral responsibility for their nation's deeds and share a number of things allowing them to bind as a nation. These things include community of place (based on geographical location), community of memory (sharing a history), psychological community (face-to-face personal interactions governed by sentiments of trust, cooperation and altruism), and community of hope (people who share a common vision) (Nkondo, 2007). Building a national identity allows individuals living in a society to have a sense of belonging and particularly with young adults who face a number of developmental challenges and are trying to develop their own identity, having such a collectivistic society can be considered a protective factor against mental health problems like suicide. Unfortunately, there is growing concern that the philosophy of Ubuntu is becoming weaker and weaker in South Africa. This is due to the transition that traditional culture is currently undergoing in South Africa due to the influence of westernisation. As this transition is fostered by the influence of western values and systems particularly amongst the youth, the basic tenet of Ubuntu which ore society once thrived on is being eroded (Netshiombo & Mashamba, 2012). This means that as South Africa moves to a more individualistic society, this could increase individual's risk to engage in suicidal behaviour.

Furthermore from a cultural point of view, certain norms and beliefs in South Africa's society can also put individuals at risk for engaging in suicidal behaviour. For example, in South Africa's society, men are generally considered the chief breadwinners in the family. Even in situations where women work, men still earn higher salaries and therefore are considered the main financial contributors for the family (Netshiombo & Mashamba, 2012). This can put extreme pressure on males to maintain their status as the breadwinner and in situations where males fail to live up to these expectations, this can lead to feeling of inferiority and inadequacy. This may then be viewed by men as the stripping of their

masculine role in the family and consequently can result in depression, low self-esteem and ultimately suicide (Netshiombo & Mashamba, 2012).

With cultural norms and beliefs, also come social roles and values that individuals are often expected to fulfil. However, in the South African context, young adults often face conflicting social roles and values in the context of contemporary acculturation pressures. This was found in a study conducted by Beekrum, Valjee and Collings (2011) who found that Indian women who had attempted suicide alluded to conflicts between value systems taught by their parents and the value systems of their peers. The respondents appeared ambivalent regarding these two sets of attitudes: one traditional and one more consistent with contemporary western culture. The authors reported that this ambivalence is indicative of a community in a social or cultural transition as the Indian community in South Africa appears to currently be (Beekrum et al., 2011). Another study conducted in South Africa investigating suicidal behaviour amongst Indian women, also found that role of socio-cultural transition was important (Wassenaar, van der Veen & Pillay, 1998). Traditionally Indian families were and in some cases still are patriarchal and women tend to occupy submissive positions and have domestic and familial responsibilities in extended family structures. Given the changing roles of women in South Africa with more women gaining a tertiary education and placing a large emphasis on having a career, conflict may arise between the role that Indian women want to occupy and the role that they are expected to occupy. This may in turn have adverse effects on emotional functioning, marital functioning and quality of life therefore leading to suicidal behaviour.

The complex nature of suicide is clear from the exploration of risk factors above in the South African context. Figure 2 below provides an overview of all the risk factors discussed above presented in Bronfenbrenner's ecological systems model. The interrelation between the systems provides us with a concise conceptualisation of suicidal behaviour specific to the South African context. Having now laid down a framework in order to understand suicide amongst young adults, the next section will focus on the current literature of views towards suicidal behaviour that young adults hold.

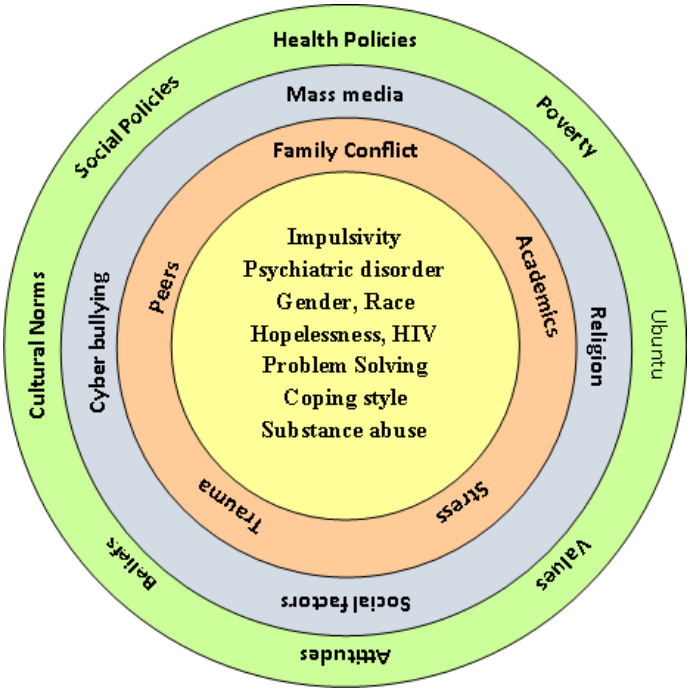


Figure 2. Risk factors influencing suicidal behaviour, presented in Bronfenbrenner's ecological systems model.

2.3 Views towards suicidal behaviour

The importance of investigating views towards suicidal behaviour has been extensively highlighted above. This appears to be the case given that the way we think about suicide will influence the way we react and respond to individuals who do engage in suicidal behaviour. Research has pinpointed a number of important factors that can influence an individual's views on the causes and motives of suicidal behaviour. This includes gender, religion and culture; factors which are central to this study and will be explored below. These factors will be discussed in terms of international literature but with a specific focus on the African context.

2.3.1 Gender

Research exploring the role of gender on suicidal behaviour has primarily illustrated that there are certain associations of masculinity and femininity associated with suicidal behaviour. This has been showed to be irrespective of gender. From a social constructionist lens, men and women's identities behaviour and the expectations placed on them reflect socially constructed ideas about femininity and masculinity (Payne, Swami & Stanistreet, 2008). This will be investigated below in more detail particularly focusing on how this can affect views on suicidal behaviour.

Firstly, research has shown that gendered interpretations of suicidal behaviour may exist. For example, a study conducted by Scourfield, Jacob, Smalley, Prior and Greenland (2007) found that young adults associated successful suicides with masculinity focusing on strength, honour, impulse and decisiveness. On the other hand failed suicide attempts where associated with femininity focusing on love, manipulation, revenge and a cry for help. These results were found to be irrespective of the participants' gender. The authors explained their results by arguing that different kinds of self destructive behaviour have different cultural associations with masculinity and femininity. Certain kinds of behaviour are expected in men and other different kinds are expected in women (Scourfield et al., 2007). Scourfield's et al. (2007) study supports the gendered 'cultural script' theory proposed by Canetto (2008). This theory argues that suicidal behaviour is socially scripted and socially regulated in all cultures of the world. In other words, in every community and nation there are collective, implicit beliefs about the meaning and permissibility of suicidal behaviour. These beliefs, called cultural scripts, influence individual suicidal behaviour including when suicidal behaviour becomes a possibility as well as the form it takes (Canetto, 2008). Furthermore, these cultural scripts determine an individual's course of action, their interpretations and responses to suicidal behaviour.

Research has shown that these ideas of masculinity and femininity are not only considered interpretations of suicidal behaviour, but often are also considered the motivating factors. For example, Knizek, Kinyanda, Owens & Hjelmeland (2011) conducted a study in Uganda examining men's perceptions of what causes suicide as well as their views towards suicidal behaviour. The results illustrated that the majority of men believed that suicide was a response to illness or disease and problems with relationships followed by perceived pressure to live up to certain expectations, a lack of control and economic hardship. Another study conducted by Adinkrah (2012) also found that men in Uganda resort to suicidal acts to deal with extreme shame stemming from such myriad factors as sexual impotence and imminent criminal prosecution. In addition, when males felt they had failed to meet their culturally prescribed male roles they resorted to suicide (Adinkrah, 2012). This was because of the constant exhortation that males must be strong, resilient and independent, forbidden to show any vulnerability and emotional weakness. Furthermore, due to this stereotype males are not granted any emotional expressiveness in Ghana that allows them to seek assistance with personal challenges and emotional support (Adinkrah, 2012).

Adinkrah (2012) explained these results by arguing that cultural constructions of masculinity exist in Ghana which includes a belief in fundamental distinctions between male

and female behaviour. For example, maleness is associated with greater mental and physical strength therefore prohibiting the expression of anxiety, pain or sadness as these are attributed as weaknesses. Furthermore, it is considered 'unmanly' for men to express or admit feelings of emotional dependency. Because of the economic and social contexts of these African countries, men often face problems in finding adequate jobs and maintaining their position as the breadwinner of the family frequently resulting in the idea that they are constantly being judged and evaluated for their actions as men. Therefore, they are often under stress to fulfil internal and external expectations which are often extremely difficult to meet because masculinity is linked with dignity and self-control. This then leads to suicidal behaviour (Knizek et al., 2011).

Literature has identified the multiple expressions of masculinities across and within societies, in many cases hierarchically organised in relation to each other as well as in relation to femininities (Adinkrah, 2012). Hegemonic masculinity is a concept that denotes the ideal-typical form of masculinity embodied by the socially most powerful males of a society. Men tend to aspire or compare themselves against this ideal (Connell & Messerschmidt, 2005). The pursuit of this ideal includes what Connell & Messerchmidt (2005) refer to as "toxic practices" including acts of aggression, violence and competitiveness. Therefore, men's relational positions to hegemonic masculinity, the tensions these create and the overtly self-destructive practices that at times result, can lead to suicidal behaviour among men. In a literature review conducted by Payne et al. (2008), they also attribute masculinity and male gender-roles to stress robustness and strength. Masculinity is commonly associated with a desire for power and dominance and men are expected to display courage, independence, rationality and competitiveness while concealing vulnerability and weakness. Masculinity also traditionally places men as the breadwinners in the family therefore prioritising independence and resistance which are central to hegemonic masculinity. This restricts help-seeking behaviour as this implies a loss of status and autonomy (Payne et al., 2008). Payne et al. (2008) also argue that generally men experience greater social pressure to endorse gendered stereotypes. This not only puts them at an increased risk to engage in suicidal behaviour, but it also influences their views about gender and male gender roles particularly linked to suicidal behaviour.

While literature on hegemonic masculinity can be found in abundance, less has been written about hegemonic femininity or 'emphasised femininity'. This concept focuses on compliance to patriarchy which is still largely prevalent in many cultures (Connell & Messerschmidt, 2005). Payne et al. (2008) further argue that the traditional female role

typically includes characteristics such as fragility, emotionality and expressiveness as well as family orientation. Furthermore, it is far more acceptable for women to seek help than it is for men. Research has also shown that for women social constructions of femininity include family roles and a caring orientation and this may offer women benefits why they fulfil such stereotypes. Lastly, a review by Canetto (2008) on suicidal behaviour in women cross-culturally emphasised that a wide heterogeneity exists in women's patterns and meanings of suicidal behaviour across cultures. This can also influence the beliefs about the causes of women's suicidal behaviour which has been shown to differ across cultures. For example, in the USA women's suicidal behaviour is interpreted as a symptom of individual psychopathology whereas in China suicidal behaviour is considered a normal response to serious family conflict.

Lastly, differences between socially constructed masculinities and femininities have also been shown to impact the methods males and females use when engaging in suicidal behaviour. Research in South Africa has shown that the predominant methods of suicide chosen amongst males are considered more violent and include hanging and firearms. For females however, their choice appears to often be methods of ingestion such as poison followed by hangings (Burrows, et al., 2007; Donson, 2009). This could explain why more men complete their suicidal acts whereas more women survive their suicide attempts. A gendered view of such differences highlights the fact that suicide methods are intricately connected with demonstration of hegemonic gender roles. If men are expected to be tough and strong then surviving a suicidal act will be considered inappropriate and this will influence their choice of a more violent method. This means that according to Canetto's (2008) theory lethal suicidal behaviour among men may be seen as an act of masculine expression. Callanan and Davis (2012) also argue that there are three reasons for these gender differences. Firstly, the most common perception is that women are more likely to use less lethal methods because they do not really want to kill themselves. This related to the message that is intended and therefore it could be insinuated that women who attempt suicide are 'crying for help' instead of being motivated to die. Secondly, gender socialisation decreases the likelihood that women will own, have access to or be as familiar with firearms compared to men and therefore will turn to other methods such as poisoning. Lastly, women tend to use less violent methods because they are concerned about the physical disfigurement of their body and this has been argued to be the result of society's emphasis on female physical appearance (Callanan & Davis, 2012).

Thus, it is clear that gendered stereotypes relating to masculinity and femininity are held by individuals in certain societies and cultures. What is perhaps more important however, is the effect this can have on people's views about suicide. Generally when a man exhibits feminine characteristics for example being physically weak, he becomes the target of stigma and social sanction much like women do who display behaviour that is typically in line with masculinity (Schippers, 2007). Therefore, there is a large amount of pressure for men and women to live up to the expectations put forward by our society. If they do not do that, then they may experience withdrawal, feelings of inadequacy and hopelessness ultimately leading them to engage in suicidal behaviour. These social constructions also appear to influence the methods individuals may choose when engaging in suicidal behaviour therefore influencing the finality of the act.

2.3.2 Religion

So far it is clear that gendered stereotypes can influence the views individuals have about suicidal behaviour. However, views towards suicide are quite complex and are often also intertwined with religious ideology and practices. This section will explore the way religion can influence an individual's views of suicidal behaviour. Research has shown that individuals who are exposed to religious education do not accept suicidal behaviour when compared with those who are secular (Eskin, 2004). Other research also found that amongst individuals, suicide acceptability was negatively related to religious wellbeing for both suicide attempters and non-attempters (Anglin, Gabriel & Kaslow, 2005). This means that individuals who attempt suicide endorse higher levels of suicide acceptability and lower levels of religious well-being than do their counterparts who did not attempt suicide. Therefore religion appears to be a major dimension of views towards suicide.

Generally, suicide is condemned by major religions such as Christianity, Islam, Judaism and Hinduism. In Christianity, views towards suicide are extremely hostile despite many references of suicide in the Bible (Colucci & Martin, 2008). Judaism also presents firm negative attitudes towards suicide. In Judaism the duty of preserving life, including one's own is considered of paramount importance. In this instance, suicide is considered to interfere with human purpose on earth as well as superseding God's role as the judge in who is rewarded and who is punished. Therefore Judaism holds the view that taking one's life places man in that supreme role and by killing oneself, one is presuming to be powerful enough to take over a right that belongs to God alone (Witztum & Stein, 2012). Islam has a very condemnatory attitude toward suicide and is it considered a crime under Islamic law

with suicide attempts often leading to prosecution (Colucci & Martin, 2008). Furthermore, the severity of the sin is so strong that people are not allowed to offer the funeral prayer for suicide.

In contrast to some religions' condemnation of suicide, both Hinduism and Buddhism teach transmigration of souls. Their philosophies believe in reincarnation and that life and death are a great cycle that does not end until one reaches Nirvana, the state that is characterised by the cessation of desire and suffering and epitomises bliss and peace. Unless Nirvana is reached, death is considered just the beginning of another cycle of pain and suffering (Lizardi & Gearing, 2010). While suicide is not viewed as the correct and appropriate way to reach Nirvana, Buddhists do still believe the individual will be reincarnated. African traditional religion refers to a set of beliefs, customs and practices indigenous to Southern Africa. It is constructed around fluid oral traditions that manifest as a set of interacting practices, worldviews and beliefs that create multiple life worlds (Brittian, Lewin, & Norris, 2013). Furthermore, African traditional religions focus a great deal on the social, natural and supernatural world, deeply concerned with disturbances in this harmony. Lastly, it is also focused on respect for ancestors and a belief in the possibilities of witchcraft, evil forces, malignant and protective ceremonies, the importance of dreams and the possibilities of information being received via divination (Brittian et al., 2013). There are various religious understandings of suicide in Africa. For example, a person who is mentally ill is considered to have been bewitched through black magic and when such a person 'has no strength' they hang themselves or become an evil spirit not going to the kingdom of the ancestors (Schlebusch, 2005).

Despite the fact that religion is regarded as the most influential social force among African people, the influence of religion on views toward suicide has been investigated very little (Mugisha, Hjelmeland, Kinyanda, & Knizek, 2013). One study conducted by Osafo, Knizek, Akotia and Hjelmeland (2013) in Ghana found that most of the participants (who were Christian) were religiously committed and viewed religion as a prime requisite norm for survival and coping with life. This meant that they rejected suicidal behaviour because it did not conform to their religious beliefs and practices. Furthermore, the results found that the participants perceived religion as a protective factor in crisis specifically suicidal ones. What was also an interesting finding in this study was that irrespective of the fact that the participants found suicidal behaviour unacceptable, they were motivated by religion to help during a suicidal crisis (Osafo et al., 2013). The authors explained this finding by highlighting that Ghana's society is one of connectedness and of showing care to other people

when they need it irrespective of whether their actions are agreed with or not. Another study conducted in Uganda, found that the vast majority of the participants (who were Catholic or Protestant) held negative views about suicidal behaviour. In particular, the results showed that suicide was largely seen as a breach of God's doctrine and that the consequences of such a breach would be punishment from God and punishment from the Church (Mugisha, et al, 2013).

While both these studies have investigated lay views towards suicide, some research has also focused on professionals views towards mental illness particularly relating to their religion. For example, in South Africa a study conducted by Padayachee and Laher (2013) investigated the views of Hindu psychologists regarding mental illness. The results showed that despite their Western training, the Hindu psychologists seemed to advocate that religion plays a crucial role in defining and understanding the causes of mental illnesses. However, it was additionally found that a tension existed between psychologists' awareness of the influential function of religion, particularly amongst collectivistic communities such as the Hindu community and their occupational understandings and practices which were deeply rooted in Western thought. Lastly, the psychologists' argued that while the Hindu community tends to place a great deal of importance on familial and community relationships which can be supportive and protective, when negative they may cause a great deal of psychological distress in individuals (Padayachee and Laher, 2013). In a study conducted by Knizek, et al., (2011) investigating views towards suicide amongst psychology university students in Ghana, the results showed that the students expressed negative and condemning views towards suicide. This was because the students seemed to respond from a more religious perspective rather than a professional one. This could possibly be explained by the fact that in African countries such as Ghana suicide is considered criminal and therefore carries legal as well as social sanctions (Knizek, et al., 2011). Culturally suicide is strongly prohibited and in certain subcultures those who attempt suicide need to go through some purification rites in an attempt to cleanse the victim and the family of shame and calamity. The stigma suicide carries affects not only the individual involved but also families and even generations (Hjelmeland et al., 2008).

Clearly religion influences individual's views on suicidal behaviour and this appears to be affected by two variables: 1) generally belonging to a religious denomination and 2) the specific religious denomination one belongs to. Generally however, individuals who are religious seem to hold negative views towards suicide irrespective of which religion they

follow. Despite these negative views however, it seems as though most individuals would still assist someone who had engaged in suicidal behaviour.

2.3.3 Cultural Context

While the influences of gender and religion have been outlined above, a third factor has also been prominent until this point; that of culture. Culture is extremely important as it intertwines with a number of factors including religion, gender and certain norms and beliefs. This can then shape the expression of mental illness as well as the views individuals hold on mental illnesses such as suicide. This then ultimately influences the way individuals can get help as culture will shape the pathways to interventions. Furthermore, many Western theories do not always comply with non-Western cultures meaning that it is essential to integrate the respective culture's beliefs and values in order to understand mental illness such as suicide (Padayachee & Laher, 2012). Therefore it is clear that the influence of culture is very important.

One way culture can influence views on suicidal behaviour relates to the meaning attributed to suicide. Lester (2008) argues that suicidal behaviour is differently determined and has different meanings in different cultures. For example, in industrialised countries, suicide is thought of as deliberately self-inflicted death. However in other countries, it is not necessary for death to be self-inflicted to be treated as a suicide as in the case on the Lusi widows in Papua New Guinea (Canetto, 2008). This means that suicide is viewed very differently by various cultural groups. For example, research has shown that individuals in a developing country often have more restrictive views towards suicidal behaviour when compared with individuals from a more Western world. Hjelmeland et al. (2008), compared views towards suicide amongst psychology students in Norway, Ghana and Uganda. The result showed that the Norwegian students considered suicide to be a right more often than the African students. Furthermore, suicide was not only considered less taboo in Norway but views towards the definition of attempted suicide differed between the countries. The Norwegian students tended to view suicide attempts as cries for help whereas the African students regarded it as a way of obtaining revenge or to punish someone. Generally, the students in Ghana and Uganda held more restrictive views on suicide than the students in Norway (Hjelmeland et al., 2008). What is also important to remember is that there may be one cultural meaning of suicide in any given culture. Many cultural meanings may be present in the culture and different cultural meanings may exist for different subgroups of the culture (Lester, 2011). Therefore, Lester (2011) highlights the importance of interviewing a

representative sample of individuals in various cultures in order to assess their views toward suicide.

Culture can also influence the views individuals have about what motivates suicidal behaviour. For example, research in Canada and the USA has found that female suicide is thought to be triggered by trivial interpersonal problems such as argument with a significant other or the end of a romantic relationship (Canetto, 2008). In South Africa Peltzer, Cherian and Cherian (1998) found that the most common reasons Grade 11 school learners thought would result in suicidal behaviour was failing to solve a problem and mental illness. In a study by Knizek et al. (2011) among psychology students in Ghana, the participants expressed strong views on what they thought motivates suicidal behaviour. These motives could be divided into intra- (e.g. emotions, identity, stress), inter- (loss, lack of support) and extra-personal (e.g. spiritual, economic, norms) causes with the intra-personal causes presenting as the most prominent causes. More specifically, the intra-personal causes were divided into a number of subcategories. The first of these was perceived obstacles with participants reporting that they felt disasters, drugs and incurable diseases such as AIDS would render individuals to engage in suicidal behaviour (Knizek et al., 2011). The second category was emotions and under this category loneliness, hopelessness and depression were frequently mentioned. The third category involved a lack of coping mechanisms and the fourth category was related to identity including a lack of confidence and low self-esteem.

An interesting point was noted by the authors of the last study. They noted that despite African culture focusing on the community, the vast majority of causes mentioned by the participants were intra-personal. They explained this by arguing that this could either be a way of protecting the community by blaming specific individuals or signal a transition towards more individuality (Knizek et al., 2011). Despite this, the authors did also note that most of the intra-personal causes mentioned were connected to the relationship between the individual and his/her social context and problems in that relationship which could cause suicidal behaviour (Knizek et al., 2011). This result indicates that individual's will hold different views about what motivates suicidal behaviour in different cultures. This may be especially influenced by whether the culture focuses on collectiveness and communities as opposed to cultures which focus on the individual.

Culture can also influence views held by individuals' about the choice of method utilised in suicidal behaviour. Cultural acceptability appears to be an important influence on method choice. This means that when a method that is culturally acceptable for one group is also a more immediately fatal method, the suicide mortality for that group is higher (Canetto,

2008). For example the most common method for suicide in the United States is firearms. This could be explained by the fact that by law individuals have the right to own firearms in the United States and therefore a large proportion of the population do so. Research has shown that in nations where a large proportion of the population own guns, higher numbers of suicide are committed (Lester, 2008). Therefore in other countries where stricter gun laws are enforced, individuals instead use other methods of suicide. Since methods chosen for suicide differ between cultures, this can affect the views individuals in different cultures have about the method chosen.

2.4 Conclusion

The literature has reviewed the risk factors of suicidal behaviour in South Africa as well as the influence of gender, religion and culture on views towards suicidal behaviour. Existing research has revealed that there is a need to consider suicidal behaviour in a cultural context given that international understandings of suicide cannot be transposed to other developing countries. Research has also established young adults as a particularly vulnerable group for suicidal behaviour. Overall, most studies on suicide have focused on quantitative measurements in order to establish risk factors of suicidal behaviour instead of exploring views towards suicidal behaviour. Given that this research is limited in the South African context, this study aimed at addressing this gap in the literature.

CHAPTER THREE

3.1 Methodology

As mentioned in the introduction, the current study aims to investigate the views that young adults in South Africa hold about suicidal behaviour. Therefore, it was decided that the nature and richness of these views would best be accessed by utilising research methods in line with these aims. The present chapter sets out to provide an overview of the research design employed by the present study. This will be followed by a detailed description of the procedure, the instrument used and the participants' characteristics. Thereafter the analysis method employed will be described and the ethical considerations of the study are presented.

3.2 Research Design

A qualitative design was chosen for this study as qualitative research paradigms are fundamentally interpretive and exploratory using both inductive and deductive approaches. In contrast to quantitative research, qualitative research does not attempt to control or predict, but rather focuses on description, analysis and interpretation (Rossman & Rallis, 2011). Given that there is a limited amount of rich interpretive research focusing on young adult's views towards suicide this study will use a qualitative design. This will allow for a greater investigation into the breadth, complexity and range of the data therefore generating deep and rich data enhancing the results of the research. Furthermore, qualitative methods can be used to understand complex social processes, to capture essential aspects of a phenomenon as well as to uncover beliefs, values and motivations of individuals (Curry, Nembhard, & Bradley, 2009). As the current study was concerned with how young adults appraise suicide, the research method needed to allow open and detailed expression. Therefore, using semi-structured interviews was considered the most appropriate method as it enabled naturalistic conversational exchange which reflected the participant's views towards suicidal behaviour. Furthermore, this method allowed the researcher to adapt the questions to each participant.

3.3 Procedure

Firstly, ethical approval for this study was obtained from the Ethics Committee of the University of the Witwatersrand (see: Appendix A). Once the ethical approval had been received, the interview questions (see: Appendix B) used in the study were developed based on a literature search. In order to recruit participants, Psychology Honours students were initially approached and voluntary participation was requested. However, this did not prove

to be successful as the students had already committed to other projects. Therefore a snowball procedure was adopted which led to the recruitment of the remainder of the participants. The participants who volunteered to take part were contacted either telephonically or by e-mail and a meeting was arranged to conduct the interview at a convenient time for the participant. All the interviews were conducted between August and October 2012 and were held in one of the therapy rooms at the Emthonjeni Centre at the University of the Witwatersrand. All the interviews were conducted in English and lasted between 25 and 50 minutes. Demographic information was collected at the start of the interview and the research consent process (see: Appendix C- F) was adhered to. Due to the flexible nature of semi-structured interviews, the participants were allowed to guide the interview while the researcher used various probing questions to elicit deeper responses. The interviews were audio-recorded and then transcribed verbatim. Transcribed interviews were stored and utilised for analysis, interpretation and for accuracy. Thereafter, the data was repeatedly examined in order to form codes and themes, utilising Braun and Clarke's (2006) method of thematic content analysis.

3.4 Participants

The participants consisted of ten students who attended the University of the Witwatersrand. There were seven females and three males with an age range from 20 to 25 years. Of the ten participants two were in their 4th year of Speech and Hearing Therapy, one was completing Honours in Psychology, three were currently doing a Masters in Psychology, two were in their first year of a BA Law degree and two were completing their Honours in Dramatic Arts. Nine of the participants where White and born in Johannesburg and one participant was Black and originated from the Free State. Furthermore, in terms of religion two participants reported that they were Jewish, one being Orthodox and the other being Progressive, two reported that they were Greek Orthodox, three reported that they were Christian and three reported that they were Atheist. All the participants described their cultural background as South African.

3.5 Instrument

The research instrument used in this study consisted of semi-structured interviews. One-to-one in-depth interviews were conducted using a semi-structured open-ended interview schedule allowing for a spontaneous dialogue relating to suicide leading to rich and meaningful data. The interview schedule was developed based on the literature search and the open-ended questions were aimed at investigating the following research questions:

- What do individuals understand by suicide?
- What do individuals believe motivates suicidal behaviour?
- What do individuals believe are common ways in which suicide is attempted and what are the reasons for this?
- What role does culture play in influencing these views?
- What role does religion play in thinking about suicide?
- How is gender constructed in suicidal narratives?

Socio-demographic information was also collected at the start of the interview including the participants' age, gender, religious affiliation, ethnic origin, cultural background, current degree and the town they grew up in.

3.6 Method of data analysis

The method of data analysis used was thematic content analysis. Braun and Clarke's (2006) model was used to identify, analyse and report themes providing a rich, detailed and organised analysis of the data (Braun & Clarke, 2006). It can be used to highlight differences and similarities across the data set, summarize key features in a large data set as well as allow for rich interpretations of the data (Braun & Clarke, 2006). The technique has been previously used to describe and compare cultures as well as investigating various topics such as suicide. Braun and Clarke (2006) outline a six phase guideline as to how themes are created in thematic content analysis and these steps were followed when analysing the data.

The first step of data analysis was data familiarisation and this included transcribing the interviews in order to take notes of any patterns of interest, searching for latent or thematic themes and noting down initial ideas (Braun & Clarke, 2006). The second step was generating data codes which involved reading across the entire data set, identifying interesting features and collating data relevant to each code. Once all the data had been coded the different codes were sorted into potential themes and all the relevant coded data extracts were collated within the identified theme. This led to the identification of main themes as well as sub-themes and all the data extracts that had been coded in relation to them. The fourth step involved reviewing the themes and checking to make sure the themes worked in relation to the coded extracts and the entire data set before finally refining the specifics of each theme and generating clear definitions and names for each theme. The final step of the data analysis involved selecting vivid and compelling extract examples and conducting a final

analysis of the selected extracts whilst relating them back to the analysis of the research questions and the existing literature (Braun & Clarke, 2006).

3.7 Ethical Considerations

Upon arrival, the participants were provided with an information sheet containing all the information pertaining to the study (see: Appendix C). They were also provided with a consent form (see: Appendix D) which they were asked to sign before participating in the study permitting the tape-recording of the individual interviews (see: Appendix E) and the use of direct quotes (see: Appendix F) in the research report. Before the interviews began, the participants were informed that participation was voluntary and that they had the right to withdraw at any point during the study. The participants were informed that while anonymity could not be completely ensured between the researcher and the participants as the interviews were conducted face-to-face, anonymity would be upheld at all times with participant's identities in the written research report. No identifying information was included therefore safe guarding participant's anonymity through the use of pseudonyms. Regarding confidentiality, all the participant's responses were kept confidential, however confidentiality was limited as the interview material was shared with the supervisor. Furthermore, all the participants were provided with information for counselling services should the interview illicit any emotional responses for the participants and they required counselling. These counselling services included the Emthonjeni Centre, the Counselling and Careers Development Unit and the South African Depression and Anxiety Group. Finally, the participants were informed that the interview material would be kept in a locked cupboard and would be safe guarded electronically under password protection. They were also informed that the data will be deleted and destroyed after two years should publications arise or after five years should no publications arise.

CHAPTER 4

4.1 Results

This research study examined the views held by young adults in the South African context towards suicidal behaviour. The results revealed that the participants understood the causes of suicide as a combination of both psychological risk factors and socio-cultural risk factors. This reflected the assumptions laid down by Bronfenbrenner's (1977) model; particularly the effect interrelated factors can have on individuals. In addition, the participants emphasised the influence of the social and cultural context and in particular how this influenced their views and narratives. This was further noted by participants to be the most crucial influence on their own views towards suicide. Lastly, the participants identified the role of gender stereotypes and beliefs in society as an important factor in making meaning of disparities.

4.2 Perceived risk factors

When attempting to identify and unravel the risk factors associated with suicidal behaviour, the complex nature of suicide became apparent. It was apparent that this was a multidimensional concept which was difficult to simplify and reduce to a singular or a linear causality.

I think suicide is a deeply complex issue and it's an issue that has all sorts of causes, all sorts of effects and all sorts of reasons…it's very reductionist or simplistic to kind of just go "Ok well suicidal people are like this", you just, you just can't do that (Eddie).

Instead the participants identified a wide ranging, multitude of interdependent risk factors of suicide. Both psychological and socio-cultural risk factors were identified as crucial when understanding the causes of suicidal behaviour. At an individual level, psychological risk factors such as the presence of emotions including depression and helplessness, negative cognitions, a lack of effective coping mechanisms and the psychological impact of terminal illness were identified. The socio-cultural risk factors were reflective of the influence that the exo-system and macro-system had on individuals. Lack of social support, the experience of life events and stressors and the influence of religion were implicated in the aetiology. The participants also highlighted that South Africa is a country in transition and therefore young adults find themselves with fewer economic and career

opportunities as well as hardships, while at the same time trying to live up to materialistic expectations put forward by society.

4.2.1 Psychological risk factors

The most common psychological risk factor put forward by the participants (60%) was depression. Depression was not understood as a mental illness but instead was referred to as an emotional state, which was comprised of low mood resulting from a combination of feelings of helplessness, hopelessness and isolation.

Somebody who's in a very desperate situation when they're so depressed or so overwhelmed by some sort of circumstance that they feel that there's no other option (Elaine).

A sense of desperation and helplessness were identified as central to depression, and this was particularly the case when an overwhelming and defeating situation was present. The presence of this extreme emotional state coupled with an inability to find a solution or relief from their current life situation was identified as central to the experience of depression.

I understand that people get depressed and that depression gets to a point where they actually don't believe that life's really worth it…pushes them to the point that they feel worthless (Thomas).

Some participants (30%) commented that when depression was present, there was often a sense of defeat around the will to continue living. There was a sense that life was not worth living and with that there was no motivation to do so. This existential motive highlights that individuals who engage in suicidal behaviour do so to end a perceived meaningless existence. In other words they have no reason to continue living and can justify to themselves why it is better to be dead than alive.

I think they either get to a point where there's just pure despair and it's kind of painful for them to be here or there's actually no underlying motivation for them to carry on living (Thomas).

When perceiving a meaningless existence, individuals often feel worthless and unwanted by others. This can reinforce the cognitive distortion that they are a burden on

others, facing their hardships alone with no one to help them. Thwarted belongingness therefore occurs, as a desire to be socially connected to others is unmet and ultimately results in a desire for death.

I think that a lot of the time what's going on in people's mind when they are suicidal is that they think that they're alone and they think that no one would understand or that no one can change the situation (Natalie).

In these instances suicide was seen as the only option for individuals to escape from their feelings of helplessness and desperation. The need to escape was often associated with *"the feeling of entrapment"* (Irene). These emotions were thought to be so extreme, that individuals became driven and motivated to engage in an act reflective of their emotional state. For many, this was through suicidal behaviour although suicide was often seen and considered as a last resort.

(It's) somebody being driven by their situation or I suppose usually driven by very negative…you have a situation where you don't think that you can carry on and then take your own life (Alice).

It's usually when someone feels like they no longer have any option and this is the only way out, or rather this is the best way for them to numb their pain or to no longer face whatever challenges they are facing or dealing with (Anne).

They feel very trapped and stuck and they can't think rationally or think of a solution. There's no solution, there's nothing else than can be done (Irene).

Depression was also linked to the experience of negative emotions and a dysfunctional thinking pattern. In particular, some of the participants mentioned that experiencing a depressed mood fuels a cycle of negativity which individuals cannot remove themselves from. They then find themselves embedded in this cycle and cannot engage in positive thinking anymore. This then continues to reinforce their depressed mood until the individual can no longer continue, resulting in them engaging in suicidal behaviour.

Their thoughts and negative thoughts kind of fuel it [suicidal behaviour]… this pathological negativity to the point where they can't think of anything positive. I think that's to the point where they're almost depressed (Rita).

Depressed mood and negativity would need to be present in individuals for long periods of time. Experiencing a depressed mood was considered to be a sustained, ongoing process and one from which individuals could not remove themselves.

It can be a kind of very low moment but I think it's more. It's a kind of more sustained thing, so it's not just "I had a bad day"…It's a longer process of not feeling like this is going to end (Alice).

While the presence of depression was identified by participants as a crucial risk factor of suicidal behaviour, not all individuals with depression were expected to engage in suicidal behaviour. Some of the participants (30%) suggested that this was as a result of the kind of coping mechanisms individuals possessed. An individual's coping mechanisms were however attributed to inherent abilities. Coping mechanisms where not identified as factors that can be learnt from the environment, but rather were assumed to be embedded in an individual's biological make-up. Therefore, individuals were either born with effective coping mechanisms or were not. Ineffective coping styles were reported to lead to poor problem solving abilities whereas adaptive and effective coping mechanisms were considered a buffer to suicidal behaviour.

People who are able to cope better…they are able to think rationally what is more important and kind of deal with the problem and go on (Irene).

Suicide was often considered the method of communication by participants when individuals felt unable to express their distress in a conventional manner and when they lacked effective coping mechanisms. Verbal communication was often considered to be inadequate, therefore leading participants to communicate their emotions in a physical and direct way through suicide. These individuals did not necessarily have a strong desire to die but instead were considered to be 'crying for attention' as a plea for help (40%).

They need someone to listen to them and they don't have that...so it's like screaming for help, not necessarily seeking attention, but they're reaching out (Anne).

Having close relationships with family and friends can allow individuals to communicate their emotions in a healthy and productive way. Providing emotional support for individuals can also allow individuals to feel important and wanted by their loved ones therefore preventing them from engaging in suicidal behaviour. This illustrates the interrelated nature of risk factors to suicidal behaviour as highlighted by Bronfenbrenner's (1977) model. Specifically, the interrelatedness of the presence of negative emotions (at the individual level) as well as the absence of social support (at the micro-systemic level) was considered to increase an individual's vulnerability to engage in suicidal behaviour.

I come from a family that is very open to discussing emotions and to being open and I think that helps a lot because…everyone goes through crisis moments and then if you are unable to speak about it or to be able to find someone in your family that you can lean on and be able to find a solution I think it makes it a lot harder (Irene).

This highlights the importance of open communication and understanding. When individuals have the opportunities to communicate in an open way to others, particularly in distressing situations, the support they receive can greatly assist in dealing with their current situation constructively. Consequently, individuals who do not have this opportunity find themselves unable to verbally communicate their desperate situation to others and without help they become immersed in their depressed mood and are unable to find a solution. This makes them particularly vulnerable to suicide. The assumption that suicidal behaviour can have a communicative function raised some queries amongst the participants about whether an individual would genuinely be in distress or whether they were seeking attention. Instead of wanting to die, individuals who attempted suicide were seen as seeking attention, hopeful that someone would help them or that their situation and life would improve.

People who are attempting…probably feel that maybe there are other options so they still feel that maybe this isn't the last option…I guess they perhaps have a little bit more hope inside them (Rita).

Those who attempted suicide were viewed as still having some hope and faith that their situation could improve and that they would find a solution to their problems. Interestingly, the Atheists (30%) amongst the participants strongly advocated against the term 'attention-seeking' as an explanation of attempted suicide.

I really don't ascribe to this thing of suicide being an attention seeking measure like it is. I think that if you are compelled to kind of even make an attempt no matter how feeble at your own life, there's something kind of deeply distressing going on (Eddie).

Instead, they argued that attempted suicides were very important acts and should be taken seriously at all times. This was because they ascribed any kind of suicidal behaviour to emotional distress and extreme unhappiness.

The majority of the participants (60%) in this study also identified the presence of a terminal illness as a risk factor for suicidal behaviour. When the illness was considered to be severe and incurable, death was considered the better option due to the suffering both the individual and their loved ones would experience. However, it was not the terminal illness itself that was considered a risk factor, but rather the emotional consequences of the illness particularly if it was long lasting and resulted in a great deal of suffering.

I can definitely imagine someone being diagnosed with something completely terrible and where the outcome of death would be better than living through that terrible illness (Rita).

A diagnosis of a terminal illness had a number of implications, including the development of depression, emotional distress about the diagnosis and prognosis of the illness as well as anxiety about the terminal illness and issues around dying.

I don't know if I would want to go through the process of getting sick and losing my dignity. It's much easier just to kill yourself, you're going to die anyway just do it while you've got the dignity (Sam).

This highlights that terminal illnesses are also associated with prolonged pain and suffering which might be detrimental to individuals and can result in negative effects both physically and emotionally. Physically, stress can occur as a result of fear over a slow,

unbearable, painful death as well as the perception that before a terminal illness kills you it can mutilate you. This can then result in feelings of shame, guilt and anger, therefore increasing individuals' vulnerability to engage in suicidal behaviour. Interestingly, some participants (30%) considered HIV and AIDS to be a prominent diagnosis. Contracting HIV and AIDS was described as a *"death sentence"* (Sam) given that individuals already knew that death was imminent. This could raise a number of emotions such as fear and anxiety over dying, questions over the meaning of life, and anger as to why it happened to them. The identification of HIV and AIDS as prominent diagnoses is logical, given that South Africa has the highest HIV prevalence rate in the world. Thus awareness campaigns, psycho-education and support systems are continuously promoted in South Africa. This has resulted in the production of a great deal of knowledge nationwide about HIV and AIDS as well as its consequences and effects.

4.2.2 Social and cultural risk factors

The core ideas relating to this subtheme are illustrative of influences from Bronfenbrenner's exo-system and macro-system. While the participants highlighted individual risk factors for suicide, socio-cultural issues were described as being interrelated with influences from environmental factors. These factors were identified as conditions particularly prevalent in the South African context and included: the experience of life events and stressors, the lack of opportunities and hardships present in the South African context as well as the expectations put forward in society which young adults are expected to live up to, as well as a lack of social support.

A traumatic experience or a life stressor was considered to be one of the most important risk factors for suicide behaviour. The majority of the participants (60%) suggested that the exposure or the experience of an event that was either stressful (30%) or traumatic (30%) could predispose an individual to engage in suicidal behaviour. The general consensus from these participants was that any event could be considered stressful or traumatic if perceived that way by an individual. Furthermore, most of the participants (50%) emphasised that exposure to more than one traumatic event would increase the risk of engaging in suicidal behaviour. Dealing with one event at a time was suggested to be more feasible and easier to cope with. However, exposure to multiple events would place greater pressure on resources including support structures and coping mechanisms, ultimately increasing individuals' vulnerability to suicide.

I think that when people face one thing at a time it's easier for them to deal with it. But then when a lot of things come piling on you all at once…there's just a lot of things that you can't handle then it probably would push you over (Anne).

While the experience of traumatic events and life stressors were generally considered to increase individuals' vulnerability to suicide, specific examples of traumatic events were provided. The events and situations identified were found to be central and relevant to the South African context.

I'm sure it's high [in South Africa] because there's poverty and crime and violence and all kinds of really serious things that happen and lots of trauma that people have to deal with (Natalie).

This highlights three key factors prevalent in the South African context: poverty, crime and violence. Poverty levels are still high in South Africa, highlighting the social and economic disparity of the country. It is often associated with a number of factors including poor living conditions, unemployment, a lack of job opportunities and a lack of food security. However, the effects of poverty are far more widespread. Poverty is often associated with a breakdown in family life and this can then lead to a number of social problems including child abuse and neglect, substance abuse, crime and violence. In addition, poverty often involves constant emotional stress, particularly feelings of helplessness in changing the current situation. Therefore, poverty can increase individuals' vulnerability to suicide.

Exposure to crime and violence were identified by participants as key risk factors for suicidal behaviour primarily because of the emotional effects of trauma. Trauma is deeply rooted in society with South Africa often considered as one of the most violent countries in the world. Experiencing trauma was considered to be extremely emotionally stressful and possibly a cause of depressed mood which could increase individuals' vulnerability to engage in suicidal behaviour. Two other life stressors which were mentioned by participants were bullying (20%) and failing at university (30%). Both of these were highlighted as particularly common amongst young adults. Bullying was emphasised specifically in the context of technology and social networking.

I think especially now with how technology has become and social networking…social bullying is becoming way more prominent than it ever was because it is not like a child can

now escape bullying when they go home, there's bullying around them all the time and I think that may influence way more suicides now especially in South Africa (Irene).

Cyber-bullying was identified as a growing concern amongst young adults in South Africa particularly due to the growth in technology and access to media in South Africa. The biggest issue with cyber bullying is the psychological impact that it can have on the victim. Since technology and social mediums are so easily accessible to individuals, cyber bullying can happen 24 hours a day meaning that there is no escape for the individual. Anxiety, depression and ultimately suicide are the results of cyber bullying because it is present at all times. The growth in technology and access to media in South Africa also highlights the transition that South Africa is currently going through and the effect this transition is having on its youth. Sixty percent of the participants highlighted that South Africa's current social, economic and political situation is greatly influencing the fate of the country's young adults. As transformation continues to occur in South Africa, the effects of this will continue to influence the population, particularly the young adults who are considered as central to shaping the future of the country.

Things are quite difficult in our country and I think that might be a group that really feels disempowered and disenfranchised because they might not feel like they have the opportunities for varsity or they might not have the opportunities for growth and jobs or might feel quite hopeless about the situation they find themselves in (Natalie).

This perceived lack of opportunities to attend university or to find a job has placed extra pressure on young adults when they do attend university as they are expected to make the most of the opportunity and do well academically. Furthermore, young adults are often afforded the opportunity of attending university through bursaries and scholarships. Failure in passing thus often results in the removal of financial aid. Therefore failing university can often lead to great stress for young adults as they risk losing funding assistance, fail to meet expectations and lose their academic opportunities. This could result in depression, anxiety and often suicidal behaviour. Furthermore, South Africa is currently in a period of transition, and with that young adults are becoming exposed to more Westernised experiences. This is leading to an increase in an expected way of life for young adults, one which includes financial security, materialistic possessions and a prestigious job.

There's kind of a lot of requirements on a person like socially and do you have a good job and do you have the material stuff that go with that and so maybe that pressures people more and makes them more at risk not being able to be all those things and then feeling inadequate within themselves (Alice).

There is also the assumption amongst young adults that in order to be happy, one must lead a modern, materialistic lifestyle with financial gains and status. This then results in a drive from young adults to live this lifestyle and achieve this happiness despite the fact that it is not possible for a number of individuals. Failure to achieve this lifestyle which has been set as the norm in society can then lead to the contemplation of suicidal behaviour.

There's this absolute drive towards gratification and there's this drive towards being happy and having the best life and so we are constantly moving towards something, to find this ideal that might not actually be possible for the large majority of us (Natalie).

This emphasis on being happy can increase the risk for suicidal behaviour as people often find themselves afraid to acknowledge challenges and problems they are experiencing. This may be due to concern over how they will be viewed, particularly whether they will be judged or misunderstood. Therefore individuals who are constantly confronted with the expectation to always be happy and who cannot subscribe to that may find themselves feeling hopeless as they think there is no other alternative to this lifestyle. In addition to these pressures, young adulthood is a developmental time when individuals are trying to establish their own identity. This can result in a turbulent time for young adults as they transition from teenagers to adults dealing with the pressures from their family, peers, and social and cultural environments, while at the same time trying to establish their identity and themselves as unique individuals.

It's a huge transition in development so I'd see how there are a lot of pressures that come with that. And because you haven't established yourself as a person and strong personality then obviously it's easy for you to feel helpless (Anne).

During this developmental period, young adults may find themselves conflicted between developing into the person they want to be, and the person they are expected to be by their families, culture and their communities. In the South African context where there are

eleven official languages, multiple cultures, religions and different communities, this conflict becomes even more pronounced. Not only are young adults faced with increasing Westernised influences, but they are also exposed to a number of different local cultures each with their own values, traditions, beliefs and customs. This conflict can create a great deal of stress for young adults and can lead to feelings of helplessness, hopelessness and depression, ultimately increasing their vulnerability to suicidal behaviour. Furthermore, some participants (40%) reported that during this difficult times, if individuals' are faced with a lack of social support, this may further increase the likelihood of them feeling vulnerable. Consequently, having a concrete and consistent support structure was seen by participants as a protective buffer against the emotional consequences of life stressors during young adulthood.

I believe you have the ability to bounce back…if you have the necessary support…you won't really fall to the point that you want to commit suicide (Thomas).

Social support was therefore believed to be crucial to the prevention of suicidal behaviour. Support structures at universities and other institutions were also considered to be important by the participants. These structures were considered important because of the safe space they provided for young adults to express themselves without judgement or conflict. Furthermore, professionals with knowledge and expertise directed at these support structures were considered as central to assisting young adults within their tertiary education systems, not only with their academic demands but with peer pressures, traumatic events and life stressors too.

4.3 The influence of the socio-cultural context

At a social and cultural level, the participants not only identified risk factors for suicide, but also emphasised the influence of this context on the views held towards suicide. According to Bronfenbrenner's (1977) model, developing individuals are exposed to a range of information from different sources, including their family at the micro-system, their religions and communities at the exo-system, and the beliefs, stereotypes and norms at the macro-system. Therefore they are influenced in multiple ways and this influences their views, beliefs and attitudes. A widespread assumption held by the participants irrespective of gender, religion or race, was that their families, religious denomination and communities within South Africa, hold predominantly negative views towards suicide. Interestingly however, while the views of the individuals reflected a negative stigma towards the act, their

views also reflected a desire to help either the families of those who had committed or those who had not succeeded. Furthermore, while describing these negative views towards suicide, almost all of the participants advocated for the campaign to raise greater awareness of suicide in order to reduce the stigma and taboo surrounding suicidal behaviour.

4.3.1 "It's a sin"

The majority of the participants reported that in the eyes of their family, religion and community, suicide was seen as something *"always frowned upon"* (Sam), *"as a sin"* (Oscar), *"taboo"* (Elaine) and *"a very selfish act"* (Anne). This was considered to be the case because the act of suicide opposes the teachings, values and beliefs that religions preach and that families and communities within South Africa tend to hold. This was found to be the case irrespective of which religious denomination participants belonged to. Furthermore, participants reported that their families viewed the act of suicide as selfish because the individual had not considered how their actions would affect others. Instead the loved ones of that individual were left behind filled with feelings of hurt, anger and numerous questions.

With my religion you have a responsibility to your family and your community, you don't live in isolation so you have family members, you have people that care about you so if you are doing something like that, that means you don't show that you care about those people (Anne).

Some participants (20%) reported that their families did not accept excuses for not finding solutions to problems. Suicidal behaviour in these instances was seen as a weakness and as an excuse to avoid dealing with responsibilities. Engaging in suicidal behaviour was therefore not acceptable.

I know my parents…they kind of see it in a sense…a weak way to get out of things or not being able to deal with your own problems better (Thomas).

Participants from different religious denominations often spoke about the rules and practices that are emphasised by their religions and how these are influenced by someone engaging in suicidal behaviour. For example, the participants who were part of Christianity described suicide as the greatest sin an individual could commit. In particular, this sin was considered unforgivable with one participant commenting that it was *"considered worse than*

killing someone else" (Rita). In Christianity, life was reported to be a gift and was considered very precious. Therefore, it was considered something that only God could choose to take away not man. A similar view was reported by those who practice Judaism. According to their religion this ultimately put the soul into limbo because it could not progress to heaven but also cannot return to the body. These participants also described the burial and mourning process for the death of individuals. When individuals in this religious denomination had committed suicide however, they would not be entitled to any burial rights.

If you have committed suicide you aren't entitled to be buried in the Jewish cemetery, you have to be buried somewhere else and you're not entitled to a lot of the mourning rights…that are associated with other people who have passed away (Elaine).

In the Jewish faith this was considered to be a terrible thing, because they believe that when the Messiah comes the dead will be resurrected together. If someone was not buried in a Jewish cemetery then they would not be resurrected.

Some participants (40%), particularly the Atheists, strongly denounced the negative views that religions held towards suicide. These participants argued that if an individual has passed away they deserved some respect and dignity irrespective of how the death occurred.

I think that it's a phenomenon that is deeply misunderstood and it's kind of viewed quite superficially by religion…people who had committed suicide have lived through a period of great distress in their life and they deserve some sort of respect in death…and I think that it's a pity and a great shame that even in death they don't get the respect that they desire (Eddie).

In particular, the Atheists felt that mental illnesses such as suicidal behaviour were not understood by religions. Instead of trying to understand the complexity, causes and explanations for suicide, religions simply ignore it and criticise anyone who engages in suicidal behaviour. The superficial understanding of suicide from a religious perspective was reported to create a great deal of emotional stress for individuals. In particular, it was emphasised that holding a negative view towards suicide can increase the stress an individual contemplating suicide experiences. It may also present the situation as even more hopeless if they feel as though they cannot turn to their faith for guidance.

Not only are they thinking about suicide but now if they do commit suicide they are going to hell and they've committed a sin and I just think that's the last thing you need to be thinking about when you're in such a desperate position (Natalie).

This appeared to highlight the perceived lack of support provided by religions to individuals who need it in moments of crises. Instead religions were seen to emphasise feelings of guilt, shame and worry by denouncing those who did not follow their teachings. Religions can become a great source of conflict for individuals as they try to follow the teachings laid down while at the same time cope with their own life stressors. This can create a great deal of emotional stress and anxiety for these individuals which cannot be dealt with as they do not have their faith or their religion to turn to. While the effects of religion on individuals are important, the negative impact on their families was also considered essential.

People think that when you commit suicide you're going to go to hell and I think for a lot of people that are religious and families, I think that's a really big added hurt for them…not only have they lost their loved one but their loved one is going to hell because they've committed suicide (Alice).

For the families of those who have engaged in suicidal behaviour, religion should also be a support structure during this distressing time. However, they face equally as much emotional stress and anxiety over the fate of their loved one. For many families, knowing that a loved one is safe and at peace once they have passed away is a great source of comfort. This assists with coming to terms with their death, beginning the healing process and finding purpose and meaning again now that they have gone. However, in the case of a suicide, there are often questions about their death. Families often do not have answers or cannot find meaning and understanding about the suicidal act. In addition to this, to know that their loved one may not be in heaven and may be ostracised by religious figures and communities can lead to great distress for the family. Despite the negative connotations held towards suicidal behaviour, some of the participants (50%) felt that if an individual had failed in their suicide attempt, their families, religions and communities would assist that individual. A great deal of empathy and sympathy existed towards the bereaved illustrating an ambiguous engagement with the act of suicide.

Although they wouldn't be proud that you tried to commit suicide, they'd definitely try and help you. Our religion believes in forgiving and helping people (Oscar).

Instead of ostracising the individual and their family, forgiveness and aid were expected to be present. Communities were reported to invest a great deal of time and effort to ensure that such an individual was cared for and to assist them so that they would not feel compelled to engage in such an act again. Forgiveness was found to be a central feeling towards those who had engaged in suicidal behaviour. In many ways, assisting someone who had attempted suicide was seen as a way of preventing a death particularly in the case of a young adult.

I think the community sort of feels very powerless when there's a completed suicide and when there's an attempted suicide you know there's sort of an opportunity for people to get involved and intervene in some way (Elaine).

There was also a sense that close-knit communities support each other and are always there to assist one another. Given that South Africa consists of so many different communities and cultures, there is often a tendency for these groups to cluster together since they share traditions and customs. They further offer each other support and guidance particularly during times of crises. Even in situations where they do not agree with the circumstance, participants reported that this was overlooked and help and support were instead provided to individuals. This was also reported to be the case with families of an individual who had committed suicide. The family would not be ostracised primarily because the family would not be blamed in such a circumstance. Instead, it was reported that the community would step in and assist where they could.

I think if it's the father, people would probably step in with financial help, emotional support for the wife and kids (Sam).

South Africa's notion of Ubuntu is central to a collectivistic society. This concept promotes co-operation between individuals and cultures as well as social values including group solidarity, compassion, respect for human dignity and collective unity. Therefore, the idea that families and communities will come together to help others is a core principal of Ubuntu. This point made by the participants illustrated that despite influences from social

groups, the influence of an overarching ideology such as Ubuntu is still central to their views and beliefs. Lastly, the participants reported that there would be no reason for their family and community to shun the family of someone who had committed suicide. This was primarily reported to be the case because the family was already experiencing a traumatic event through the loss of a loved one and there would be no reason to worsen the situation by ostracising the family. However, the participants argued that instead of making negative connotations for suicidal behaviour, churches and communities should be used as a safe space for individuals who are contemplating suicide. Instead of fearing that they will be stigmatised, people should be able to turn to their religion and use it as a resource seeking support and assistance when they require it.

4.3.2 Breaking the cultural dilemma

One interesting point that emerged was that all the participants knew someone who had either attempted or committed suicide. The participants therefore seemed to hold some very different views from their family and their religion or culture regarding suicidal behaviour. A number of the participants (40%) reported that while their cultural upbringing had influenced their views on suicide to some extent, through their own experiences they had also developed different views to those held by their families or religion. Rather, their current views were a reflection of the education they had had, the work they had been involved in and the life events they had experienced growing up within South Africa. This supports the assumption made by Bronfenbrenner's (1977) model that an individual's beliefs are influenced not only by their family, but by their peers, their education and other leading figures. As individuals are active participants, interacting with all these factors, they are influenced in multiple ways.

I've been involved with a lot of work that involves people so I think I'm very influenced by other people whether they're from different cultures, people that have been through different life experiences, I get influenced by them (Sam).

This was also attributed to the fact that these participants felt as though they belonged to a different generation from their parents; one which was a lot more open to discussing suicidal behaviour.

I think my parents are quite old fashioned and I mean their parents used to be like "Just shrug it off"…but I think now with my age group, it's a lot more talked about, we understand a lot more about depression and suicide (Thomas).

This generation gap was seen as a key component of explaining suicidal behaviour and highlighted the changes that have occurred in society. For example, the media has now become a great source of information, accessible to almost anyone in the world. With that, education and portrayals of mental health are now common in the media. Myths around mental illnesses have diffused and with the advancement of technology and research, suicidal behaviour has become more accepted as a form of mental illness which requires medical and psychological intervention. Rather that viewing suicide as a taboo subject the current generation of young adults, appear to have a great deal of empathy and sympathy towards those who found themselves in such a desperate situation that they felt compelled to engage in the act of suicide. They also reported that they felt a great deal of sadness for those individuals and often wondered what they could have done to help. Based on this, most of the participants (70%) argued that a change needed to occur and that suicide should no longer be considered a taboo subject but instead it should be openly discussed.

I think it should be a subject that should be open to discussion so that those walls can be broken down and so that those stigmas attached to it can be broken down so that people can then come out and start to talk more about it (Irene).

The participants advocated for further open communication about mental illnesses such as suicide, about the identified risk factors and about the normalisation of negative emotions. This was seen as crucial in order to de-stigmatise suicide. Some participants (20%) noted that suicide is often considered a daunting topic and therefore it tends to be avoided.

I think people are scared of suicide, they are scared of addressing suicide as kind of an issue and so they kind of tend to try and avoid thinking about it unless they are immediately confronted with it (Eddie).

This highlights the misconceptions and misunderstandings regarding suicidal behaviour. Fear over a subject often highlights a lack of knowledge, education and information on the topic therefore illustrating that raising awareness and creating

understanding is crucial in order to address the fear. Other participants called for change to continue occurring, commenting that an attitude change towards suicide was imperative in order to understand more about suicidal behaviour and prevent it. Furthermore, they commented that suicidal behaviour is perceived in such a way in our society that it makes people feel as though they cannot speak about it. In addition to this, these states that cultures and religions often imply that there is something wrong with you if you are considering engaging in suicidal behaviour and this view needs to be changed in order for prevention to take place.

4.4 The role of gender

A common view presented by all the participants (100%), is the idea that men commit suicide more often than women do. This is in response to unbearable pressures to meet social and cultural expectations of what it means to 'be a man'. Participants explained that men are expected to live up to masculine stereotypes present in our society even at the cost of their own well being. This means that men may experience a great deal of physical and emotional stress in order to fulfil their masculine role in our society. If this stress is not dealt with, the effects can be detrimental, often leading to suicidal behaviour. On the other hand, some participants expressed the idea that women attempt suicide more often than men do. This was because women were considered to behave in line with feminine stereotypes predominantly portrayed as weak, emotional and irrational. These views were held irrespective of the participant's gender. The participants explained the gender differences in suicidal behaviour in three ways: the expression of emotions, the choice of method and gender stereotype roles present in our society.

The majority of the participants (70%) discussed the influence emotions can have in contributing to the decision to engage in suicidal behaviour. Some of the participants (40%) raised the concern that men are not allowed to express their emotions because this is considered a threat towards their masculine identity.

I do feel maybe for men…they're so used to keeping their emotions in because that's kind of what's expected of them in society (Rita).

There's kind of more pressure on men to be stronger…and a lot of the men I know hide their emotion a lot…so I think maybe it's the pressures of having to be so strong (Alice).

The suppression of emotions by men was attributed by the participants to expectations placed by South Africa's society. The idea that men were expected to be strong was highlighted by a number of participants who argued that strength was associated with masculinity. The expectation to be strong, meant that South African men often kept their emotions hidden from others and would not openly discuss them. Suppressing emotions was therefore considered to not be conducive to men's psychological well being and consequently was seen as one of the main reasons as to why men engaged in suicidal behaviour. Many cultures in South Africa do not allow for the expression of emotions amongst men and this is instead considered a feminine trait. Fifty percent of the participants agreed with this. Consequently, women were considered to engage more in attempted suicide because they were considered to be emotional and expressive.

I think females in general are more emotional than men and they probably blow things out of proportion a lot depending on how they feel (Oscar).

Women are allowed to be more emotional and more expressive (Alice).

The expression of emotions was seen as more socially acceptable for women in South Africa as this indicated weakness and irrationality, traits which were perceived as common in women. Being irrational, overwhelmed and impulsive were key characteristics participants attributed to women. This often resulted in an act of suicide on the 'spur of the moment', and usually to make a statement, or gain attention but rarely to die. The expression of emotions in women was described by participants as a 'cry for help' when women needed assistance and help from others, because they could no longer cope with their current situation. This then resulted in the engagement of suicidal behaviour.

Maybe this attempt is about…sending a very clear message that she's not coping and that she actually needs assistance and asking might be a little too hard but showing might be easier and maybe that's why there are more attempts for women than for men (Natalie).

In South Africa, as women were allowed to express their emotions, this meant that it was also considered more acceptable for women to seek help more often than for men. This was associated with the perceptions that men were strong and could cope by themselves, whereas women were weak and needed assistance. Some participants reported that they had

been taught these gendered stereotypes from their environments and therefore these views were considered norms and were accepted as such. Families, cultures and social environments held these gendered assumptions and as a result of this, these were the participants own views.

I can't see men go to seek treatment…because I know there's that idea that men don't cry, men don't get depressed and stuff like that because of what we've been taught…I actually see women going to seek help more than a guy would (Thomas).

For men on the other hand, the portrayal of weaknesses was seen as a threat to their masculinity and therefore men were not viewed as likely to seek help. Furthermore, not being allowed emotional expressiveness meant that they were not seen as likely to seek assistance with emotional support during crises.

I think there's also you know a lot of problematic constructions of masculinity that sort of don't allow men to seek help and see themselves as weaker and failures maybe because they aren't coping with something (Elaine).

There's this cultural belief about what it is to be a man…and so if things seem hopeless they might not be able to recognise the resources that they have because it's not aligned with how they understand their identity (Natalie).

Accessing formal sources of support was thought to be resisted by men because it meant admitting that they were not capable of solving their problems on their own. Admitting difficulties and asking for help was seen as a failure and resulted in feelings of shame, guilt and anxiety. Asking for help could be seen as a shameful act and would therefore constitute failure and weakness when men are supposed to be successful and strong. In the absence of support structures coupled with the expectations of masculine independence and identity, for some men the only option to deal with these emotions was through suicide.

The participants also explained that men completed suicide more often than women as a result of the chosen method. Men were viewed by the majority of participants (80%) as more likely to commit suicide because they used more violent means to kill themselves. These included methods such as jumping off a bridge (90%), the use of a firearm (80%),

hanging (50%), and gassing (50%). The methods were considered the most lethal and the most final indicating that chances of surviving would be slim.

Men are more violent as a gender so if men attempt suicide they're more likely to complete it than women and because they'll use a much more violent means (Eddie).

Men do sort of opt for more lethal methods so jumping from buildings or shooting themselves (Elaine).

Men don't attempt as much as they're choosing very fatal options (Natalie).

Some participants (20%) further attributed the lethality of the method men choose with the perception that men are more aggressive and impulsive. The assumption that men display high levels of impulsiveness and risk taking when compared to women was a gender trend amongst some of the participants. Furthermore, men were also described as more determined to complete suicide because they could not face the embarrassment and shame of having failed a suicide. Failing to complete a suicide would be seen as a sign of weakness and would greatly influence their status and their identity. This was seen as too much to handle for men and so the participants reported that men would ensure they completed the act so as not to face the consequences.

If they [men] attempted suicide but it wasn't successful, that would be too embarrassing or too crippling on their status or their pride…so they make sure that it actually happens (Alice).

On the other hand, women were commonly associated with either taking an overdose (80%) or slitting their wrists (50%). While the severity of these methods was highlighted by the participants, the general consensus was that these methods were commonly used when individuals where not actually pursuing death. For most of the participants, women's suicidal behaviour had more of a communicative function than men's. Either by trying to influence people around them, or by signalling for help, female suicides were understood as a way of sharing their emotional distress.

I think you can still hurt yourself really badly but it may just be more of a cry for help or an attention thing…because they don't really want to go through with it (Irene).

Therefore, these methods were perceived as commonly selected by women because they did not ensure the completion of the act. Instead, they afforded the individual the opportunity to either be found or to change their mind before completing the act. This was because women were not perceived as having the strength to engage in a final act as a result of their weaknesses. Another explanation was that women often would not have accessibility to violent methods such as firearms. A number of participants (40%) highlighted the issue of accessibility. This was a common theme for both male and female suicides with some participants suggesting that if a method was not accessible to an individual, that method would not be utilised.

Whatever you have at your disposal…if you don't have a gun you're not going to use a gun (Natalie).

There was the assumption that men would be more likely to have access to methods such as firearms whereas women would be more likely to have access to medication such as pills but would be less likely to have access to a firearm. This would therefore result in women overdosing more often than men and consequently not committing suicide as often as men.

I think often women are more likely to have been diagnosed…and maybe have access to sleeping tablets or something they could use to overdose (Elaine).

It is important to note however, that a number of participants (30%) argued that irrespective of gender, if someone genuinely wanted to commit an act of suicide and no longer wanted to live then they would ensure that they did not survive. The individual would therefore make sure that a method which would result in a completed suicide would be chosen.

Throughout the participants' discussions on the assumptions around emotional expressiveness and choice of method, underlying gender stereotypes and roles were raised. For all of the participants (100%), gender stereotypes and roles placed by our society, were central in making meaning of disparities. One widespread assumption was that both men and

women were compelled to engage in suicidal behaviour when they did not fulfil the roles and expectations laid down for them by South African society. This was considered a failure and as putting their masculinity and femininity into question, causing great emotional distress to the individuals and possibly leading to suicidal behaviour. For men, the stereotypical masculine role included being employed, being able to provide for their family and acting as an authority figure in the family environment. The majority of the participants (60%) reported that this masculine ideal placed a great deal of responsibility and burden on men and if for whatever reason they could not fulfil this role, they were considered a failure.

We live in a really kind of patriarchal society and men are still expected to provide for a family, to care for a wife and put their kids through school…and if they aren't able to do that for whatever reason they may be inclined to do that [suicide] (Eddie).

If you are not able to provide for your family and are seen as a failure then those are things that could make you commit suicide or feel like you are not worthy…because you are not able to do those male related things that you are supposed to, or rather that society expects of you (Anne).

Unemployment, job retrenchment and a lack of finances were considered to be key causes relevant to South Africa, would could result in the failure to fulfil a masculine stereotype. The emotional consequences of feeling like a failure were also emphasised. In particular participants argued that this could result in feelings of depression, shame, guilt and anger amongst males. Generally, anything which was regarded as putting men's masculinity and power into question was considered to result in suicidal behaviour. One such example provided by a number of the participants (30%) was the issue of homosexuality for men. Homosexual individuals experience an immense pressure to suppress who they are and what they feel in order to avoid being ostracised by other people. Furthermore, when they do find the courage to express themselves, they are often met with disappointment and stigma for not fulfilling their masculine role.

I feel like they have a lot harder time of coming out…the pressure is put on the male to you know carry on the name and if you disappoint as a male then it's probably a lot worse (Sam).

When discussing the gender stereotypes and roles around South African females, some participants (60%) reported that failing to fulfil a feminine role could also predispose women to engage in suicidal behaviour. In particular the female role was seen as one where the woman takes on the role of mother, wife and woman. A woman who did not get married or who did not have children was also viewed in the eyes of the participants as failing to fulfil her mothering role. Some participants cited this as a source of great stress for women and one which could predispose them to engage in suicidal behaviour.

Women are the expected caregivers and if they feel like they're unable to care for their kids or their husbands adequately, they might commit (Eddie).

Women however, were not only considered to have to take on the role of a mother and caregiver, but were also considered to have a new role; one which placed them in the working world as a businesswoman. For some participants, this meant that the expectations and roles that women had to fulfil were greater than for men.

I think women have to deal with a lot more than men have to in their lives in terms of pressure from society not only to be like a successful woman in the world, also though to still retain this like motherly nurturing thing to get married and to have children (Irene).

However, there was also an acknowledgement that the roles of men and women are changing in our society and more women are beginning to challenge the patriarchal notions that are embedded in our understanding of suicide. The end of apartheid in South Africa brought a great deal of change for its people, particularly improving gender equality. Women are considered as equal to men in the country today and this has resulted in the challenge of the gender norms and patriarchy which in many religions and cultures in South Africa are central ideologies. The challenge against patriarchy can become stressful for women as they face constant battles not only in the workplace but also at home, in their cultures and communities.

A woman who is genuinely trying to break the gender mould and kind of take on patriarchy…might become incredibly frustrated to have to fight that kind of battle everyday (Eddie).

This is resulting in the changing role of men as well. Men may find themselves now competing for jobs against women, given that both men and women routinely engage in paid employment. Women are also gaining more power in both the public and private spheres leaving men with contrasting demands. More and more men are now expected to participate more actively in child-care tasks, to be more emotionally accessible and less authoritarian and to share power with their wives. In the context of these competing expectations, attempting to maintain a traditional role as a male inevitably leads to strain and can increase individuals' vulnerability to engage in suicidal behaviour. At the same time this can lead to strain for women as they attempt to adapt to their changing role in society and engage in a power struggle, challenging the traditional norms of patriarchy. One participant highlighted that with the changing roles of women in our society there is now also a greater pressure for women to present themselves and look a particular way. More and more women are unhappy with their physical appearance, striving to reach the heights set by other women who appear in the media.

Women have a lot more worries…about their appearance and how they look and how they're seen by other people, so I think that can often be a thing that leads women to be quite depressed and unhappy with who they are (Alice)

This is also a result of influences from the Western world particularly through the media. Women are currently portrayed as slender, thin and beautiful, an image which many women strive to achieve. These images have reshaped the view on what women should look like and how they should present themselves therefore constructing new norms on what happiness looks like for women. Therefore, women are also currently trying to live up to expectations of how they should look striving to achieve a look which they are happy with and which fulfils the gender stereotype of a woman.

4.5 Conclusion

The participants in this study generally acknowledged the complex nature of suicidal behaviour which was reflective in their perceptions of risk factors. These risk factors predominantly reflected views on social and cultural risk factors for suicidal behaviour, specific to South Africa ignoring the influence of psychopathology. In addition, the participants commented on the influence of the social and cultural context on developing views towards suicide. The participants attributed the different views they held from their

families, religions and communities to their exposure to the social and cultural context around them. While they reported that those around them held negative views towards suicide, they appeared to have a great deal of sympathy and understanding towards those who had attempted or committed suicide, and seemed to denounce the negative views of those around them. In addition, the results indicated that men and women are likely to engage in suicidal behaviour because they cannot fulfil the expectations and pressures of their gendered roles. It is important to integrate and contextualise these findings with relevant literature in order to fully understand the views held by the participants regarding suicidal behaviour. Together with insight into the current trends in the Psychology profession, this will be discussed in the next chapter.

CHAPTER 5

5.1 Discussion

The purpose of this study was to explore the views of young adults towards suicidal behaviour in the South African context. Such research was limited in the South African context and so it was deemed both valuable and necessary to conduct this research. The results of the study indicated that participants understood suicidal behaviour to be multi-factorial, interrelated, and predominantly psycho-social in nature. Interestingly, suicide was not viewed as an individual phenomenon that was understood solely in terms of the psychopathology paradigm, but rather as one that occurred in the interpersonal, social and cultural domain. Furthermore, the influence of the social-cultural environment was deemed to be an important contributing factor to the views held by individuals. Lastly, gendered stereotypes and roles as identified in the general literature were also acknowledged in the present study.

According to Roen, Scourfield and McDermott (2008), young adults focus more on the social nature of suicide because as they engage in the process of becoming adults and negotiate their relationships with their peers and the myriad possibilities of becoming adults, they consistently focus on their socio-cultural context. Therefore, suicide inevitably becomes meaningful to young adults in relation to their socio-cultural context (Roen et al., 2008). Elaborating on this argument, if young adults consistently focus on their socio-cultural environments while they are developing, then perhaps it is plausible to suggest that young adults in South Africa may focus considerably more on socio-cultural factors given the country's recent social transformation after the end of apartheid. The political, economic and social transformation since 1994 impacted on all population groups and filtered through to every facet of life. This has resulted in young adults having to adapt to social changes that are occurring around them. In particular, young adults in South Africa face significantly greater challenges that their counterparts in countries where society is more stable (Steyn, Badenhorst & Kamper, 2010). The extent of these challenges is reported on an almost daily basis in the media including poverty, unemployment, violence, crime and HIV/AIDS. These challenges are faced by all young adults across racial boundaries in South Africa in varying degrees (Steyn et al., 2010).

The predominance of these social issues in everyday life in South Africa make it perhaps unsurprising that young adults in the current study would focus on socio-cultural explanations of suicide as these issues are central to everyday life in the South African context. This

finding has also been documented in the South African literature. For example, Samouilhan and Seabi (2010) conducted a study investigating university students' beliefs about the causes and treatments of mental illness. Their results illustrated that stressful events particularly embedded in the socio-cultural context were identified as the primary causes for mental illness. In particular, the participants saw the broader, potentially damaging social contextual factors in South Africa as leading to the cause of mental illness. In addition to this, a study conducted by Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003), found that most participants in the general population, understood medical disorders to be caused by an exposure to stress related factors. Therefore, psycho-social explanations of suicidal behaviour appear to be at the forefront of young adults understanding of suicidal behaviour in South Africa.

While these studies have emphasised individual psycho-social risk factors, it is the interrelatedness of risk factors mentioned by the participants in the current study, which is imperative towards an understanding of suicide. Ayyash-Abdo (2002) argues that any suicidal outcome is a complex, multidomain, interactive effect of many factors over long periods of time and therefore cannot be explained from an individualistic approach in terms of isolated factors. Mpiana, Marincowitz, Ragavan, and Malete (2004) conducted a study illustrating this, on patients who had attempted suicide in a hospital in the Limpopo Province. The results illustrated that the participants perceived the reasons for their attempted suicide to be a combination of biological factors (e.g. chronic medical and mental health conditions), psychological factors (e.g. adverse emotional reactions including depression, hopelessness and worthlessness) and social factors (e.g. unemployment, financial problems and relationship problems). If an attempt to understand suicidal behaviour in young adults is approached in an eco-systemic way, then the fact that the participants identified interrelated and multi-factorial risk factors is not surprising. Bronfenbrenner's (1977) eco-systemic model does not tend to focus on the young adult as an individual but rather as a result of an interaction among a number of factors including personal, interpersonal and socio-cultural. Therefore, Bronfenbrenner's (1977) model clearly states that individuals' are influenced from multiple systems which may result in the development of integrated views from these different systems. This could then possibly result in multi-factorial views on risk factors of suicide as found in the current study.

Schlebusch et al. (2003) further emphasise the importance of the socio-cultural context. They argue that one of the biggest influences young adults in South Africa face is the increasing influence of First-World forces as post-Apartheid South Africa becomes less

isolated internationally and adopts a Western lifestyle. This process places high expectations on the youth to perform academically, professionally and socio-economically and when they do not do so, it can lead to feelings of despair and hopelessness which can trigger suicidal behaviour (Schlebusch et al., 2003). Roen et al., (2008) also argue that often young adult's emotional distress is not taken seriously and the emotional impact of being 'seen but not heard' can lead to the engagement of suicidal behaviour in order to be heard. Studies investigating young adult's experiences of suicidal feelings suggest that it is the very nature of being young that leads to a lack of meaning and worthlessness. This may be due to the connotations associated with being 'young' which may contribute to a sense of not belonging, not being valued and feeling hopeless ultimately leading to suicidal behaviour (Roen, et al., 2008). Steyn, et al. (2010) further highlight that young adults emerging identities are influenced by their social, political and economic contexts supporting the macro-systemic dimension of Bronfenbrenner's (1977) eco-systemic model. Therefore, the influence of culture on young adults transition to adulthood and with that the development of their identity is of paramount importance. Young adulthood is a time of life with openness to diverse cultural beliefs and behaviours. Often young adults have not settled on particular beliefs and views at this stage and therefore when exposed to local and international cultures, identity confusion may take the form of bouncing between different cultural identities across situations and contexts (Jensen, 2011). Therefore, a young adult's socio-cultural context is important not only for their own development but also for the impact it has on their own views and beliefs.

With international and global influences, there often comes a widening gap between young adults and their parents in terms of experiences, views and beliefs. Wyn and Woodman (2006), argue that a concept of generation locates young adults within a specific set of economic, social, cultural and political conditions. What this means is that young adults today are growing up in a world that is significantly different and is experienced as different from the world in which their parents grew up. Furlong, Woodman and Wyn (2011), argue for example that young adults today are expected to remain in education for longer periods. They no longer expect or do not want a job for life or to see their lives clearly mapped out for them. Health and social policies also require young adults to negotiate forms of support suited to their specific circumstances as they realise that they cannot rely on their parents' experiences (Furlong et al., 2011). As a result of growing up in a specific political, historical and social environment, young adults are often exposed to different situations and have different experiences than their parents had; consequently developing their own sets of

values, beliefs and ideals. The participants in the current study all transitioned as young adults in a post-apartheid South Africa, one with very different political and social policies then when their parents were young adults during the apartheid regime. Therefore, using the concept of a generation, it is plausible to suggest that the participants held different views towards suicide than their parents because they have grown up in a different historical circumstance.

Two other factors which have also continued to influence the development of the young adults, is their exposure to education and with that, their experiences with peers who come from different backgrounds, religions and cultures. In the past, students who attended tertiary education in South Africa were seen as a highly privileged groups heading towards middle class careers (Furlong et al., 2011). This has now changed and with the end of apartheid, tertiary education was transformed from an elite experience to a common experience amongst all races and cultures. This has therefore resulted in an environment which has become much more complex and diverse. Therefore, young adults today increasingly have interactions with peers from diverse cultures and are consequently exposed to a number of different views, beliefs and traditions (Jensen, 2011). This can explain why the participants in the current study denounced the negative views of their religions and families and instead held views of sympathy and compassion towards those who had engaged in suicidal behaviour. Being exposed to diverse views and beliefs placed with a tertiary educational environment, may have resulted in the participants having more knowledge about suicidal behaviour. This could therefore result in open-mindedness towards those who had engaged in suicidal behaviour.

Within the focus of the socio-cultural context, one predominant theme highlighted by the participants was that of religion. Religion has to do with both supernatural beliefs such as believing in Gods and spirits, but it is also a kind of social activity which someone does with other people (Bloom, 2012). This means that religion can influence an individual's view because many of the beliefs associated with religions are associated with communities and people that individual's trust. This means that individual's believe the claims put forward by religion because they trust the sources and accept them on faith (Bloom, 2012). Views towards suicide are quite complex and intertwined with the values and religious perspectives of a person (Osafo et al., 2013). The participants in the current study reported that their religions held strongly negative views towards suicide. Their religions primarily being Christianity and Judaism, condemned suicide and viewed it largely as a breach of God's doctrine confirming the findings in the general literature (Mugisha et al., 2013; Osafo et al.,

2013). The view of suicide as a sin and a taboo subject from a religious perspective is unsurprising given that the majority of religions condemn it (Colucci & Martin, 2008). What is perhaps surprising is how the participants did not completely follow the beliefs of their religion unquestionably, but instead held different views from their religions. It appeared as though because they were influenced on a multi-systemic level by their peers, their educational experience and their socio-cultural context as mentioned above, they held different views towards suicide than their religions.

The influence of religion as a protective factor or a risk factor was also confusing for the participants. On the one hand religion was considered to have a protective effect against suicide as it may discourage young adults from engaging in suicidal behaviour to avoid stigma and negativity (Copeland-Linder, 2006; Ryle, 2007). However on the other hand religion was seen as a risk factor as often religions hold negative or condemning views on topics such as suicide (Colucci & Martin, 2008; Page et al., 2013). This means that religion was considered to be a double bind. If we go with the assumption that individuals trust the beliefs put forward by their religions and then two conflicting views are put forward, this can confuse individuals about what their own views are. For example, religion may increase compassion with religious beliefs and practice increasing one's empathy, care and love. However, on the other hand religious beliefs may also increase one's prejudice and intolerance particularly toward those who are seen as outside of the community (Bloom, 2012). Therefore, individuals may be confused when someone in their community engages in suicidal behaviour as on the one hand their religious beliefs promote compassion and care for that person but on the other hand promotes intolerance for someone who fails to adhere to certain religious beliefs. This can create conflict for an individual on how they should view suicide and consequently how they should react to such an incident. This may therefore explain why religion was viewed by the participants as being both a risk and a protective factor for suicide.

Despite holding negative views about suicide, the participants reported that their families, religions and communities would be motivated to assist someone who had attempted suicide or the family of someone who had committed suicide. This finding is possibly a reflection of the collectivistic society of South Africa. The philosophy of Ubuntu and the principle of caring for others well being and providing support is central to the South African context. However, in particular Ubuntu is the commitment to the core norms of the social ideal and places primary importance on communal interests, obligations and duties over and above the rights of the individual (Nkondo, 2007). Therefore based on this premise,

individuals within families and communities would place other people's well-being or distress before their own beliefs and views. Furthermore, Ubuntu emphasises the need for an individual to be bound to a particular community in which their identity has been constituted (Nkondo, 2007). Therefore, families which belong to certain religions or communities may place heavy emphasis on assisting others or following the principles of Ubuntu because they feel an attachment to that community and this attachment is far greater than their own personal beliefs or views.

In addition, one interesting point observed in the current research was that participants often struggled to distinguish between religion and culture. For most of the participants there was no concrete difference between these two constructs but instead they often viewed religion to be part of their culture. This ambiguity has been discussed in depth by many authors and there still does not seem to be a clear cut definition on whether religion and culture can be considered the same or different constructs. Cohen (2009) however, has proposed one explanation in line with the participant's views. He argues that it is very difficult to define culture because there are many forms of culture. Despite this, there is a general consensus that culture consists of three main characteristics these being: 1) culture emerges in adaptive interactions between humans and environments, 2) culture consists of shared elements and 3) culture is transmitted across time periods and generations (Cohen, 2009). Based on these characteristics Cohen (2009) argues that religion is one kind of culture. This is mainly because religion is marked by different kinds of group affiliations and contains cultural dynamics different from one another. Furthermore, religion is also accountable for a large amount of variation in transmitted norms, values, beliefs and behaviours. These are important cultural influences and can therefore be considered as such (Cohen, 2009).

Lastly, the participants also considered gender to be a socially constructed variable that plays a part in explanations of suicidal behaviour. Rather than being seen as a demographic characteristic, gender was considered to be an inter-dependent variable that impacts on other factors within an individual's eco-system. The concept of gender is a complex one and when it comes to understanding why men are more successful in completing suicide than women are, exploring the social construction of gender in society is fundamental. From a social constructionist lens, gender is something that one does concurrently in interaction with others, and not something that has been ascribed at birth (Payne et al., 2008). Therefore, gender is viewed as dynamic, changing and performative as individuals perform gender based on the gender rules and frames of their culture (Canetto & Cleary, 2012). Furthermore, in this way the social and dynamic nature of gender as well as the way social structures such as

government laws (the macro-system) and norms such as community traditions (the exo-system) shape an individual's gender beliefs and behaviours (Canetto & Cleary, 2012). In this way, men and women's identity, behaviour and the expectations placed on them reflect socially constructed ideas about femininity and masculinity because through performance, gender becomes accountable and assessed by others. This means that certain aspects of gendered identity are normalised (Payne et al., 2008). Men and women are defined as gendered beings while contributing to social conventions of gender. This then encourages conformity to dominant norms of masculinity and femininity (Payne et al., 2008).

The gender differences in making meaning of suicide can therefore be explained by our societies socially constructed ideas about femininity and masculinity. When men do not express emotions, especially distressing emotions as found in the current study, this can be considered a risk factor for suicide (Adinkrah, 2012; Netshiombo & Mashamba, 2012). This has been linked theoretically with the idea that particular constructions of masculinity endanger men's health. In particular, this has been linked with Connell's theory of hegemonic masculinity (Connell & Messerschmidt, 2005). Connell (2002, as cited in Canetto & Cleary, 2012) argues that becoming a man is a process of creative development with different types of local masculinities emerging through every day practices and relationships. These local masculinities compete for power and normative status with hegemonic masculinity referred to as the dominant type. Therefore, when men struggle to live up to this hegemonic ideal they feel shame and inadequacy (Connell, 2002, as cited in Canetto & Cleary, 2012).

Hegemonic forms of masculinity construct men as stoic and invulnerable which constrains them in seeking help for both physical and psychological conditions. Therefore, within this construction of masculinity, admitting to psychological distress presents particular difficulties as it implies weakness and is connected to the feminine domain (Cleary, 2012). As a result of this men tend to underplay emotions and do not report distress therefore allowing stress to build up and create vulnerability for suicidal action (Canetto & Cleary, 2012). On the other hand, women were reported to actively seek social support more often than men do and this has been explained to be as a result of social constructions of femininity (Meehan et al., 2007). In particular, Payne et al. (2008) argued that the traditional female role typically includes characteristics such as fragility, emotionality and expressiveness as well as family orientation. This indicates that it is far more acceptable for women to express emotions and fragility than it is for men to do so as a result of the social constructions our society holds of femininity.

The social practices required for demonstrating femininity and masculinity can also have a profound impact on the choice of method used in suicide as they are associated with access to, acceptability and the intent of a particular method (Payne et al., 2008). Consistent with the general literature, the participants reported that men were more likely to choose more lethal means which would ensure the finality of their act (Burrows et al., 2007; Donson, 2009), and that men were more likely to have access to lethal means including firearms (Biddle, Donovan, Owen-Smith, Potokar, Longson, Hawton, Kapur & Gunnell, 2010). A gendered view of such differences highlights the fact that suicide methods are intricately connected with demonstrations of hegemonic gendered roles. Gender stereotypes dictate that men are expected to be tough and strong meaning that surviving a suicidal act is perceived as inappropriate (Payne et al., 2008). Therefore, lethal suicidal behaviour among men may be seen as an act of masculine expression or as an attempt to escape the negative associations of surviving a suicide attempt (Payne et al., 2008). In terms of the message that an individual intends to relay through the act of suicide, gender differences play a role here too. In choosing less violent methods, women may be seeking be seeking to protect others. In addition, women may choose methods which will not have an effect on their attractiveness. This is consistent with gender differences in image and beauty (Payne et al., 2008).

The ideals of masculinity and in particular hegemonic masculinity can also explain the gendered stereotypes and roles which the participants discussed. In particular, South Africa still remains a strongly patriarchal society. Men remain the chief breadwinners in the family and are placed under a lot of pressure to maintain this status (Netshiombo & Mashamba, 2012). According to Meisenbach (2010), there are three primary social roles associated with masculinity that stem from the male being the breadwinner and these include: 1) being fathers to their wives children, 2) providing for their families and 3) protectors of their wives and children. On the other hand, women take on a more domestic role remaining mothers, housewives and wives. Given that most of these gendered norms are socially constructed, there are expectations for men and women to live up to their gendered stereotypes and roles and when they do not do so, they are often met with feelings of inadequacy making them vulnerable to suicidal action. Furthermore, a loss of power or status, unemployment and retrenchment are terms associated with threats to masculinity. This was supported by Cleary (2012) who reported that unemployment and economic disadvantage can increase the risk of men engaging in substance abuse. The changing role of women in the workplace can also challenge a man's ability to fulfil his role as breadwinner, therefore challenging his masculinity. As women increasingly enter labour markets, they may be viewed by men as

rivals to job security. This can also results in feelings of loss of control or self-esteem among men particularly if men's ideas of masculinity still relate strongly to their occupational role (Payne et al., 2008).

Furthermore, sexual orientation can also be considered a threat to hegemonic masculinity therefore becoming a risk factor for suicide. This is particularly true for gay men as the transgression is more marked for men than for women and the distance between hegemonic masculinity and gay masculinities is greater, therefore constituting more of a threat to mental health (Payne et al., 2008). McAndrew and Warne (2010) conducted a study and found that being gay increased these individuals' risks in engaging with suicide. These young men felt that they had to develop behaviours attributed to their own sex while at the same time resisting to conformity leading to interpersonal and intrapersonal conflict. This then led to a sense of being a failure in terms of meeting the cultural expectations placed on them (McAndrew & Warne, 2010). Failing to live up to gendered expectations and roles can produce feelings of shame, reduced self-esteem, isolation and depression, therefore increasing the risk to engaging in suicidal behaviour (Payne et al., 2008).

The results of the present study indicated that women could engage in suicidal behaviour for one of two reasons: either they were failing to fulfil their gendered role as mother, wife and caregiver, or they were trying to break the gender mould. These two reasons can be considered contradictory risk factors. On the one hand, increasing engagement in paid work has been found to produce benefits including independent access to income, opportunities for self-esteem, increased social support and reduced rates of suicidal behaviour (Payne et al., 2008). However, many women who enter the workplace are doing so in an attempt to break the gender mould. In a patriarchal society, women are often submissive to the dominant males. This in itself can result in increased stress which may lead to the contemplation of engaging in suicidal behaviour. However, this can also result in the desire for women to resist this submissive environment, instead trying to break the gender mould. Wassenaar et al. (1998) argued that the changing roles of women in South Africa may result in conflict amongst women who come from generally submissive cultures. This includes for example, Indian women and may in turn have adverse effects on her emotional functioning ultimately leading to the engagement in suicidal behaviour.

In addition to this, entering the workplace may result in women finding themselves unable to fulfil their gendered roles including those of mother and wife. Niehaus (2012) explored narratives of male and female suicides in the South African lowveld, and found that young women committed suicide when they failed to establish their roles as wives with

supportive husbands, mothers with their own children and the running of their own home. Furthermore, Niehaus (2012) also found that women often engaged in suicidal behaviour when they were trying to escape from violence and patriarchy. Therefore, it is clear that the social construction of gender can explain gender differences in suicidal behaviour, although its impact is complex and beyond the scope of this research to explore in depth.

5.2 Implications of findings for suicide prevention

The findings of the present study provide a number of implications for suicide prevention which need to be mentioned. While South Africa has individual and regional suicide prevention programmes a national suicide prevention programme has not yet been implemented (Schlebusch, 2012). It has been proposed that in order to do this, a range of strategies should be pursued through health care services or directed at the general population. These services should include the partnerships and alliances within communities, professional groups and government sectors (Schlebusch, 2012). While young adults have been identified as the most at-risk group for suicidal behaviour prevention programmes need to be targeted at the general population, not only at this group. This is because as the participants in the current study mentioned, individuals in their social environments hold negative views towards suicide. Therefore, prevention programmes need to be targeted at individual levels, community and social levels as well as national levels.

Firstly, a primary goal of prevention programmes should be to reduce risk factors and promote protective factors. Understanding the reasons why individuals engage in suicidal behaviour may help to identify possible risk factors to assist with the planning of interventions. Given that participants in the present study focused on social and cultural risk factors of suicide, it may be more appropriate for prevention programme in South Africa to focus on psychosocial rather than psychiatric understandings of suicidal behaviour. Since young adults seem to view suicidal behaviour in psychosocial terms, it could also be argued that perhaps they need to be educated about the role mental illness plays in suicide. On the other hand, prevention programmes can utilise the psychosocial nature of suicidal behaviour and instead develop strategies which speak to young adults. This is supported by Schlebusch (2012) who argues that a primary strategy for suicide prevention is the recognition of both pharmacological and psychological risk factors. Creating awareness about the risk factors of suicidal behaviour amongst health professionals and educators can assist with the identification of potential individuals who may be at an increased risk for suicidal behaviour.

Secondly, another primary goal of prevention programmes is to increase support to individuals, families and communities affected by suicidal behaviour. Given that the participants of the present study identified the presence of social support as a protective factor against suicide, there is a need to increase social support particularly to young adults. This can be done through the use of psychological services at university, government counselling services and added health service providers. Given the numerous stressors that a country in transition presents to its youth, such support services are imperative structures which need to be implemented in order to prevent suicidal behaviour. However, even if these support services are implemented negative views and stigma do exist around suicidal behaviour as the participants reported. This means that awareness campaigns aimed at reducing the stigma associated with mental illness will play a vital role in suicide prevention programmes. These awareness campaigns need to be implemented at different structural levels to ensure they reach as much of the population as possible. For example, according to Burrow and Laflamme (2006) interventions targeted at the individual level can include suicide education and screening programmes to benefit all groups and peer support programmes, crisis centres and hotlines.

Thirdly, one area identified by participants as desperately needing attention were the negative views and stigmas held by religious leaders. This means that religious leaders should be trained and educated about risk and protective factors in suicidal behaviour as well as how to reduce stigma towards suicidal persons. Since religious leaders are often trusted and respected, an act of compassion from them towards suicidal people could be instrumental in reducing stigma about suicide. This was supported by Osafo et al. (2013) who argued that education and training on reducing judgemental attitudes and increasing care and compassion should be organised for all religious leaders. Furthermore, the authors argued that religious individuals could be trained to identify warning signs of suicidal behaviour and how to provide first aid before referring the person to a professional mental health provider. In addition, religious leaders can also initiate support groups and social counselling assisting people with handling life's crises so that they do not feel as though they need to engage in suicidal behaviour.

In terms of the gendered stereotypes that the participants held towards suicide, prevention programmes could address men's positions to masculinity and women's positions to femininity and the tension these roles create for them. According to Canetto (2008), for prevention programmes potential dysfunctional cultural beliefs about suicidal behaviour need to be identified and then used to educate others about. The challenge would be how to do this.

Adinkrah (2012) for example highlighted that one solution would be to change gender socialisation patterns. This could be done through agents of socialisation either families or schools who can convey for example to males the benefits of emotional expression for mental and physical well being. This could then promote help-seeking behaviours and using social support systems that have been put in place by promoting counselling as an acceptable option for males (Adinkrah, 2012).

Lastly, it is clear that the views toward suicide held by the participants in this study give ground for optimism regarding suicide preventative efforts. South Africa seems to have a generation of young adults who do not hold the highly negative and condemning views towards suicide that they report older generations to hold. Furthermore, it was clear that these participants understood the value in suicide prevention and viewed it as imperative. This is optimistic for the future of suicide prevention programmes and their implementation.

CHAPTER 6

6.1 Conclusion

The primary aim of this study was to explore the views held by young adults in South Africa towards suicidal behaviour. Given that investigating views towards suicide can provide valuable information to the understanding and conceptualisation of suicide, the contribution of this study was considered crucial to advancing the field of suicide. In addition, the limited research that currently exists in the South African context and the need for context and culture-specific research further highlighted the importance of the current study. Therefore this study not only assisted with gaining knowledge and enhancing our understanding of suicidal behaviour, but it also greatly contributed to the field of suicide prevention.

What clearly emerged from the results of the study was the complex, multi-dimensional and multi-factorial nature of suicide. The study found that young adults understood suicidal behaviour not so much as a symptom of mental illness but rather as a dynamic interrelation between psychological and social risk factors. The identified risk factors appeared to be embedded in the socio-cultural context of South Africa drawing on the political, economic and social changes the country has experienced since the end of apartheid. The impact of the exo-systemic and macro-systemic systems of an individual where further reinforced through the acknowledgment that an individual's views are shaped through those systems. The influence of religion, family, education and culture were all identified as factors which impact on an individual's view point. Furthermore, the participants held views towards suicide which were very sympathetic in nature and contradictory of their families, religions and cultures. While suicidal behaviour was not advocated for by any of the participants, there was a sense of understanding and compassion towards those who were seen as so distressed that they felt the need to engage in suicidal behaviour. On the other hand, the participants reported that their families, religions and cultures held very negative views towards those who engaged in suicidal behaviour which they strongly denounced. What the participants did advocate for however was increased education and stigma reduction so that suicide would no longer remain a taboo subject. This was viewed as crucial by the participants in order to assist those who were in complete states of hopelessness and despair. Lastly, the results of the current study found that men are more likely to engage in suicidal behaviour as a result of the failure to meet the expectations of a dominant hegemonic masculinity in society. This was evident in both the emotional expression and the methods chosen by each gender. These

gender differences were explained by participants in terms of the gender stereotypes and roles that individuals in our society are expected to comply with.

In conclusion, the present study suggests that there are many ways to understand suicidal behaviour. These different ways all need to be considered when trying to comprehend the complexity of suicidal behaviour. Despite the findings of this research, the understanding that young adults have about suicidal behaviour need to continue to be extensively explored. This study has merely attempted to make a start in this regard and to indicate further paths that future research may embark upon to deepen the understanding of suicidal behaviour.

6.2 Limitations

The limitations of the study are important to consider in evaluating the results of the current research. The most notable limitation of the study is the small sample size. While a rich amount of data emerged, only ten participants were interviewed from a single university. Therefore, in terms of diversity, the results of the current study cannot be taken as representative of gender, race, religion and cultural variations in the South African context. Therefore, the results obtained from the interviews of the participants are limited and cannot necessarily be generalised to the general population of young adults in South Africa. Furthermore, participants were subjected to a single interview and therefore this may not have been entirely representative of the complete range of views they held.

An important consideration to also take into account is the role of the researcher in the present study. The researchers aim was to understand the participant's views towards suicide while at the same time being aware that no absolute relationship exists between what the participants expressed and what they had experienced. However, the researcher is the primary interpretative instrument and the process of thematic analysis is highly subjective. Therefore it is important to consider that the researcher's pre-existing knowledge on suicidal behaviour may have influenced the analytic process. Furthermore, it is possible that the researcher's own views on suicidal behaviour and own ideological framework, may have influenced the way she analysed the data.

6.3 Implications for future research

Despite the above limitations, this study provides valuable information which has implications for future research into the field of suicidology. However, it is apparent that more research on this subject is needed as extensive gaps in the literature remain. In particular, in order to overcome the biases in this study's sample, it will be valuable to extend

the cohort in future studies to include young adults from other racial and cultural groups. South Africa is a country rich in diversity, and therefore it is valuable to explore suicidal behaviour within its different cultures and races in order to determine whether there are similarities or differences with regards to suicidal behaviour. While some research in South Africa has focused on suicidal behaviour among Black young adults (Schlebusch et al., 2003; Shilubane et al., 2012), there is a need for more extensive research to be conducted in this group. Schlebusch et al. (2003) argue that South Africa is a society in transformation and Black South Africans appear to be a higher risk group for suicidal behaviour due to acculturation, socio-economic factors and high crime and violence rates. Therefore, the influence of these factors needs to be researched in order to assist with the development of prevention programmes and interventions which can be specifically tailored for vulnerable groups.

Furthermore, given that research has suggested a link between poverty and poor mental health including suicide (e.g. Lund et al., 2010), this indicates that there is a need for research to be conducted in rural or poverty stricken areas. This seems to particularly be the case given that 40% of South Africa's population find themselves in acute poverty conditions (Steyn, et al, 2010). Furthermore, young adults living in rural areas are often faced with a host of other difficulties given the social and cultural context of South Africa including unemployment, a lack of opportunities, supporting families and high crime and violence. In addition Schlebusch et al. (2003) have pointed out that as a result of human rights violation during the Apartheid years, the trauma experience by individuals and communities in South Africa is much deeper than is generally realised. Many people still continue to grapple with the negative consequences of these actions. Therefore, future research should focus on these communities and groups in order to assist with the development and implementation of prevention programmes specifically tailored for these groups.

Lastly, given the psycho-social nature of the identified risk factors and causes of suicidal behaviour, extensive research needs to be further conducted in this field in order to further establish the influence of social and cultural determinants on young adults in South Africa. Furthermore, this research needs to be focused on exploring the interrelation of factors and their influence rather than focussing on one risk factor at a time. This will also assist with the development of theoretical and conceptual frameworks in understanding suicide in South Africa as well as provide guidelines for the development and implementation of interventions and prevention programmes.

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APPENDIX A: ETHICS APPROVAL

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Student Number: 692199

MS A RONTIRIS
P O Box 786315
Sandton
2146

9 May 2012

Dear Ms Rontiris

APPROVAL OF PROPOSAL FOR THE DEGREE OF MASTER OF ARTS BY COURSEWORK AND RESEARCH REPORT IN COMMUNITY BASED COUNSELLING PSYCHOLOGY

I am pleased to be able to advise you that the readers of the Graduate Studies Committee have approved your proposal entitled "*Investigating young adults' views about suicidal behaviour: Does culture matter?*". I confirm that Dr V Jithoo has been appointed as your supervisor in the Psychology Department.

The research report is normally submitted to the Faculty Office by 15 February, if you have started the beginning of the year, and for mid-year the deadline is 31 July. All students are required to RE-REGISTER at the beginning of each year.

You are required to submit 2 bound copies and one unbound copy plus 1 CD in pdf (Adobe) format of your research report to the Faculty Office. The 2 bound copies go to the examiners and are retained by them and the unbound copy is retained by the Faculty Office as back up.

Please note that should you miss the deadline of 15 February or 31 July you will be required to submit an application for extension of time and register for the research report extension. Any candidate who misses the deadline of 15 February will be charged fees for the research report extension.

Kindly keep us informed of any changes of address during the year.

Note: All MA and PhD candidates who intend graduating shortly must meet your ETD requirements at least 6 weeks after your supervisor has received the examiners reports. **A student must remain registered at the Faculty Office until completion of degree.**

Yours sincerely

JA Poyser

Julie Poyser
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APPENDIX B: INTERVIEW GUIDE

What do you understand by suicide?

What do you think motivates suicidal behaviour?

How does your culture view suicide?

What do think are common ways in which suicide is attempted and what are the reasons for this?

How does your religion view suicidal behaviour and death by suicide?

Why do you think males engage in suicidal behaviour?

Why do you think females engage in suicidal behaviour?

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APPENDIX C: PARTICIPANT INFORMATION SHEET

Hi,

My name is Anastasia Rontiris and I am currently a student enrolled for the Masters in Community-Based Counselling Psychology degree at the University of the Witwatersrand. For the purpose of obtaining my degree, I am conducting research on young adults' views on suicidal behaviour. I am interested in investigating what individuals understand by suicide, what they see as the motives for suicidal behaviour, if culture influences these views, the role of religion and the role of gender.

I would like to invite you to participate in this study. Taking part in the study is voluntary. Should you decide to take part in the study, you will be interviewed by me at a time and place that is convenient for you for approximately one hour. You may refuse to answer any questions you would prefer not to and you may choose to withdraw at any point. There are no direct risks or benefits for participating in the study. Should any of the questions elicit emotional responses in you, feel free to make use of the free counselling services listed below.

With your permission the interview will be recorded and transcribed and my supervisor and I will be the only people who will be allowed to access the interview material. This material will be safe guarded to ensure no unauthorised access. The interview material will be kept electronically under password protection so that only the researcher will have access to for the duration of two years. Hard copies will be kept in storage under lock and key for two years should publication arise or for five years if not published and will then be destroyed.

The interview material will be shared with my supervisor therefore limiting confidentiality. However, your identity will be protected as I will use a code in place of your name and remove any identifying information. Your anonymity will be respected in the research report and while quotes may be used from the interview there will be no identifying

information. If you are interested in the findings of the research you can contact me using the details provided below and I will provide you with an executive summary of findings. The results of the research will be written up as a research report and the final report may also be published in a journal article.

If you are willing to participate in the study please contact me telephonically or by email. We will then arrange a meeting to conduct the interview at a time and place that suits you. If you have any additional questions about the study please feel free to contact me or my research supervisor.

Kind regards

Anastasia Rontiris
Tel. 073 154 6021
Email: stacey.rontiris@gmail.com

Research Supervisor: Dr. Vinitha Jithoo
Tel: 011 717 4522
Email: vinitha.jithoo@wits.ac.za

If after participating in this study you would like to access counselling services, please contact either of the following:

- Emthonjeni Centre: 011 717 4513
- Counselling and Careers Development Unit: 011 717 9140
- South African Depression and Anxiety Group: 011 262 6396

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

APPENDIX D: PARTICIPANT CONSENT FORM

I, _____, have read the Participant Information Sheet and give my permission to participate in this research study. I understand that:

- Participation in this study is voluntary.
- I do not have to answer any questions I do not want to.
- I may withdraw from the study at any time with no consequences.
- My identity will be protected.
- The interview material will be shared with the researcher's supervisor.
- There are no direct risks or benefits in participating in this study.

Signed:_____

Date:_____

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

APPENDIX E: CONSENT TO RECORD AND TRANSCRIBE INTERVIEW

I, _____, have read the Participant Information Sheet and give my permission to have my interview recorded and transcribed. I understand that:

- The interview material will be kept confidential and my identity will be protected.
- The interview material will only be processed by the researcher and will only be available to the researcher and the supervisor.
- The interview material will be stored in a safe location by the researcher for two years should publication arise or for five years if not published and will thereafter be destroyed.

Signed:_____

Date:_____

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

APPENDIX F: CONSENT TO USE DIRECT QUOTES

I,_____, have read the Participant Information Sheet and give my permission to use direct quotes from my interview in the final report. I understand that:

- All identifying personal information will be removed.

Signed:_____

Date:_____