

THE PSYCHOLOGICAL FUNCTIONING OF PATIENTS ADMITTED TO A RURAL
WESTERN CAPE HOSPITAL FOLLOWING AN EPISODE OF NON-FATAL SUICIDAL
BEHAVIOUR: STRESS, COPING AND PERCEIVED SOCIAL SUPPORT

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**Thesis presented in fulfilment of the requirements for the degree of Masters of Arts
(Psychology) at Stellenbosch University**



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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own original work, and that I am the authorship owner thereof (unless to the extent explicitly stated), and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Suicide is one of the leading causes of death worldwide and is associated with feelings of depression, anxiety and hopelessness, as well as ineffective coping strategies and perceived lack of social support. The data from interviews conducted with 34 patients admitted to a rural Western Cape hospital following an episode of non-fatal suicidal behaviour, was used for this study. The study set out to examine the relationship between stress; determined by depressive symptoms, symptoms of anxiety, and symptoms of hopelessness; and various coping strategies; as well as the relationship between stress, coping and perceived social support. Furthermore, the study aimed to determine whether these relationships offered insight into the roles of coping strategies and social appraisal, and whether these should be addressed in intervention and prevention programmes.

Quantitative research was conducted by means of interviewer-administered questionnaires. The results indicate a significant positive relationship between symptoms of depression and anxiety; followed by a significant positive relationship between symptoms of depression and hopelessness; symptoms of anxiety and hopelessness; and symptoms of depression and avoidant coping. The results showed a significant negative correlation between symptoms of depression and social support-seeking coping, and between social support appraisal and anxiety. Hopelessness emerged as a positive predictor of depression. In addition, social support-seeking coping was positively correlated with social support appraisal, which in turn has emerged as a significant negative predictor of stress (symptoms of depression and anxiety).

Possible support for Lazarus and Folkman's stress-coping model and Farberow and Shneidman's communication theory was established and inferences were made for possible intervention and prevention programmes. It is recommended that further research includes

longitudinal studies in order to gain a better understanding of the potentially changing nature of the underlying psychological functioning of patients following an episode of non-fatal suicidal behaviour.

OPSOMMING

Selfmoord is een van die hoof oorsake van sterftes wêreldwyd en word geassosieer met gevoelens van depressie, angstigheid en hopeloosheid, asook oneffektiewe hanteringsstrategieë en 'n tekort aan sosiale ondersteuning. Die data wat voortgespruit het uit die vraelyste van 34 pasiënte, opgeneem in 'n landelike Wes-Kaapse hospitaal weens nie-noodlottige selfmoordgedrag was gebruik vir hierdie studie. Die studie het gepoog om die verhouding te ondersoek tussen stres; insluitend simptome van depressie, simptome van angstigheid en simptome hopeloosheid; en verskeie hanteringsstrategieë; sowel as die verhouding tussen stres, hanteringsstrategieë en die ervaring van sosiale ondersteuning. Verder het die studie gepoog om vas te stel of hierdie verhoudings insig bied in die rolle van hanteringsstrategieë en sosiale ondersteuning, en of dit moet aangespreek word in intervensie- en voorkomingsprogramme.

Kwantitatiewe navorsing was uitgevoer deur middel van onderhoudvoerdergeadministreerde vraelyste. Die resultate dui op 'n beduidend positiewe korrelasie tussen depressie en angstigheid, gevolg deur 'n beduidend positiewe verhouding tussen simptome van depressie en hopeloosheid; simptome van angstigheid en hopeloosheid; asook simptome van depressie en vermydingsomgaan. Die resultate dui ook op 'n beduidend negatiewe korrelasie tussen simptome van depressie en sosiale ondersteuningsoekende omgaan, asook tussen vermeende sosiale ondersteuning en simptome van angstigheid. Hopeloosheid het as 'n beduidend positiewe voorspeller van depressie na vore gekom. Verder was daar 'n beduidende positiewe korrelasie tussen sosiale ondersteuning-soekende omgaan en sosiale ondersteuning, wat weer om die beurt as 'n beduidende negatiewe voorspeller van stres (simptome van depressie en angstigheid) na vore gekom het.

Moontlike ondersteuning vir Lazarus en Folkman se stres-hanteringsmodel en Farberow en Shneidman se kommunikasie teorie was gevind en afleidings was gemaak vir

moontlike intervensie- en voorkomingsprogramme. 'n Aanbeveling vir verdere navorsing, insluitende langtermyn studies, ten einde 'n beter verstaan te ontwikkel van die moontlike veranderende natuur van die onderliggende sielkundige funksionering van pasiënte na 'n episode van nie-noodlottige selfmoordgedrag.

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CHAPTER 1

Introduction

1.1 Introduction: Problem statement and focus

Globally, suicidal behaviour and related mental health have been widely researched and statistics suggest that variation exists between countries in terms of suicidal tendencies (Baumann et al., 2010; Beautrais, 2006; Beck et al., 1989; Beekrum et al., 2011; Bertolote et al., 2010; Blaauw & Kraaij, 1997; Brown et al., 2000; Gonzalez, 2012; Huisman et al., 2010; Ivanoff & Jang, 1991; Kerkhof et al., 1995; Klonsky et al., 2013; Lakeman & Fitzgerald, 2009; Ottino, 1999; Sarfati et al., 2003; Steer et al., 1993; Van Orden, 2011; Yip, 1998; You et al., 2011). Most research has focused on suicidal behaviour, suicide prevention, and the ethical considerations to be taken into account when researching suicide, as well as the role of hopelessness as a predictor of suicidal tendencies. According to the World Health Organization (WHO), an estimated 800,000 individuals commit suicide annually. The WHO also indicated that in 2016, suicide was considered the second leading cause of death for individuals between the ages of 15 and 29 (WHO, 2018).

In Africa, research on non-fatal suicidal behaviour is relatively limited, with the existing research focusing mainly on the characteristics of suicidal behaviour and the societal views of suicidal behaviour (Adinkrah, 2011; Hjelmeland et al., 2008a). Notably, however, the surge of research on the subject in the past decade suggests that suicide and suicidal behaviour are increasingly receiving attention, particularly in the South African context where much research has been conducted on the broad concept of non-fatal suicidal behaviour (e.g., Africa & Scale, 2005; Beekrum et al., 2011; Moosa et al., 2005; Pillay & Wassenaar, 1997; Pillay et al., 2004; Schlebusch et al., 2003; Taljaard, 2013; Van Renen & Wild, 2008). The main research themes covered in these studies are recent stressors as possible triggers for non-fatal suicide behaviour,

demographical variance and the role of familial conflict (Africa & Scale, 2005; Beekrum et al., 2011; Pillay & Wassenaar, 1997).

While the subject of non-fatal suicidal behaviour seems to have generated interest both on the African continent and specifically in South Africa, the psychological functioning of patients admitted to South Africa's rural hospitals following an episode of non-fatal suicidal behaviour, and particularly in the Western Cape, remains an under-researched terrain. Research on this area is central to the deepening of understanding and promotion of mental health of those at risk of engaging in suicidal behaviour. One of the few South African studies focusing on non-fatal suicidal behaviour within the hospital context was conducted by Du Toit, Kruger, Swiegers, van der Merwe and Calitz (2008) at Pelonomi hospital in the Free State province. The study focused on the profile analysis of patients admitted to hospital following an episode of non-fatal suicidal behaviour. No previous study of note has focused on the psychological functioning of patients admitted to hospital for non-fatal suicide behaviour in South Africa, at least not in the rural Western Cape context. This factor renders this study even more warranted.

The primary aim of the present study was to investigate the psychological functioning of patients admitted to a public hospital following an episode of non-fatal suicidal behaviour. Particular focus was given to the inter-connected relationships between stress, coping and the perceived social support of these patients.

1.2 Research rationale

During my time as a voluntary Registered Counsellor at a rural Western Cape Hospital ██████████ in 2010, I noticed that a vast number of patients are admitted for non-fatal suicidal behaviour. This raised the question as to why there is such a high rate of patients admitted to hospital following an episode of non-fatal suicidal behaviour and what is being

done to understand the psychological factors and psychological functioning that lead to suicide?

Initial research on the topic indicated that high and rising suicide statistics call for urgent scholarly attention to this topic. According to Bantjes and Kagee (2013), accurate statistics on suicide are very difficult to obtain due to a lack of reliability in the data reported by the Mortuary Surveillance Systems, as well as misreporting on causes of death, however, they do offer some indication of the prevalence of suicidal behaviour. A study by Mayosi et al. published in 2009, found that, in South Africa, 10% of all injury deaths are as a result of suicide. The same study reported the number of deaths per year for suicide to be between 5,514 and 7,582, whereas non-fatal suicide rates indicated between 110, 280 and 151, 646 reported cases.

Meel and Leenaarsa (in Bantjes & Kagee, 2013) reported South African suicide statistics to be 13.25 suicides per 100,000 individuals, while the predominantly rural- and poverty-stricken former Transkei region had an average suicide rate of 32.5 per 100,000 individuals over a 5 year period. While these statistics indicate the increased prevalence of suicide in the rural communities of the Eastern Cape, the same is not known for the rural Western Cape. This difference, however, suggests that specific and/or comparative urban-rural research deserves more attention. The current study sought to contribute to the wealth of academic knowledge on suicidal behaviour within the rural context.

It is difficult to draw conclusions on the psychological state of suicide victims, because they are no longer alive to provide information. The survivors of episodes of non-fatal suicidal behaviour, however, are valuable sources of information. Given that non-fatal suicidal behaviour is considered to be the strongest indicator of suicide risk (WHO, 2014), individuals who have engaged in this type of behaviour are able to give researchers a better understanding of the thought processes and psychological functioning of suicidal individuals.

While previous research has focused more on the societal and psychological influences that lead to suicidal behaviour, research on the psychological functioning, in particular psychological functioning in relation to coping strategies (in response to these influences) and social appraisal, remains limited, especially within the South African context. In response to Lazarus and Folkman's stress-coping model, this study sought to investigate whether a study of the psychological functioning of patients, could provide new insights that would contribute to the broader research and clinical environment, especially in the application of intervention and prevention programmes.

Given that suicidal thought and behaviour constitute a global public health crisis (United Nations, 1996), and that research on this subject should be at the forefront of the broader promotion of mental health (see Bantjes & Kagee, 2013), the study of patients admitted to hospital following an episode of non-fatal suicidal behaviour should be seen as part of this larger mental health research agenda.

The current study sought to gain insights into the underlying psychological factors and psychological functioning of individuals following an episode of non-fatal suicidal behaviour. Specific questions that the present research sought to have answered included the following:

1. What is the demographic profile of the individuals admitted to the rural Western Cape hospital of [REDACTED] following an episode of non-fatal suicide behaviour?
2. What are their stress (symptoms of depression, anxiety and hopelessness) levels, and which coping strategies are predominantly used to deal with the stress?
3. What is the nature of the statistical relationship between stress, coping, and perceived social support?

1.2.1 Research aims and objectives

The primary aim of the study was to investigate the nature of the psychological functioning of patients admitted to a rural Western Cape Hospital following an episode of non-fatal suicidal behaviour. To achieve this aim, the study had the following set of objectives:

1.2.1.1 To quantify (measure) stress levels (symptoms of depression, anxiety and hopelessness).

1.2.1.2 To determine which of the three coping strategies (problem-solving, support seeking or avoidance) have been used by the sample of patients admitted to a rural Western Cape Hospital following an episode of non-fatal suicidal behaviour.

1.2.1.3 To examine the nature of the statistical relationship between stress and the coping strategies used.

1.2.1.4 To ascertain the nature of the statistical relationship between stress and perceived social support.

1.2.1.5 To determine if perceived social support emerges as a significant predictor of any of the two stress indicators (symptoms of depression and anxiety).

1.2.1.6 To ascertain if hopelessness emerges as a significant predictor of any of the two stress indicators (symptoms of depression and anxiety).

1.2.1.7 To ascertain which of the three coping strategies (problem-solving, social support-seeking or avoidant) predict perceived social support.

1.2.2 Research Hypotheses

The proposed study tested ten hypotheses:

1. There will be a significant positive correlation between symptoms of anxiety and hopelessness.
2. There will be a significant positive correlation between symptoms of depression and avoidant coping.
3. There will be a significant negative correlation between symptoms of depression and social support-seeking coping as well as problem-solving coping.
4. There will be a significant negative correlation between social support appraisal and symptoms of anxiety.
5. Hopelessness will emerge as a significant positive predictor of symptoms of depression.
6. Social support appraisal will emerge as a significant negative predictor of stress (symptoms of depression and anxiety);
7. Problem-solving coping will emerge as a significant negative predictor of stress (symptoms of depression and anxiety);
8. Problem-solving coping will emerge as a significant positive predictor of social support appraisal.

1.3 Operational definitions of main concepts

In order to assist in the reading and understanding of the present study, defining of the key concepts is warranted. The concepts discussed here include fatal suicidal behaviour, non-fatal suicidal behaviour, fatal self-injurious behaviour, non-fatal self-injurious behaviour, stress, coping and perceived social support.

1.3.1 Suicidal behaviour

The evolution of the classification methods for suicidal and self-injurious behaviour has played an important role in ensuring accurate representation of statistics. Initial classification models lacked uniformity and clarity in definition, and showed little regard for intent or outcome, which led to the misrepresentation of data in many cases (Nock, 2014). Consequently, establishing intent and outcome is crucial for accurate classification of suicidal behaviour.

For the purpose of this study, it is important to make four distinctions in behaviour pertaining to suicide and self-injury, namely fatal suicidal behaviour, non-fatal suicidal behaviour, fatal self-injurious behaviour, and non-fatal self-injurious behaviour. As defined by Nock (2014), a *fatal suicidal behaviour* is an act of self-injury with the intent and outcome of death; *non-fatal suicidal behaviour* is an act of self-injury with the intention, at least in part, to die with the believed potential of resulting in death, but does not result in death; *fatal self-injurious behaviour* is an act of self-harm without the intention of death, but with the outcome of death; and lastly, *non-fatal self-injurious behaviour* is the act of self-harm without the intent or outcome of death.

Even though the classification of these behaviour keep evolving, many challenges still arise when defining suicidal and self-injurious behaviour. One of the challenges that arise when trying to establish intent, specifically when attempting to distinguishing between fatal suicidal behaviour and fatal self-harm, is that the victim is no longer alive to account for the intention of their actions. It is thus often not possible to determine whether the victim's death was deliberate (i.e. fatal suicidal behaviour) or as a result of the severity of injuries sustained during an episode of self-harm (i.e. fatal self-injurious behaviour) (Nock, 2014).

Another challenge associated with determining intent is the inference of the victim's intent. Firstly, it is possible that the victim denies the intent to die, but perceives the severity

of their actions as having the possibility of resulting in death. Secondly, the inference of an episode of non-fatal suicidal behaviour can also be made when there is no other possible explanation to the victim's actions (Nock, 2014).

Defining and classifying of suicidal behaviour remains an iterative process. However, intent and outcome pervade the most current efforts to assess and define suicidal behaviour more uniformly and reliably (Nock, 2014).

1.3.2 Stress

For the purpose of this study, the term stress is used to describe symptoms of depression and anxiety, which are widely documented in literature as indicators of stress (Carver & Scheier, 1994; Folkman et al., 1986a; Monat & Lazarus, 1991; Rutter et al., 2013), and symptoms of hopelessness, as a predictor of stress. Symptoms of depression includes feelings of unhappiness, anhedonia, despondency and a lack of interest or involvement in daily activities (Cunningham, 2006). Folkman, Lazarus, Gruen and DeLongis (1986b) define stress as the relationship between the individual and the environment; where the environment is perceived as taxing or possibly exceeding the individual's resources with the consequent risk of endangering personal well-being. Lazarus and Folkman (1984) also suggest that when belief is lost, hopelessness emerges, which includes feelings of discouragement and a negative attitude towards the future. Symptoms of anxiety can be described by feelings of excessive worrying, anxiousness, muscle tension and restlessness (Donegan & Dugas, 2012). Feelings of depression, anxiety and hopelessness have been reported to be associated with suicidal behaviour (O'Connor & Sheehy, 2001; Steer et al., 1993).

1.3.3 Coping

Coping, as defined by Lazarus and Folkman (1984), is the continuous attempts by the individual to manage internal and external demands, conflict, or stressors in specific situations by means of cognition and behaviour. Consequently, it is an active attempt by the individual to engage with a distressing situation to eliminate potential danger.

Emphasizing the notion that coping is predicated on the extent to which the stressor and problem that stands to be managed, gets appraised and evaluated, Folkman et al. (1986b), have gone as far as distinguishing between what they term the *primary* and *secondary* appraisal – which they argue is central to coping. Primary appraisal refers to the individual's assessment of what he or she stands to lose or gain in a specific situation – in other words, determining the extent to which the individual will be affected by the stressor. In contrast, secondary appraisal refers to the individual's assessment of a stressor in order to find a solution to overcome or improve the situation (Folkman et al., 1986b).

1.3.4 Perceived social support

According to Vaux et al. (1986), perceived social support refers to the individual's perception of the support he or she is receiving from family members, friends and unspecified significant others. Cohen and Wills (1985) explain that there is a significant positive relationship between social support and well-being; with a lack of positive social support negatively influencing the individual's psychological well-being – a factor that may lead to stress, notably, feelings of anxiety and depression. Many studies have indicated that the mere perception of available social support can positively influence an individual's health and mood (Cobb, 1976; Cohen & Hoberman, 1983; Kleiman & Riskind, 2013; Nasser & Overholser, 2005). Moreover, perceived social support may also discourage individuals from suicide ideation or behaviour triggered by impulsivity and stressful life events (Kleiman & Riskind, 2013).

1.4 Chapter overview

This chapter provided an overview of non-fatal suicidal behaviour with relation to stress, coping and perceived social support. The motivation for the study was clarified and the main operational definitions were introduced. The subsequent chapters will be set out as follows: Chapter 2 is a review of available literature, with specific focus on Global, African and South African perspectives on non-fatal suicidal behaviour, stress, coping and perceived social support. In Chapter 3 the methodology used in the study is discussed, including the research design, sampling and participants, measuring instruments, reliability, data collection and analyses, as well as ethical considerations. In Chapter 4 the data analysis and research findings are presented. Finally, Chapter 5 offers a discussion of the research findings, strengths and limitations of the study, as well as recommendations for future studies and concluding remarks.

CHAPTER 2

Literature Review

2.1 A Global perspective

Suicide is considered one of the leading causes of death worldwide (WHO, 2012). The World Health Organization (WHO) reported in 2016 that one suicide is committed worldwide every 40 seconds, while an attempt at suicide is made every 3 seconds. Suicide mortality statistics reveal a global average of 10.5 suicides per 100,000 individuals (WHO, 2016). These alarming statistics are not the only cause for concern, global statistics on suicide also show a gradual annual increase. One study found an increase from an estimated 782,000 in 2008 to an estimated 804,000 in 2012 (Jiménez-Treviño et al., 2015), while the WHO suggests that the prevalence of suicide has increased by 60% over the last 45 years. Research also reveals that the prevalence rate of non-fatal suicidal behaviour is 20 times higher than completed suicides and that low-income to middle-income countries contribute up to 79% of global suicides (WHO, 2016).

Non-fatal suicidal behaviour is considered to be the strongest indicator of suicide risk (WHO, 2014). It is reported that 15–30% of suicides were preceded by an episode of non-fatal suicidal behaviour in the preceding year (Karasouli et al., 2015). Risk factors associated with repeated episodes of non-fatal suicidal behaviour include depression (Goldney, 2000; Kerkhof, 2000; O'Connor & Sheehy, 2001; Reynolds & Eaton, 1986), hopelessness (O'Connor & Sheehy, 2001; Reynolds & Eaton, 1986), unemployment (Ogbuanu, 2014), poverty (Holtman et al., 2011; Ogbuanu, 2014), social isolation (Luxton et al., 2013), conflicting familial relations (Holtman et al., 2011) and traumatic experiences (Goldney, 2000; Kerkhof, 2000).

Suicides and episodes of non-fatal suicidal behaviour do not merely occur, they are the end result of a psychological process (Zubin, 1974). Suicide is caused by immense psychological distress (O'Connor & Sheehy, 2001) and is a means of avoiding or escaping the unbearable psychological pain the individual experiences. It is considered the ultimate escape from painful self-awareness (Baumeister, 1990).

Many factors, such as depression and traumatic experiences (Goldney, 2000; Kerkhof, 2000), can be considered influential in this process. Depressed mood, often associated with a sense of hopelessness, is one of the most prominent aspects of non-fatal suicidal behaviour (O'Connor & Sheehy, 2001). A study conducted by Steer, Kumar and Beck (1993) reported that people who engage in non-fatal suicidal behaviour experience constant feelings of hopelessness and depression. Ayub (2009) argues that suicidal individuals often feel hopeless about the future, have negative expectations and cannot foresee any conceivable positive outcome or hope for the future. The central aspects of hopelessness - negative thoughts or reflection on past failures, feelings of worthlessness and a negative self-evaluation - are associated with increased feelings of depression (Clark et al., 1990). Interestingly, the extent to which an individual experiences hopelessness is more highly correlated with suicidal ideation, the intensity of the suicidal intent, and the eventual act of, or attempt at, suicide than depression (Beck et al., 1985, 1993; Bedrozian & Beck, 1979; Wetzel et al., 1980). This supports the finding by Brown, Beck, Steer and Grisham (2000) that severely hopeless individuals are at a significantly increased risk of eventually reverting to suicide, as the hopeless individual is less likely to seek any alternatives to suicide in times of desperation or crisis. It could be that hopelessness cuts across depression and worry to such an extent that hopeless individuals find thinking about ending their lives as the only possible or available 'escape' from misery. It is noteworthy that many studies have indicated that the correlation between suicidality and depression is due to the influence of hopelessness (Emery et al., 1981; Minkoff et al., 1973;

Weissman et al., 1979; Wetzel et al., 1980), as hopelessness results in the prospects for the future being experienced as bleak.

Maris (1991) reported on suicidality within the depressive cycle, and indicated that episodes of non-fatal suicidal behaviours are more prevalent in individuals coming out of a depressed episode rather than those who are still in the midst of an episode. O'Connor and Sheehy (2001) have argued that this phenomenon occurs because as depressive symptoms are subsiding, individuals are often left with feelings of motivation and energy, which in turn give them the energy needed to follow-through with an attempt to end their lives.

Steer, Kumar and Beck (1993) reported strong associations between anxiety and depression. A debilitating state of worry could be a compounding factor in the enduring state of emotional dejection that suicidal individuals experience (McDowell et al., 2011). Whether this worry should be considered serious or intense enough to play a role in the individual engaging in non-fatal suicidal behaviour remains unclear.

The presence of depression coupled with other psychosocial risk factors (e.g. social isolation, poverty or substance abuse) increase suicide risk (O'Connor & Sheehy, 2001). It is important to understand suicidal behaviour within the social environment in which it occurs. Research conducted by Bilici et al. (2002) in Turkey, for example, highlighted the influence of religion in how suicidal ideation and suicidal attempts are experienced. Suicidal ideation can increase feelings of guilt and isolation. In a conventional religious sense, suicide and thoughts about it are viewed as “bad” or “sinful”. Discussions about suicide tend to be avoided (with matters of life and death understood as regulated by a divine, supernatural power), and are usually spoken of in ‘hushed’ tones, and often involve challenge in relation to the concept of the afterlife. This results in suicidal individuals internalising their feelings and thoughts about committing suicide. Because of the religious condemnation of suicidal behaviour, the individual

isolates himself or herself out of fear of being rejected socially. This can increase feelings of depression and hopelessness, which can ultimately lead to suicidal behaviour.

Social isolation in individuals with heightened emotional vulnerability, coupled with diminished perceptions of social support received from significant others, is documented as an attributable factor to suicidal thought and behaviour (Maris et al., 2000). Notably, Chehil and Kutcher (2012) reported that perceptions of loss of social support can trigger suicidal ideation or behaviour. These authors also categorised factors influencing suicidal risk as either lower risk, higher risk or increased suicide risk. According to this perspective, stable relationships and positive social support are regarded as lower risk factors; while social isolation, conflicted relationships and unemployment are considered higher risk factors; and lastly, family discord and a lack of social support are regarded as increased-suicide risk factors (Chehil & Kutcher, 2012) - clearly indicating the predictive power of social support on emotional well-being. Against this background, and given that diminished perceptions of social support are considered to be among the highest risk factors influencing non-fatal suicidal behaviour (Chehil & Kutcher, 2012), it would be worth investigating the social support appraisals of patients admitted to a Western Cape rural hospital following attempted suicide.

Another aspect that is critical in the understanding of suicidal thought and behaviour is the means by which suicide was attempted. Chien, Lai, Chung, Pai and Chang (2013) conducted a study in China, and suggest that establishing how serious an individual is about intending to die can be measured by the method used to engage in non-fatal suicidal behaviour. To this effect, a distinction has been made between the *invasive* and *non-invasive* methods of suicide or episode of non-fatal suicidal behaviour. Invasive measures include methods that inflict more pain on the individual such as shooting, hanging, burning, falling and stabbing, while non-invasive measures that inflict less pain include overdosing and inhalation of toxic substances

(Card, 1974). Accordingly, more invasive methods increase the probability of dying, because of the magnitude with, and the ‘invasive’ nature in which the suicidal behaviour is enacted. In contrast to the invasive methods, it could be argued that individuals opting for less invasive measures (given the diminished probability of dying) were less certain as to whether or not they actually wanted to die, and may have used this attempt at suicide as a means of conveying their emotional distress. The concept of suicidal behaviour as a means of communicating distress (also interpreted as a symbolic cry for help) was introduced in Farberow and Shneidman’s (1961) Communication Theory. This theory, as is further discussed in the theoretical framework section of this study, is premised on the idea that suicide is the communication device for an outward expression of inward pain or discomfort. Many lack the verbal ability to express their unhappiness, and engage in non-fatal suicidal behaviour as a means of conveying their distress. Farberow and Shneidman, also argue that suicidal communication coupled with the sympathetic understanding and appraisal of a loved one often inhibits any self-destructive tendencies.

Factors cited as attributable to non-fatal suicidal behaviour include symptoms of depression (Steer et al., 1993), symptoms of hopelessness (Holtman et al., 2011; Ivanoff & Jang, 1991), symptoms of anxiety (Steer et al., 1993), maladaptive coping mechanisms (Holtman et al., 2011), and a general lack of social support (You et al., 2011). While the subject of the underlying psychological experiences and functioning of individuals who attempt suicide ranks as one of the most researched topics worldwide to date, most of the research on the subject of non-fatal suicidal behaviour has been undertaken in Western countries, with limited research coming out of the African continent in general, and out of South Africa, in particular. The next two sections focus on the African and South African perspectives, respectively – with specific focus on research trends on non-fatal suicidal behaviour, statistics on suicide and societal influences.

2.2 An African perspective

A global suicide report published by the WHO indicated a 38% increase in suicide rates in low-income and middle-income countries in the African region. The report indicated an average suicide mortality rate of 8.8 per 100,000 individuals for the African population, which can be considered low when compared to the global average of 10.7 per 100,000 individuals (WHO, 2015). However, as reported by Bertolote and Fleischmann (2009), many of the underdeveloped countries (mostly in Africa) do not produce accurate representation of mortality statistics as they do not have the necessary structures in place to capture and process suicide data accurately – possibly resulting in the underreporting of suicide rates. Moreover, some countries only rely on hospital-based statistics, which could inaccurately reflect a lower incidence of suicidal tendencies as many individuals attempting or committing suicide might not be hospitalised, and will therefore not be represented in the data. Consequently, one needs to take the above-mentioned factors into account when analysing African suicide statistics.

As indicated, limited research on non-fatal suicidal behaviour has been undertaken in Africa, with research on this subject having been conducted in countries including Egypt (Okasha & Lotaif, 1979), Ethiopia (Alem et al., 1999; Bekry, 1999; Kebede & Ketsela, 1993), Ghana (Adinkrah, 2011; Hjelmeland et al., 2008a), Kenya (Sindiga & Lukhando, 1993), Nigeria (Eferakeya, 1984; Nwosu & Odesanmi, 2011), Uganda (Hjelmeland et al., 2008a; Kinyanda et al., 2004, 2011; Ovuga, 2005; Ovuga et al., 2007), Zimbabwe (Gelfand, 1976; Williams & Buchan, 1981), and South Africa (Bantjes & Kagee, 2013; Bantjes & Swartz, 2017; Bantjes et al., 2017; Schlebusch, 2005b; Schlebusch et al., 2003).

African literature on non-fatal suicidal behaviour indicates variance between countries in terms of gender (Schlebusch & Burrows, 2009). Studies indicate a predominance of male attempters in southern and central Africa (Schlebusch, 2005a; WHO, 2015), which is consistent

with the profile of Western countries (Gelfand, 1976; Williams & Buchan, 1981; Schlebusch, 2005a), whereas eastern, western and northern Africa indicated a mixture between male and female predominance (Schlebusch & Burrows, 2009). Furthermore, research indicates that the predominant individuals resorting to episodes of non-fatal suicidal behaviour are the African youth under the age of 30 (Alem et al. 1999; Eferakeya, 1984; Kebede & Alem, 1999; Kebede & Ketsela, 1993; Kinyanda et al., 2004; Odejide et al., 1986).

Moreover, research also shows similarity in the method used to engage in non-fatal suicidal behaviour. Literature indicates that the method of choice in attempting suicide is strongly influenced by accessibility, familiarity with the method, cultural influences, mental status as well as the knowledge, or lack of knowledge, of the lethality of the method (Schlebusch, 2005b). Research indicates that overdose emerged as the predominant method of non-fatal suicidal behaviour in Africa (Schlebusch & Burrows, 2009). This includes cities such as Kampala (Kinyanda et al., 2004), Ibadan (Odejide et al., 1986), Benin City (Eferakeya, 1984), Cairo (Okasha & Lotaif, 1979) and major cities in South Africa (Schlebusch, 2005b). Attempted suicide by means of hanging and poisoning emerged as the most predominant method in Butajira (Alem et al., 1999) and Addis Ababa (Kebede & Alem, 1999).

Many contributing factors can influence suicidal thoughts and behaviours, however, within the African perspective, special attention should be given to cultural norms and values (Hjelmeland et al., 2008a), religious belief systems (Wu et al., 2015), legal prosecution (Meissner, 2013), and familial conflict (van Renen & Wild, 2008). Careful consideration of these factors is warranted when analysing the existing research (Hjelmeland et al., 2008a). For example, in Ghana, suicide is deemed a criminal act punishable by law. If the individual is no longer alive, however, there can be no prosecution. Similarly, engaging in non-fatal suicidal behaviour is a criminal activity that is reported to the police and that is prosecuted (Hjelmeland

et al., 2008a). The fact that suicidal behaviour is punishable by law will significantly impact on the suicide statistics: Only 287 cases of fatal and non-fatal suicide behaviours were reported over a two-year period in Ghana. This is significantly lower than other countries worldwide (Adinkrah, 2011). The illegal status of suicidal behaviour in Ghana clearly influences the number of reported cases, consequently, the number of individuals who have suicidal ideation and psychological dysfunction is probably much higher than statistics seem to suggest (Adinkrah, 2011). This under-representation the true psychological well-being of the population cannot be determined accurately, statistically.

Similarly, research conducted in Uganda reported that attempted suicide is a crime and that it is considered a “bad omen” that carries enormous stigma, for which cleansing rituals are required (Hjelmeland et al., 2008a). It was also reported that the people of Uganda view suicidal behaviour as shameful and this disapproval causes the suicidal individual to feel that he or she does not belong or fit in socially, with the resultant increase in feelings of loneliness. This study found that cultural norms and religious beliefs can cause the suicidal individual to isolate himself or herself from social support systems in order to avoid rejection. The risk factors that influence the psychological well-being of individuals who attempt suicide in Uganda are feelings of depression, hopelessness about the future, anxiety and low self-esteem (Kinyanda et al., 2011).

Consistent with the theme of legality and stigmatisation of suicide, a Nigerian study done on the profile and risks of suicidal behaviour reported that there is often stigma attached to the relatives of a person who has committed suicide. For this reason, it is unlikely that the family will give a true account of the actual cause of death. The dearth of suicide statistics is compounded by the fact that in Nigeria registration of a death is not compulsory; thus many deaths by suicide are not recorded (Gureje et al., 2007).

Supporting the theme of social isolation as a result of stigmatisation, research conducted by Ogbuanu (2014) focussed on the impact of cultural stereotyping on suicidal behaviour in African countries. The study reported that the stigma attached to suicidal behaviour often creates difficulties for the suicidal individual to freely express thoughts and feelings - thus inhibiting meaningful intervention. Consequently, the life stressors individuals are faced with remain unresolved and their coping strategies and social support are lacking. Thus, they are unable to adequately process their stressors, which can result in suicidal behaviour (Hjelmeland et al., 2008a).

Familial conflict has also been associated with attempted suicide (Henry & Stephenson, 1993; Pillay & Wassenaar, 1997; Schlebusch, 2005a). Schlebusch (2005a) reported that familial conflict increases stress levels and suicidal behaviour. The study indicated that many of the individuals felt unable to cope with the on-going familial conflict, they no longer wanted to exist in a conflict-ridden environment and subsequently reverted to engaging in non-fatal suicidal behaviour. In a study of 40 suicidal individuals, Pillay and Wassenaar (1997) reported that the majority of participants (77.5%) experienced parental conflict within a few hours preceding their episode of non-fatal suicidal behaviour.

To conclude, the contributing factors to suicidal ideation and behaviour within the African perspective has been discussed. Subsequently, suicidality within the South African context will be discussed in the following section.

2.3 The South African context

To date, South Africa has seen cumulative interest and attention given to suicide and suicidality research, with the bulk of scholarly work having been on areas including attempted suicide as a result of mental disorders (Bantjes & Kagee, 2013; Khasakhala et al., 2011), suicide prevention and behaviour (Bantjes, 2005; Schlebusch, 2005a), as well as the risk factors in

repeated attempted suicide (Moosa et al., 2005; Schlebusch, 2005a). The WHO reported the South African suicide mortality statistics to be an average of 10.7 per 100,000 (WHO, 2015). However, more recently the South African Depression and Anxiety Group (SADAG, 2015), reported that the South African suicide rate is 17.2 per 100,000 individuals, accounting for 8% of all deaths, with one successful suicide committed every hour, and more than 20 attempts at suicide made every hour. SADAG also reported that 60% of individuals who engage in non-fatal suicidal behaviour are depressed, and that suicide in the age group 10–14 years has more than doubled in the last 15 years. Consequently, research clearly indicates an increase in suicidal behaviour. Taljaard (2013) also reported that the age group at highest risk for engaging in suicidal behaviour is between 15 and 19 years, clearly indicating a need for intervention focussed on youth. Risk factors associated with suicides include the presence of mental illness, a history of suicidal behaviour, and drug and alcohol abuse (SADAG, 2015). Consistent with global findings, the youth (ages between 15 and 19 years) emerged as the most prevalent population group to attempt suicide with associated risk factors as mentioned (Taljaard, 2013). Further investigation is warranted to understand the influence of these risk factors on the psychological functioning of individuals resorting to episodes of non-fatal suicidal behaviour.

As previously mentioned, attempted suicide is the strongest predictor of suicide (WHO, 2014). As a result, many studies suggest a similarity in risk factors associated with fatal and non-fatal suicidal behaviour (Beautrais, 2000; Brown et al., 2000; Weng et al., 2016).

Supporting the findings of the associated risk factors, a study conducted on the profile analysis of attempted suicide patients admitted for evaluation and treatment at Pelonomi Hospital in the Free State province of South Africa by Du Toit et al. (2008), found that the most significant factors associated with engaging in non-fatal suicidal behaviour were problematic relationships, arguments with friends or family, feelings of low self-esteem,

worthlessness and hopelessness, unstable family life and the lack of social support. These factors negatively influence the individual's psychological functioning, as these feelings or risk factors can cause emotional distress, which can lead to overwhelming negative thoughts and ultimately suicidal ideation or behaviour. Given the frequency by which relational conflict appears as a risk factor in literature on suicide, the influence of relational conflict on the suicidal individual warrants further attention.

Similarly, Schlebusch (2005a) also found that the associated risk factors for engaging in non-fatal suicidal behaviour include interpersonal problems, substance abuse, family history of suicidal behaviour, history of sexual abuse, psychological disorders (especially depression) and prior suicidal behaviour. The influence of traumatic experiences such as sexual abuse and substance abuse will have a significantly negative effect on the individual's psychological well-being (Fine et al., 2012). If left unresolved, these experiences can result in emotional numbness and isolation.

Expanding on the detrimental effect of emotional numbing and social isolation on well-being, Taljaard (2013) argues that emotional numbness and isolation can lead to impaired psychological functioning, which is directly linked to suicidal ideation or behaviour. Moreover, over-exposure to emotionally draining experiences such as the aforementioned risk factors, can result in emotional numbness. Emotional numbness includes the inability to experience emotions, having emotionally blunt reactions to otherwise emotionally arousing encounters and a sense of emotional detachment from individuals or situations (Swanepoel, 2003). Isolation can include either physically removing oneself from social structures and influences or emotionally detaching oneself from relationships or situations (Kgosimore & Makofane, 2006). Often, with emotional isolation, the individual experiences high levels of distress,

believing that no-one fully understands what he or she is experiencing, or feeling ashamed of what he or she is feeling and fearing rejection by loved ones.

A study by Bantjes and Kagee (2013) on the prevalence of suicide in the former Transkei¹ homeland of the Eastern Cape (a poverty-stricken rural area) found that suicide rates had increased from 26.4 per 100,000 individuals in 1996 to 38.6 per 100,000 individuals in 1999 and 2000. The study reported that poverty, unemployment, lack of mental health services and limited educational opportunities are the most probable reasons for engaging in suicidal behaviour.

Lastly, as mentioned by Bantjes and Kagee (2013), the availability of mental health services also needs to be taken into consideration. Bateman (2014) reported that SADAG receives approximately 400 calls per day of distressed individuals contemplating suicide, and about 600,000 views on their website per month. Bateman also reported on the availability, per 100,000 South Africans, of an estimated 0.28 psychiatrists, 0.32 psychologists and 2.8 in-patient beds. The limited availability of mental health services could be a contributing factor to the high prevalence of suicidal behaviour in South Africa. Consequently, many suicidal individuals must rely on their own means of dealing with their distress as they do not have access to the required psychological services. Untreated mental illness or prolonged stress could lead to episodes of non-fatal suicidal behaviour (Shaffer & Gutstein, 2003).

To conclude, this review of relevant global, African and South African literature provides a broader understanding of suicidology. The themes covered in the literature review include

¹ The Transkei area, situated across the Kei River – on the north-eastern part of the Eastern Cape province of South Africa, was one of the former homelands of the TBVC states (Transkei, Bophuthatswana, Venda and Ciskei) that existed in the pre-1994 era in South Africa. After 1994, the Transkei homeland, together with the then-Ciskei, was incorporated into the present-day province of the Eastern Cape.

demographical variance, methodology and societal influences. A discussion of the theoretical frameworks, on which the present study was based, follows.

2.4 Theoretical Frameworks

The two theoretical frameworks used in this research are the stress-coping (transactional) model of Lazarus and Folkman (1984) and the Communication Theory (Farberow & Shneidman, 1961) – the latter having been salient in previous studies of suicide (notably, Hjelmeland et al., 2008b; Nock & Kessler, 2006; O'Connor & Sheehy, 2001; Pillay & Wassenaar, 1997; Widiger & Rinaldi, 1983). The application of the stress-coping model has been central in the understanding of how individuals who engage in non-fatal suicidal behaviour cope with the demands and challenges imposed on them (transactional model), while the Communication Theory offers valuable insight into suicide as a possible symbolic representation of the communication of distress, helplessness and hopelessness that these individuals, in engaging in non-fatal suicidal behaviour, were making to people in their social networks (Communication Theory).

An alternative stream of thought relating to the understanding of suicidology – not used for this study, yet noteworthy – is the so-called critical suicidology. It is a movement away from traditional, quantitative, positivist research towards a more comprehensive, contextualised, quantitative, subjective and ethnographic approach towards understanding suicidal behaviour, beyond mental disorders (Hjelmeland et al., 2012; Kral & White, 2017; Marsh, 2016). From the critical suicidology perspective, it is argued that much of the experience-rich information are lost with a quantitative positive approach to suicidal behaviour. It calls for the consideration of cultural influence, personal experience and a general shift from *explaining* to *understanding* suicidal behaviour (Hjelmeland, 2010). Critical suicidology argues that approach creates the possibility for new, innovating and creative approaches to

helping and understanding suicidal behaviour – as opposed to the mainstream research trends, which are criticized for being privileged, repeating and focusing on pathology, the individual and science (Marsh, 2016).

A study from the field of critical suicidology, conducted by Hjelmeland (2010), highlighted the importance of considering cultural and contextual influence when studying suicidology and warned against the generalisation of research findings. The study argued that culture is the fundament of people's lives and therefore an integral part of their suicidology. The study indicated the variance in risk factors associated to suicidology between cultures. Consequently, it was argued that the risk factors identified during a study is culture- and context-specific and could therefore not be generalised to a larger population.

2.4.1 Stress-coping model

Lazarus and Folkman's (1984) stress-coping (transactional) model suggests that, within the social system, the individual is exposed to demands and resources available at their disposal. Particularly noteworthy within the model, is the temporal sequence that starts with the stress experience (symptoms of depression, anxiety or hopelessness), followed by appraisal (evaluating the magnitude of the stress and exploring ways of handling such stress), and coping (managing the stress). Lazarus and Folkman's transactional stress-coping model defines stress as any circumstances (demands) that pose a threat, or is perceived as threatening, to the individual's well-being and that are taxing on the individual's coping abilities. These demands can influence the individual's behaviour, emotions and thoughts. Coping, according to Lazarus and Folkman, refers to the individual's continuous cognitive and behavioural attempts to manage the demands of a situation that is perceived as taxing.

Central to the inherently linked interaction between stress and coping is the concept of appraisal, which is seen as mediating between the stress experience and the coping response.

Accordingly, when an individual experiences a physical or psychological threat, he or she tends to adopt an anticipatory mode: If the initial evaluation of the event at hand shows it to be a stressful encounter (the primary cognitive appraisal), then the individual evaluates the coping resources available at his or her disposal in order to find ways of managing such a stressful encounter (secondary cognitive appraisal) (Lazarus & Folkman, 1984). Therefore, the application of appraisal to stress is that psychological distress is conceptualised as occurring when the individual's appraisal (evaluation) of an encounter results in the subjective experience of being threatened (primary appraisal), and that the individual perceives his or her resources for coping with the stress as either limited, inadequate, or completely absent (secondary appraisal) (Lazarus, 1999; Lazarus & Folkman, 1984). Coping, then, would represent an outcome of the appraisal of stress, particularly the secondary appraisal. Thus, according to this model, at the end of the stress process, the individual appraises the stressor and its attendant threat to well-being (primary appraisal), and this would in turn determine what the individual's response to the stressor will be (secondary appraisal). By determining the mode of response, the individual effectively seeks to find avenues for coping with the stressor at hand (Lazarus & Folkman, 1984). Taking the stress-coping framework into account in the present study allowed for the investigation of the extent to which individuals surveyed attempted suicide as a function of their inability to 'negotiate' and cope with the distress that characterised their lives, thereby highlighting the role of effective coping strategies.

The literature on coping is laden with various taxonomies of coping, which merit a concise overview in this study. One such coping taxonomy has been proposed by Billings and Moos (1981), who have categorised coping as falling into two categories: In the first category coping is conceptualised as falling into an 'active coping versus avoidant coping' dichotomy (active coping entails engagement in tasks aimed at dealing with the problem, while avoidant coping refers to avoiding and disengaging from directly dealing with the problem). In the

second category, coping is understood as falling into the ‘problem-focused coping versus emotion-focused coping’ dichotomy (problem-focused coping involves directing efforts towards finding a solution to the problem, while emotion-focused coping refers to the regulation of appropriate emotional reactions in dealing with stressful encounters).

Another taxonomy of coping has been offered by Amirkhan (1990, 1994). Following up on Lazarus and Folkman’s (1984) conceptualisation of stress and coping, Amirkhan has proposed that coping responses can be conceptualised as comprising three broad categories, namely *problem-focused*-, *support-seeking*- and *avoidant* coping strategies. A closer look at this categorisation reveals a close association between these response categories and Cannon’s (1963) fight-or-flight response to threat: Problem-solving coping equates with actively and directly confronting (or “fighting”) the stressor, avoidance corresponds with the escapist (“flight”) response to threat, and social support-seeking coping represents a primitive need for human contact in the wake of stress (Amirkhan, 1990).

Given that the transactional model of stress suggests that the individual uses the resources available to cope with stressors created by the social system, and that if the stressors overload the available resources the individual will experience distress, this framework was considered appropriate for the sample of individuals who engaged in non-fatal suicidal behaviour. I hypothesized that individuals who engage in non-fatal suicidal behaviour have experienced stress (symptoms of depression and anxiety) in their interaction with significant others in their environment, that their appraisal of their encounters with stress resulted in their appraisal of the situation as hopeless, and they perceived their capacity to manage (cope with) the stress as limited.

2.4.2 Communication Theory

Another theoretical framework that has been linked to suicidology and is relevant to the present study is the Communication Theory introduced by Farberow & Shneidman (1961). The foundation of this theory is that individuals engage in non-fatal suicidal behaviour as a means of communicating their emotional distress to those around them, or as a symbolic cry for help. A study conducted by Pillay and Wassenaar (1997) supports this theory of attempted suicide as a form of communication, in that the individual uses his or her suicidal behaviour as a means of voicing dissatisfaction with his or her family functioning. It has been argued that severely depressed individuals do not necessarily possess the capacity to verbally express their emotional distress (Schlebusch, 2012), or perhaps want to avoid the repercussions of verbally expressing their distress to a loved one, e.g. confrontation, judgement, violence or rejection. It is noteworthy that O'Connor and Sheehy (2001) reported on the perception or myth that individuals who verbally communicate their desire to take their own lives will in actuality not go through with the attempt. Consequently, it could be argued that the disregard of a possible attempter's verbal cues could increase feelings of frustration, hopelessness, depression and isolation (which are all risk factors associated with attempted suicide), which in turn forces the individual to revert to a physical expression of his or her psychological distress, i.e. engage in non-fatal suicidal behaviour (O'Connor & Sheehy, 2001).

Similar theoretical frameworks that have been identified, include the Escape theory, introduced by Baumeister (1990) and later expanded on by Williams (Williams, 1997, 2001; Williams & Pollock, 2000, 2001) and suggested that three characteristics were needed for an individual to engage in suicidal behaviour, namely: defeat, no escape and no rescue. According to this theory, the presence of these three characteristics triggers a so-called "helplessness script", which could lead to suicidal behaviour (Williams & Pollock, 2000). One could argue that

in both the Escape Theory and Communication Theory, the engagement of suicidal behaviour is an outward expression of an inward sense of despair and hopelessness. Based on the similarities between these theories, only the Communication Theory was used in this study.

It was on the foundation of these two theoretical frameworks (the Stress-Coping Model and Communication Theory) that the measuring instruments were selected to appropriately address the research questions, aims and objectives. On the basis of the theoretical framework and literature review discussed, the study sought to investigate the relationship between the stress, coping, and perceived social support of individuals who engage in non-fatal suicidal behaviour. The following chapter is an extensive discussion on the methodology used in this study.

CHAPTER 3

Research Methodology

3.1 Research design

The focus of the present study was to determine the nature of the statistical relationship between the stress, coping and social support of individuals who had been admitted to hospital following an episode of non-fatal suicidal behaviour. Consequently, a quantitative research design was deemed appropriate. Quantitative research converts the properties of phenomena (e.g. attitude or emotion), by means of standardised instruments, into measurable data (Babbie et al., 2008). It also provides the researcher with generalisable, objective and replicable data (Terre Blanche et al., 2006). Although quantitative research cannot provide an in-depth understanding of phenomena, it does not expose itself to possible bias or an individual's interpretation of the data (Babbie et al., 2008). Furthermore, it allows for correlational research, which identifies significant relationships between variables, measures the strength of these relationships, and makes possible inferences or predictions (Howell, 2008). Interviewer-administered questionnaires were used to gather the necessary data.

3.2 Sampling

Purposive sampling was used for this study as participants were selected based on a specific set of predefined requirements. To participate in the study, individuals must have been admitted to ██████████ Hospital in ██████████, situated in the Western Cape province of South Africa, following an episode of non-fatal suicidal behaviour. Prior to the commencement of data collection, arrangements were made with hospital management for the researcher to be notified of all patients admitted for episodes of non-fatal suicidal behaviour. To the researcher's knowledge (and in line with the arrangements made with the hospital management), all patients

admitted during the time of data collection were approached to partake in the study. Participants had to be between the ages of 14 and 65 years and had to be willing to partake in the study. These individuals could be of any gender, socio-economic status, educational level and socio-cultural background. Excluded from participation were patients who, after being screened by the attending medical practitioner, had inadequate sense of orientation and hence could not be deemed as having the mental capacity to give informed consent and independently answer survey questions. All the patients that were approached were willing to partake in the study.

The motivation for the selection of [REDACTED] Hospital for this specific study was that patients at the hospital represent a vast rural area as it serves both the Breede Valley Municipality (Worcester, De Doorns, Rawsonville and Touwsriver) and the Langeberg Municipality (Robertson, Bonnievale, Ashton, Montagu and McGregor). Therefore, it is fairly representative of the greater rural Western Cape, and was deemed a suitable institution from which to gather the necessary data. The 2011 Census reported that the Breede Valley Municipality had a total population size of 166,825 of which 63,3% were Coloured, 24,3% were African, 10,7% were White, and 1,7% belonged to other population groups (Statistics SA: Breede Valley, 2011). 2011 statistics for the Langeberg Municipality show a population size of 97,724 individuals of which 70% were Coloured, 16% were African, and 12% were White (Statistics SA: Langeberg, 2011). The research reported, for both municipalities, overwhelming dominance of the Coloured population and consequently one could expect the skewness of racial representation to reflect in the sample of the present study.

The primary aim of sample selection is representation of the population group; enabling the researcher to make accurate inferences (Terre Blance et al., 2006). Careful consideration should be given to all the elements of the population group prior to establishing a suitable sample size. A balance needs to be maintained between a not-too-small sample (i.e. not

representative of the larger population) and a not-too-large sample (i.e. non-random sample). The population associated with suicidology is characterised as high risk, emotionally vulnerable individuals; establishing a suitable sample size is paramount. Other practical constraints that influence sample selection include accessibility to participants and the resources available to the researcher. Consequently, the present study used a smaller sample group. This is consistent with other relevant South African studies on suicidology, that similarly made use of smaller sample groups (notably in Beekrum et al., 2011; Fine et al., 2012; Moosa et al., 2005; Pillay & Wassenaar, 1997; Vawda, 2012). The sample size calculation was done for this study, and following a consultation with a statistician, it was determined that the sample size was sufficient for the regression models that were calculated in this study.

3.3 Participants

The sample of this study was comprised of 34 participants, consisting of males ($n = 5$) and females ($n = 29$), with ages ranging between 15 and 64 years ($M = 25$ years, $SD = 10.26$). In terms of racial distribution, 29 (85.3%) participants identified themselves as Coloured, 3 participants (8.8%) as African, and 2 participants (5.9%) as White. In terms of home language, 30 participants (88.2%) identified themselves as Afrikaans-, followed by 3 participants (8.8%) Xhosa- and 1 participant (2.9%) as English speaking.

Regarding their marital status, 18 participants (52.9%) were reportedly in a relationship, 10 participants (29.4%) indicated that they were single, 4 participants (11.8%) indicated that they were married, and 2 participants (5.9%) were divorced. In respect of the number of dependants participants had, 20 (58.8%) reported having no dependants, 5 participants (14.7%) indicated having 1 dependant, 4 (11.8%) reported having 2 dependants, 4 participants (11.8%) indicated to have 3 dependants, and 1 participant (2.9%) reported having 4 dependants.

In terms of their educational level, 2 participants (5.9%) reported having completed Grade 4, 1 participant (2.9%) indicated having completed Grade 6, 1 participant (2.9%) indicated having completed Grade 7, 3 participants (8.8%) indicated having completed Grade 8, 6 participants (17.6%) indicated having completed Grade 9, 5 participants (14.7%) indicated having completed Grade 10, 5 participants (14.7%) indicated having completed Grade 11, and 11 participants (32.4%) indicated Grade 12 as the highest educational level obtained. None of the participants had obtained a tertiary qualification. When asked about their occupational status, 14 participants (41.2%) reported being in full-time employment, 10 participants (29.4%) were still attending school, 8 participants (23.5%) reported being unemployed, and 2 participants (5.9%) indicated that they were full-time tertiary students.

Regarding their gross family monthly income, 4 participants (11.8%) indicated an income of R1–R2,000 per month, 4 participants (11.8%) indicated an income of R2,001–R5,000 per month, 14 participants (41.2%) indicated an income of R5,001–R8,000 per month, 7 participants (20.6%) indicated an income of R8,001–R10,000 per month, 4 participants (11.8%) indicated an income of R10,001–R15,000 per month, and 1 participant (2.9%) indicated a monthly income of R15,001 or more.

When asked about their number of episodes of non-fatal suicidal behaviour, 21 participants (61.8%) indicated that this was their first attempt, 7 participants (20.6%) indicated that this was their second attempt, 4 participants (11.8%) indicated that this was their third attempt, 1 participant (2.9%) indicated that this was his or her fourth attempt, and 1 participant (2.9%) indicated more than four attempts. On investigation of the method used for their episode of non-fatal suicidal behaviour, 30 participants (88.2%) took an overdose of medication, 2 participants (5.9%) used multiple methods (both cases involved a combination of overdosing on medication and cutting themselves), 1 participant (2.9%) tried to hang himself or herself,

and 1 participant (2.9%) indicated “other” (unspecified) method. When asked whether it was their intention to die, 17 participants (50.0%) answered “Yes” to the question, and 17 participants (50.0%) answered with a “No”. Consequently, when asked whether they would engage in non-fatal suicidal behaviour again, 28 participants (82.4%) answered with a “No” to the question, 3 participants (8.8%) answered, “Yes”, and 3 participants (8.8%) seemed unsure and answered, “Maybe”. Considering their subjective ratings of their overall mental health, 15 participants (44.1%) rated themselves as having “Average” overall mental health, 12 participants (35.3%) rated themselves as having “Good” overall mental health, and 7 participants (20.6%) rated their overall mental health as “Poor”. The demographic profile of participants is summarised in Table 3.1.

Table 3.1

Demographic Profile of the Sample (N = 34)

	n	(%)
Age		
15–24	12	35.3
25–34	17	50.0
35–44	3	8.8
45–54	1	2.9
55–64	1	2.9
Gender		
Male	5	14.7
Female	29	85.3
Race/Culture		
White	2	5.9
African	3	8.8

Coloured	29	85.3
Primary Language		
English	1	2.9
Afrikaans	30	88.2
isiXhosa	3	8.8
Marital Status		
Single	10	29.4
In a Relationship	18	52.9
Married	4	11.8
Divorced	2	5.9
Number of Dependants		
0	20	58.8
1	5	14.7
2	4	11.8
3	4	11.8
4	1	2.9
Educational Level		
Grade 4	2	5.9
Grade 6	1	2.9
Grade 7	1	2.9
Grade 8	3	8.8
Grade 9	6	17.6
Grade 10	5	14.7
Grade 11	5	14.7
Grade 12	11	32.4

Table 3.1 (*continued*)

	n	(%)
Occupational Status		
Unemployed	8	23.5
Employed	14	41.2
Scholar	10	29.4
Student	2	5.9
Gross Family Monthly Income		
R1–R 2,000	4	11.8
R 2,001–R 5,000	4	11.8
R 5,001–R 8,000	14	41.2
R 8,000–R 10,000	7	20.6
R 10,001–R 15,000	4	11.8
R 15,001–more	1	2.9
Number of Attempted Suicides		
1	21	61.8
2	7	20.6
3	4	11.8
4	1	2.9
More	1	2.9
Methods of Attempted Suicides		
Overdose	30	88.2
Hanging	1	2.9
Other	1	2.9

Multiple	2	5.9
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Table 3.1 (*continued*)

	n	(%)
Intention to die		
Yes	17	50.0
No	17	50.0
Attempt suicide again		
Yes	3	8.8
No	28	82.4
Maybe	3	8.8
Overall mental health		
Good	12	35.3
Average	15	44.1
Poor	7	20.6

3.4 Measuring Instruments

All measuring instruments were translated into both Afrikaans and isiXhosa to cater for participants whose home language was not English. The Brislin method of translation was used, which requires that the questionnaires be translated to the target languages (in this case, Afrikaans and isiXhosa), and then independently translated back to English to confirm the accuracy of the initial translation (Brislin, 1976). Reliability analyses were undertaken to determine the validity of the standard measures, and the results of these analyses will be presented after a description of the measures that were used.

3.4.1 Demographic variables

A demographic questionnaire was used to gather information regarding the participants' age, sex, ethnic group, primary language, marital status, number of dependants, educational level, occupational status, number of episodes of non-fatal suicidal behaviour, method of attempt, their intention to die, whether they would engage in non-fatal suicidal behaviour again and their perception of their overall mental health. It should be noted that no identifiable information about participants (such as names, identity numbers, hospital file references or physical addresses) was documented in the questionnaires in order to maintain anonymity.

3.4.2 Beck Depression Inventory - Second Edition (BDI-II; Beck et al., 1996b)

The BDI-II, which was used to measure symptoms of depression in the present study, is a 21-item questionnaire that is a widely used and accepted method for screening depression (Thompson, 2003). The item scores range from 0 (the absence of the depressive symptom) to 3 (the severity of the symptom). A total score of less than 13 is considered "minimal depression", 14–19 is considered "mild depression", 20–28 is considered "moderate depression", and a score of 29 or more is considered "severe depression" (Alexander et al., 2014). According to Arnau, Meagher, Norris and Bramson (2001), it also measures a wide range of symptoms associated with depression. In an American study conducted on a bariatric surgery-seeking sample of 505 individuals, the BDI-II reported internal consistency reliability ranging between .72 and .82 for each subscale (Hall et al., 2012).

In a South African study conducted on 122 first-language isiXhosa-speaking participants using the isiXhosa translation of the BDI-II, the measure showed high internal consistency with a Cronbach alpha value of .93 (Steele & Edwards, 2008). Also, for each subscale there were significant mean differences in scores between depressed and non-depressed patients, indicating criterion-related validity. Since research indicates the presence of depression in

individuals who are suicidal or admitted to hospital following an episode of non-fatal suicidal behaviour (Minaar et al., 1980), the inclusion of a measure for symptoms of depression was indicated for patients admitted at a rural Western Cape Hospital following an episode of non-fatal suicidal behaviour.

3.4.3 Beck Anxiety Inventory (BAI; Beck & Steer, 1993)

The BAI, which was used to measure symptoms of anxiety in the present study, is a 21-item scale that measures the extent to which anxiety is experienced either physiologically or cognitively (Osman et al., 2004). This measure is scored from 0 (not at all) to 3 (it bothered me a lot). A total score of 7 or less is considered “minimal anxiety”, 8–15 is considered “mild anxiety”, 16–25 is considered “moderate anxiety” and 26–63 is considered “severe anxiety” (Beck & Steer, 1990). In an American study comparing psychiatric inpatient adolescents with high school adolescents of the same-age group, in terms of anxiety, the BAI showed a Cronbach alpha value of .92 for the psychiatric inpatients and .88 for the high school group (Hoffman et al., 2002). The study conducted by Steele & Edwards (2008) on 122 first-language isiXhosa-speaking participants in South Africa also used the BAI, and reported a Cronbach alpha value of .92. Previous research on individuals who were suicidal or were admitted to hospital following an episode of non-fatal suicidal behaviour showed signs of anxiety (Du Toit et al., 2008); therefore, the inclusion of a measure for anxiety was indicated for patients admitted to a rural Western Cape Hospital following an episode of non-fatal suicidal behaviour.

3.4.4 Beck Hopelessness Scale (BHS; Beck, 1988)

The BHS, which was used to measure feelings of hopelessness in the present study, is a 20-item scale that is used to measure levels of hopelessness and expectation (Beck, 1988; Hovey et al., 2014; Ivanoff & Jang, 1991; Mendonca et al., 1974). This measure consists of “true” or “false” statements and are scored accordingly. A final obtained score of 3 or less indicates a

“minimal” level of hopelessness, a score in the range of 4–8 indicates a “mild” level of hopelessness, while that of 9–14 indicates a “moderate” level of hopelessness and a score of 15 or more indicates “severe” hopelessness (Haatainen et al., 2004). From previous studies done, the BHS has proved to be predictive of suicide ideation (Ayub, 2009; Mendonca et al., 1974). In an American study using The Cultural Assessment of Risk for Suicide (CARS) measure, of which the BHS is one of the measures, conducted on 950 diverse individuals of the general population, the BHS showed a Cronbach’s alpha value of .90 (Chu et al., 2013). Previous research conducted on suicidal individuals admitted to hospital reported on the presence of feelings of hopelessness (Du Toit et al., 2008), thus validating the inclusion of this measure of symptoms of hopelessness for patients admitted to a rural Western Cape Hospital following an episode of non-fatal suicidal behaviour.

3.4.5 Coping Strategy Indicator (CSI; Amirkhan, 1990, 1994)

The CSI, which was used to measure participants’ coping strategies, is a 33-item scale that has been used to measure different responses to stress with three subscales, namely problem-solving, social support-seeking and avoidant coping strategies (Amirkhan, 1990, 1994). The items range from 1 (not at all) to 3 (a lot). In the study conducted by Amirkhan (1990), the sample consisted of 357 individuals of the general public, and the measure shows internal reliability for each subscale, namely social support-seeking (.93), problem-solving (.89) and avoidance (.84), and construct validity was much higher than other coping measures. In a South African study conducted on 198 recently bereaved Black widows the CSI reported high internal consistency with a Cronbach alpha value of .86 (Somhlaba, 2006). Previous research suggests the influence of coping strategies in suicidal individuals (Meehan et al., 2007), thus validating the inclusion of the measure for this study.

3.4.6 Social Support Appraisal (SSA; Vaux et al., 1986)

The SSA was used to measure the participants' perceived social support. This 23-item questionnaire has three subscales, namely family, friends and others (Vaux et al., 1986). The items in this measure range from 1 (strongly agree) to 4 (strongly disagree). In an American study conducted on 60 psychiatric inpatients and 57 family members, the SSA showed very high internal consistency with Cronbach alpha values of .89, .81 and .83 for the Family, Friends and Others subscales, respectively (O'Reilly, 1995). The study conducted by Somhlaba (2006) using the SSA reported an internal consistency value of .79.

Research suggests a significant relationship between suicidality and diminished and weaker perceptions of social support from significant others (Schlebusch, 2005a). Therefore, the measure was included to tap into the participants' perceptions of social support from people within their social networks.

3.5 Reliability

George and Mallery (1999) categorised coefficient alpha values, which can be used as a guideline for rating the reliability of analyses results of the present study. The scales that showed excellent internal consistency were the Social Support-Seeking Subscale of the Coping Strategy Indicator ($\alpha = .97$), the Problem-Solving Subscale of the Coping Strategy Indicator Scale ($\alpha = .95$), the Beck Hopelessness Scale ($\alpha = .94$), Beck Anxiety Inventory ($\alpha = .94$), and the Friends Support Subscale of the Social Support Appraisal Scale ($\alpha = .93$). Also showing excellent internal consistency were the Beck Depression Inventory – Second Edition ($\alpha = .92$), Social Support Appraisal Scale ($\alpha = .91$), and the Family Support Subscale of the Social Support Appraisal Scale ($\alpha = .90$).

The scale that showed good internal consistency was the *Other Support* subscale of the Social Support Appraisal Scale ($\alpha = .85$). The scale that showed acceptable internal consistency was the *Avoidance* subscale of the Coping Strategy Indicator Scale ($\alpha = .72$). The summary of these coefficients is presented in Table 3.2.

Table 3.2

Cronbach's Alpha, Mean and Standard Deviation (SD) for Each Measure

	N	α	M	SD
BDI-II	34	.92	21.9	12.9
BAI	34	.94	14.1	11.0
BHS	34	.94	6.6	6.3
CSI – Problem-solving	34	.95	18.8	5.8
CSI – Social support-seeking	34	.97	19.2	7.2
CSI – Avoidant	34	.72	20.5	4.2
SSA	34	.91	58.9	9.9
SSA – Family	34	.90	20.7	4.9
SSA – Friends	34	.93	18.2	4.5
SSA – Other	34	.85	20.0	3.6

Note. BDI-II = Beck Depression Inventory, Second Edition; BAI = Beck Anxiety Inventory; BHS = Beck Hopelessness Scale; CSI = Coping Strategy Indicator; SSA = Social Support Appraisal Scale

3.6 Data collection procedures

Data was collected at ██████████ Hospital, Western Cape, in the form of interviewer-administered questionnaires after ethics clearance was granted by the Departmental Ethical Screening Commission (DESC) and Research Ethics Committee (REC) (Humanities) at

Stellenbosch University, as well as from the Research Ethics Committee of the Western Cape Department of Health. Data collection took approximately five months, and all data was collected by the researcher.

Prospective participants were identified after they were admitted to the [REDACTED] Hospital following an episode of non-fatal suicidal behaviour. As per the hospital protocol, all patients admitted for an episode of non-fatal suicidal behaviour have to be interviewed and assessed by a doctor in the Casualty Ward, and soon after by a social worker. After this initial screening, the doctor or social worker determined which patients were potential candidates for participating in this research. They used the Mental State Examination (MSE) to determine each patient's suitability for participation by evaluating their sense of orientation and mental capacity to answer survey questions and give informed consent. Once these individuals were identified and had undergone all other mandatory medical and psychological assessments, the researcher was notified of the possible candidates. Thereafter, the researcher made contact with these individuals and invited them to participate in the study. In the case of participants under the age of 18 years, parental consent was obtained beforehand. Parents or legal guardians were informed of the nature of the study as well as the possible benefits and risk factors associated with the study.

Data was collected by means of interviewer-administered questionnaires, and took place in an office made available by the hospital. The researcher explained the nature of the study, and what was expected of each participant to complete the questionnaire. Participants' responses to questionnaire items were therefore recorded by the researcher, who conducted all the surveys for the study. In cases where participants were not fluent or fully conversant in English or Afrikaans, the researcher enlisted and made use of the services of the hospital's translator (Ms. Matilda Moleki) for the translation of items from isiXhosa to English or

Afrikaans. Each interview session (completion of the questionnaire) took approximately 40–60 minutes to complete.

3.7 Data analyses

Given the quantitative nature of the research, statistical analysis was done by means of the statistical package STATISTICA (Statsoft, 2016) and the Statistical Package for Social Sciences (SPSS; IBM Corp, 2012). As part of the preliminary analyses of the data, the validity and reliability of the measures used (validity and reliability analyses) were undertaken. Moreover, these analyses were used to test for parametric assumptions (such as normality) and factor analysis.

Secondly, the basic statistics were drawn on the dependent variables in terms of the central tendency, dispersion and variability of the scores. Thirdly, the Pearson correlation coefficients were used to determine whether statistical relationships (notably, correlations) existed between stress (depression and anxiety) and the coping strategies used, as well as between stress and perceived social support. The study also sought to ascertain the nature of the correlation between social support appraisal and stress. To determine whether a significant correlation existed between variables, a probability value of $p < 0.05$ was used.

Fourthly, multiple regression analyses were used to determine which of the two predictor variables (hopelessness and perceived social support) predicted stress (symptoms of depression and anxiety).

Furthermore, multiple regression analyses were used to determine which of the three coping strategies of the CSI predicted hopelessness, social support appraisal and stress (symptoms of depression and anxiety).

3.8 Ethical considerations

There are many ethical considerations that often arise with this type of study. Since the study involved direct interaction with human participants, and was classified as high-risk research, it was required that the necessary ethics clearance first be obtained before the study could be conducted. The first level of clearance was obtained from the Research Ethics Committee (REC) (Humanities) at Stellenbosch University. Thereafter, additional clearance was sought and obtained from the Western Cape Department of Health (as required for all research conducted in state hospitals, like ██████████ Hospital).

Participants were informed beforehand of the nature of the study, the type of information that would be gathered, as well as the purpose thereof, enabling them to make an informed decision of whether to participate in the study or not. Participation was voluntary and if participants were too uncomfortable or wanted to withdraw for any reasons, provision was made and communicated to them that they would be allowed to withdraw their participation at any time during the course of the study. For participants under the age of 18 years, parental consent was sought before contact was made with them. The gathered information was only accessible to the researcher, thereby ensuring confidentiality.

Special care was taken to prevent that any personal information on the questionnaires could be linked to the identity of participants. Anonymity was ensured by assigning a unique code to each participant's name. Once a number was assigned to a participant, no reference was made to the participant's identity thereafter. The list of numbers allocated to participants was kept electronically by the researcher and it is password protected. All research questionnaires and materials were kept in a lockable cabinet by the researcher at her home during the analysis of data – and subsequently delivered and kept in a locked cabinet in the supervisor's office. After five years, all the data will be destroyed.

Patients admitted to hospital following an episode of non-fatal suicidal behaviour represent a high-risk research population, because they are going through a time of acute emotional distress. It was possible that participants may have experienced emotional distress before, during or after participation. Therefore, psychological services were made available to the participants, and the researcher was centrally involved in facilitating referrals to the available professionals who render psychological services at [REDACTED] Hospital (these included two social workers, a psychologist and a psychiatrist). Since the researcher is affiliated to the hospital as a qualified trauma counsellor, and is also able to identify participants that require urgent referral, her insider knowledge of the hospital enabled her to establish a network of the above-mentioned professionals, to whom referrals for psychological support were made. After initial assessments, 12 participants were referred to the hospital's psychologist for further psychological support.

CHAPTER 4

Results

4.1 Introduction: The influence of stress and general key findings

The Beck Depression Inventory – Second Edition (BDI-II) was used to measure the participants' levels of depression and consequently, as indicated in Table 4.1, 9 participants (26.5%) showed “minimal” depression, 7 participants (20.6%) were “mildly” depressed, 8 participants (23.5%) were “moderately” depressed and 10 participants (29.4%) were “severely” depressed.

The findings of the Beck Anxiety Inventory (BAI) indicated that 11 participants (32.4%) had “minimal” anxiety, 11 participants (32.4%) had “mild” anxiety, 8 participants (23.5%) had “moderate” anxiety and 4 participants (11.8%) had “severe” anxiety (see Table 4.1).

The Beck Hopelessness Scale reported that 15 participants (44.1%) had “minimal” signs of hopelessness, 9 participants (26.5%) had “mild” signs of hopelessness, 4 participants (11.8%) had “moderate” signs of hopelessness, and 6 participants (17.6%) had “severe” signs of hopelessness (see Table 4.1).

Table 4.1

Classification for Severity of Symptoms of Depression, Anxiety and Hopelessness (N = 34)

	Cut-off scores	Number of respondents	% of respondents
BDI-II		34	100
Minimal Depression	0–13	9	26.5
Mild Depression	14–19	7	20.6

Table 4.1 (*continued*)

	Cut-off scores	Number of respondents	% of respondents
Moderate Depression	20–28	8	23.5
Severe Depression	29–63	10	29.4
Excluded (missing data)		0	
BAI		34	100
Minimal Anxiety	0–7	11	32.4
Mild Anxiety	8–15	11	32.4
Moderate Anxiety	16–25	8	23.5
Severe Anxiety	26–63	4	11.8
Excluded (missing data)		0	
BHS		34	100
Minimal Hopelessness	0–3	15	44.1
Mild Hopelessness	4–8	9	26.5
Moderate Hopelessness	9–14	3	8.8
Severe Hopelessness	15–more	7	20.6
Excluded (missing data)		0	

Note. BDI-II = Beck Depression Inventory, Second Edition; BAI = Beck Anxiety Inventory; BHS = Beck Hopelessness Scale

The Coping Strategy Indicator (CSI) has three subscales, namely *problem-solving coping*, *social support-seeking coping* and *avoidant coping*, which indicate different strategies used to deal with stress or tension. The study revealed that 13 participants (38.2%) made predominant use of avoidant coping, 13 participants (38.2%) predominantly used social support-seeking

coping, 6 participants (17.6%) predominantly used problem-solving coping. For the remaining two participants, coping was characterised by an oscillation between both the problem-solving- and social support-seeking coping (1 participant; 2.9%), and between problem-solving- and avoidant coping (1 participant; 2.9%) (see Table 4.2).

Table 4.2

Subscale scores on the Coping Strategy Indicator (N = 34)

	Number of respondents	% of respondents
Problem-solving	6	17.6
Social support-seeking	13	38.2
Avoidant	13	38.2
Problem-solving and Social support-seeking	1	2.9
Problem-solving and Avoidant	1	2.9

4.2 Correlation analyses of results

In order to investigate the statistical relationship between various variables, Pearson's product-moment correlation coefficient and Spearman's correlation coefficient were used. The variables that were examined included symptoms of depression, anxiety, hopelessness, coping, and perceived social support.

4.2.1 Correlation between depression and anxiety

Pearson's correlation coefficient was used to determine the nature of the relationship between symptoms of depression and anxiety (see Table 4.3). The table illustrates a significant positive correlation between depression scores and scores of anxiety ($r = .786, p < .001$). This indicates

that the higher the individual's feelings of depression were, the more pronounced his or her levels of anxiety were, and vice versa.

Table 4.3

Correlation Between Depression Scores on the Beck Depression Inventory – Second Edition and Anxiety Scores on the Beck Anxiety Inventory (N = 34).

Depression	r	p
Anxiety	.786	.000***

*** $p < .001$

4.2.2 Correlation between depression and hopelessness

In order to determine the statistical relationship between symptoms of depression and hopelessness, the Pearson correlation coefficient was used. The results, as shown in Table 4.4, indicate a significant positive relationship between scores of depression and hopelessness scores ($r = .707, p < .001$). This implies that the more pronounced the participants' feelings of hopelessness, the higher their depressive symptoms.

Table 4.4

Correlation Between Depression Scores on the Beck Depression Inventory – Second Edition and Hopelessness Scores on the Beck Hopelessness Scale (N = 34).

Depression	r	p
Hopelessness	.707	.000***

*** $p < .001$

4.2.3 Correlation between anxiety and hopelessness

The nature of the correlation between levels of anxiety and hopelessness was determined with the Pearson Correlation Coefficient. Results indicate that a positive correlation exists between scores of anxiety and hopelessness scores ($r = .678, p < .001$), as indicated in Table 4.5. This implies that the more pronounced the participants' feelings of hopelessness, the more they experienced increased levels of anxiety. Consequently, the following hypothesis was supported:

- *There will be a significant positive correlation between anxiety and hopelessness.*

Table 4.5

Correlation Between Anxiety Scores on the Beck Anxiety Inventory and Hopelessness Scores on the Beck Hopelessness Scale (N = 34).

Anxiety	r	p
Hopelessness	.678	.000***

*** $p < .001$

The interrelatedness of symptoms of depression, anxiety and hopelessness have been widely documented in literature. Consequently, for the purpose of this study, it was deemed important to establish these positive correlations between the variables as they form the foundation of some of the subsequent conclusions, and build on existing literature.

4.2.4 Correlation between depression and coping strategies

Spearman's correlation coefficient was used to determine the nature of the statistical relationship between symptoms of depression and the coping strategies of the Coping Strategy Indicator subscales (see Table 4.6). Results indicate a significant positive correlation between depression scores and scores of avoidant coping ($r = .399, p < .05$). This implies that the higher the depression scores, the more increased the propensity for participants to make use of avoidant coping strategies. As the results indicate, the following hypothesis was supported:

- *There will be a significant positive correlation between depression and avoidant coping.*

Table 4.6

Correlation Between Depression Scores on the Beck Depression Inventory – Second Edition and Coping Scores on the Three Subscales of the Coping Strategy Indicator (N = 34).

Coping Strategy	r	p
Problem-solving coping strategy	-.247	.159
Social support-seeking coping strategy	-.481	.004**
Avoidant coping strategy	.399	.020*

* $p < .05$, ** $p < .01$

As shown in Table 4.6, a significant negative correlation was established between scores of depression and scores of the social support-seeking coping strategy ($r = -.481, p < .01$). This implies that the more severe the participant's perception of their level of depression were, the less likely they were to revert to social support-seeking coping strategies. As the results indicate, the following hypothesis was supported:

- *There will be a significant negative correlation between depression and social support-seeking coping.*

Lastly, the results in Table 4.6 indicate that the negative correlation between scores on the Beck Depression Inventory – Second Edition and scores on the problem-solving coping strategy of the Coping Strategy Indicator were not significant.

The following hypothesis was consequently rejected:

- *There will be a significant negative correlation between depression and problem-solving coping.*

4.2.5 Correlation between anxiety and coping strategies

Spearman's correlation coefficient was used to determine the statistical relationship between levels of anxiety and the coping strategies of the Coping Strategy Indicator subscales (see Table 4.7). Results indicate a significant positive correlation between anxiety scores and scores of avoidant coping ($r = .375, p < .05$). This indicates that the more participants made use of the avoidant coping strategy, the more pronounced and increased were their anxiety levels.

Table 4.7

Correlation Between Anxiety Scores on the Beck Anxiety Inventory and Coping Scores on the Three Subscales of the Coping Strategy Indicator (N = 34).

Coping Strategy	<i>r</i>	<i>p</i>
Problem-solving coping strategy	-.308	.076
Social support-seeking coping strategy	-.386	.024*
Avoidant coping strategy	.375	.029*

* $p < .05$

As indicated in Table 4.7, a significant negative correlation was found between scores of anxiety and scores of the social support-seeking coping strategy ($r = -.386$, $p < .05$). This indicates that the more anxiety the participants experienced, the less likely they were to engage in social support-seeking coping strategies.

4.2.6 Correlations between perceived social support and coping strategies

Pearson's correlation coefficient was used to determine the statistical relationship between levels of anxiety and the coping strategies of the Coping Strategy Indicator subscales (see Table 4.8).

Table 4.8

Correlation Between Social Appraisal Scores on the Social Support Appraisal scale and Coping Scores on the Three Subscales of the Coping Strategy Indicator (N = 34).

Coping Strategy	r	p
Problem-solving coping strategy	.270	.123
Social support-seeking coping strategy	.634	.000***
Avoidant coping strategy	-.431	.011*

* $p < .05$, *** $p < .001$

The results in Table 4.8 indicate a significant positive correlation between social appraisal scores and scores of the social support-seeking coping strategy scale ($r = .634$, $p < .001$). This implies that the stronger the perceived social support received from significant others, the more participants made use of the social support-seeking coping strategies.

Table 4.8 also shows that significant negative correlations emerged between the perceived social support scores and scores on the avoidant coping strategy scale ($r = -.431$, $p < .05$). This implies that the less participants perceived the availability of social support received from significant others, the more they resorted to avoidant coping strategies.

Lastly, results in Table 4.8 show that the positive correlation between perceived social support scores and scores on the problem-solving coping strategy scale was not significant.

4.2.7 Correlation between anxiety and social support appraisal

In order to calculate the nature of the statistical relationship between anxiety and social support appraisal, the Pearson correlation was used. Results illustrated in Table 4.9 indicate a significant negative correlation between anxiety scores and scores on social support appraisal

($r = -.404, p < .05$). This indicates that the stronger the perceptions of social support received from significant others, the lower were their anxiety scores. As the results indicate, the following hypothesis was supported:

- *There will be a significant negative correlation between social support appraisal and anxiety.*

Table 4.9

Correlation Between Scores on the Beck Anxiety Inventory and Scores on the Social Support-Appraisal Scale (N = 34)

Anxiety	r	p
Support Support-Appraisal	-.404	.018*

* $p < .05$

4.3 Regression analyses

Multiple regression analyses were conducted to determine the nature of the predictive relationship between the main variables, including stress (depression scores on the Beck Depression Inventory – Second Edition and anxiety scores on the Beck Anxiety Inventory), hopelessness (in the Beck Hopelessness Scale), coping (in the Coping Strategy Indicator) and perceived social support (in the Social Support-Appraisals Scale).

4.3.1 Hopelessness as a predictor of depression

Multiple regression analyses were conducted to determine whether hopelessness predicted symptoms of depression. The results, as shown in Table 4.10, indicate that hopelessness emerged as a significant positive predictor of symptoms of depression ($\beta = .574, p < .001$).

This implies that heightened levels of hopelessness were strongly associated with heightened depression scores. The following hypothesis was thus supported:

- *Hopelessness will emerge as a significant positive predictor of depression.*

Table 4.10

Multiple Regression of Depression on Hopelessness (N = 34).

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	12.443	2.302		5.404	.000***
Hopelessness	1.439	.254	.707	5.658	.000***

Note. $F(1, 32) = 32.011$, $R = .707$, $R^2 = .500$, adjusted $R^2 = .484$, $SE = 9.251$

*** $p < .001$

4.3.2 Social support appraisal as a predictor of stress

In order to determine whether social support appraisal was a significant predictor of stress, multiple regression analyses were conducted. Stress, for the purpose of this study is measured by the Beck Depression Inventory – Second Edition (BDI-II) and the Beck Anxiety Inventory (BAI). Tables 4.11 and 4.12 indicate the respective influence of social support appraisal and coping on stress (symptoms of depression and anxiety).

Table 4.11

Multiple Regression of Depression on Social Support Appraisal (N = 34).

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	67.699	10.966		6.173	.000***
Social Support Appraisal	-.778	.184	-.599	-4.235	.000***

Note. $F(1, 32) = 17.936$, $R = .599$, $R^2 = .359$, adjusted $R^2 = .339$, $SE = 10.473$

*** $p < .001$

As illustrated in Table 4.11, social support appraisal emerged as a significant negative predictor of symptoms of depression ($\beta = -.778$, $p < .001$). This implies that increased social support appraisal scores were associated with lowered depression scores. Consequently, the following hypothesis was supported:

- *Social support appraisal will emerge as a significant negative predictor of stress (in this case, depression).*

Table 4.12 indicates that social support appraisal emerged as a significant negative predictor of symptoms of anxiety ($\beta = -.448$, $p < .05$). This implies that increased social support appraisal scores were associated with lowered anxiety scores. The following hypothesis was thus supported:

- *Social support appraisal will emerge as a significant negative predictor of stress (in this case, anxiety).*

Table 4.12

Multiple Regression of Anxiety on Social Support Appraisal (N = 34).

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	40.419	10.695		3.779	.001**
Social Support Appraisal	-.448	.179	-.404	-2.498	.018*

Note. $F(1, 32) = 6.242$, $R = .404$, $R^2 = .163$, adjusted $R^2 = .137$, $SE = 10.214$

* $p < .05$, ** $p < .01$

4.3.3 Coping strategies that functioned as predictors of depression

Multiple regression analyses were conducted to determine whether any of the three coping strategies (problem-solving, social support-seeking, and avoidant) of the Coping Strategy Indicator (CSI) would predict symptoms of depression. The analyses results are presented in Table 4.13.

Table 4.13

Multiple Regression of Depression on Coping Strategies (N = 34).

Coping Strategies	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	23.013	19.613		1.173	.250
Problem-Solving	-.075	.432	-.033	-.173	.864
Social Support-Seeking	-.628	.333	-.351	-1.888	0.69
Avoidance	.603	.617	.195	.978	.336

Note. $F(3, 30) = 3.239$, $R = .495$, $R^2 = .245$, adjusted $R^2 = .169$, $SE = 11.744$

As illustrated in Table 4.13, both the problem-solving and social support-seeking strategies emerged as the not-significant negative predictors of symptoms of depression. Therefore, the following hypothesis was not supported:

- *Problem-solving coping will emerge as a significant negative predictor of stress (in this case, depression).*

Moreover, the avoidant coping strategy also emerged as a not-significant predictor of symptoms of depression.

4.3.4 Coping strategies that functioned as key variables in predicting anxiety

Multiple regression analyses were conducted to determine whether any of the three coping strategies (problem-solving, social support-seeking, and avoidant) of the Coping Strategy Indicator (CSI) would predict symptoms of anxiety. The analyses results are presented in Table 4.14.

Table 4.9

Multiple Regression of Anxiety on Coping Strategies (N = 34).

Coping Strategies	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	5.361	17.698		.303	.764
Problem-Solving	-.213	.389	-.112	-.547	.589
Social Support-Seeking	-.117	.300	-.077	-.390	.699
Avoidance	.730	.557	.276	1.312	.200

Note. $F(3, 30) = 1.844$, $R = .395$, $R^2 = .156$, adjusted $R^2 = .071$, $SE = 10.597$

As illustrated in Table 4.14, both the problem-solving and social support-seeking coping strategies emerged as the not-significant negative predictors of symptoms of anxiety, thus leading to the rejection of the following hypothesis:

- *Problem-solving coping will emerge as a significant negative predictor of stress (in this case, anxiety).*

Moreover, the avoidant coping strategy emerged as a not-significant predictor of symptoms of anxiety.

4.3.5 Coping strategies that functioned as predictors of social support appraisal

Table 4.15 illustrates the results of the multiple regression analyses that were conducted in order to determine which of the three coping strategies of the Coping Strategy Indicator predicted perceived social support on the Social Support Appraisals Scale.

Table 4.15

Multiple Regression of Social Support Appraisal on the Three Subscales of the Coping Strategy Indicator (N = 34).

Coping Strategies	<i>B</i>	<i>SE B</i>	β	<i>t</i> ratio	<i>p</i>
Constant	56.404	13.147		4.290	.000***
Problem-solving coping strategy	-.149	.289	-.087	-.515	.610
Social support-seeking coping strategy	.791	.223	.574	3.547	.001**
Avoidant coping strategy	-.485	.414	-.203	-1.173	.250

Note. $F(3, 30) = 7.480$, $R = .654$, $R^2 = .428$, adjusted $R^2 = .371$, $SE = 7.872$

** $p < .01$ *** $p < .001$

As reported in Table 4.15, social support-seeking coping emerged as a significant positive predictor of perceived social support ($\beta = .574, p < .01$). This implies that the more participants engage in social support-seeking coping, the more they are aware of they perceive the availability of social support.

The results shown in Table 4.15 also illustrate that both the problem-solving coping strategy and avoidant coping strategy emerged as the not-significant predictors of perceived social support, thus implying that the use of these coping strategies was not associated with perceived social support (social support appraisal). Therefore, the following hypothesis did not find support:

- *Problem-solving coping will emerge as a significant positive predictor of social support appraisal.*

To summarize the main findings of the present study: the majority of participants were considered severely depressed, but showed minimal signs of hopelessness as well as minimal to mild signs anxiety. Furthermore, a significant positive correlation was established between symptoms of depression, anxiety and hopelessness. Similarly, a significant negative correlation was established between symptoms of depression and social support-seeking coping as well as social support-seeking coping and symptoms of anxiety. A significant positive correlation was established between symptoms of depression and avoidant coping. Moreover, hopelessness emerged as a significant positive predictor of symptoms of depression; and social support-seeking coping emerged as a negative predictor of stress (symptoms of depression and anxiety).

In the following chapter the thesis is concluded with a discussion of the main research findings.

CHAPTER 5

Discussion and Conclusions

5.1 Introduction

The aim of the present study was to determine the psychological functioning of patients admitted to a rural Western Cape hospital following an episode of non-fatal suicidal behaviour, with specific focus on the relationships between stress (symptoms of depression, anxiety and hopelessness), coping and perceived social support in the functioning of these patients following their episode of non-fatal suicidal behaviour. This chapter presents a discussion of the main findings, and includes an overview of the limitations of the study as well as recommendations for future research.

5.2 Discussion of main findings

5.2.1 Stress: Depression, anxiety and hopelessness

In this study it was important to first ascertain the levels of stress of participants, and to establish their correlations, before further inferences were made with regards to coping and social appraisal. Much research has been conducted on symptoms of anxiety, depression and hopelessness, and therefore, the present findings can easily be compared to previous results.

Findings from the present study revealed that 26.47% of participants showed signs of minimal depression, 20.59% showed signs of mild depression, 23.53% showed signs of moderate depression, while 29.41% of participants evinced symptoms of severe depression. This means that, in total, 73.53% of all participants presented with symptoms of at least mild depression. Depressed mood is associated with feelings of sadness, worthlessness, fatigue, and

perhaps most importantly, anhedonia – the inability to experience pleasure in previously pleasurable activities (Cunningham, 2006).

The prevalence of depression amongst these suicidal individuals is consistent with findings from previous studies (Al-Sayegh et al., 2015; Chu et al., 2013; Dozois et al., 1998; Grothe et al., 2005; Hales et al., 2015; Quilty et al., 2010; Schlebusch, 2005a), that found heightened depressive symptoms in individuals presenting with suicidal thoughts and behaviour. A study by Wetzler et al. (1996) – which was conducted on severe suicide attempters, non-severe suicide attempters, suicide ideators, and non-suicidal individuals – found that depressed mood was fundamentally associated with all forms of suicidality.

The findings from the present study also showed that, on the Beck Anxiety Inventory (BAI), 32.35% of participants experienced minimal anxiety, 32.35% experienced mild anxiety, 23.53% experienced moderate anxiety and 11.77% of the participants experienced severe anxiety. This means that 67.65% of the participants presented with at least mild anxiety. Notably, previous research indicated a significant correlation between high anxiety levels and suicidal behaviour (Beekrum et al., 2011; Guerreiro et al., 2015; Klonsky et al., 2013).

However, consistent with the findings of the present study, a New Zealand study by Beautrais et al. (2005) found that only 3–17% of participants with serious suicidal behaviour showed symptoms of anxiety. Similarly, a South African study by du Toit et al. (2008) established that only 7% of participants experienced symptoms of anxiety as a precipitating factor to an episode of non-fatal suicidal behaviour. While these studies suggest the influence of symptoms of anxiety to be relatively small, the surge of literature on suicidology emphasize influence of symptoms of anxiety (Carver & Scheier, 1994; Cohen & Wills, 1985; Folkman et al., 1986a; Kinyanda et al., 2011; Monat & Lazarus, 1991; O’Conner & Sheehy, 2001; Rutter et al., 2013; Steer et al., 1993).

The Beck Hopelessness Scale reported that 44.12% of participants showed minimal signs of hopelessness, 26.47% showed mild signs of hopelessness, 17.65% showed moderate signs of hopelessness, and 11.77% showed severe signs of hopelessness. This means that 55.89% of participants presented with at least mild levels of hopelessness. Based on the BHS feelings of negative future expectations, lack of positive personal experiences or opportunities and a general bleak outlook on the future could be contributing factors to this high prevalence of hopelessness.

The South African study by Du Toit et al. (2008) reported on the profile analysis of an individual experiencing an episode of non-fatal suicidal behaviour admitted to Pelonomi Hospital, Bloemfontein, South Africa and established that only 16.7% of patients experienced feelings of hopelessness. While this study suggests that the role of hopelessness is relatively small, the present findings are more in line with other international findings. Notably, previous research (Beck et al., 1996a; D’Zurilla et al., 1998; Ivanoff & Jang, 1991; Motto, 1984; Swanepoel, 2003; Taljaard, 2013; Watt & Sharp, 2001), suggests that high levels of hopelessness are associated with suicidal behaviour.

While the presence of symptoms of depression, anxiety and hopelessness is consistent with previous studies as indicated, the degrees of symptoms of depression, anxiety and hopelessness are somewhat lower than one might expect. With the exception of symptoms of depression, the majority of participants presented with minimal or mild symptoms. With regards to symptoms of depression, almost half (47,1%) of participants presented with minimal and mild symptoms. A possible explanation for this could be due to what has been referred to as the *cathartic effect*. A study of 39 patients by Sarfati et al. (2003) found a decrease in symptoms of depression, hopelessness and impulsivity following a suicide crisis which the authors attributed to what they referred to as a *cathartic effect*. Accordingly, the outward

expression of suicidality in the form of an attempt to commit suicide results in the release of emotional tension, which in turn, results in decreased levels of depression, hopelessness and impulsivity. Limited research has been conducted on the immediate after-effects of non-fatal suicide behaviour, making it difficult to draw conclusions on this phenomenon, however this study does draw attention to the possible difference in stress experienced during the build-up to an episode of non-fatal suicidal behaviour and the stress experienced after having survived one.

Maris' (1991) findings on suicidality within the depressive cycle could also shed light on the levels of depression, anxiety and hopelessness found in the present study. As discussed in the literature review, Maris found that episodes of non-fatal suicidal behaviour are more prevalent in individuals coming out of a depressed episode rather than those who are still in the midst of an episode. O'Connor and Sheehy (2001) added to this argument by explaining that this phenomenon occurs because as depressive symptoms are subsiding, individuals may find that they finally have the motivation and energy needed to follow through with a episode of non-fatal suicidal behaviour.

While it is impossible to draw conclusions based on the present findings, they draw attention to the need for longitudinal studies on the psychological functioning of individuals. Longitudinal research would allow for the evaluation of how stress levels change over time and whether the post-suicide-attempt period yields results specific to this time period. Longitudinal research would also allow for the study of depressive cycles, the possible fluctuation of level of anxiety and hopelessness, and how these relate to increasing or decreasing desires to resort to suicide.

5.2.2 Correlations between depression, anxiety and hopelessness

While the correlations between symptoms of depression, anxiety and hopelessness are well researched and known, it was important for the present study to confirm these correlations within the sample group. Establishing these correlations for this group mean that coping and social appraisal findings can contribute to, and build on, existing literature.

The present study indicated a significant positive correlation between symptoms of depression and anxiety. This finding, as mentioned, is consistent with previous literature (Cunningham, 2006; Dobson, 1985). For example, Cunningham (2006) suggested a temporal relationship between symptoms of anxiety and depression, and found that anxiety disorders preceded the onset of depression, and that, due to this temporal relationship, individuals were predisposed to develop depression as a result of anxiety. Similarly, it was found that comorbid anxiety and depression were associated with increased suicidal ideation (Lecrubier, 1998). The Beck Anxiety Inventory (BAI) predominantly measures physical factors that could predict the levels of anxiety. The prevalence of symptoms of anxiety in the present study supports the findings of Cunningham (2006).

Findings from the present study show a significant positive correlation between symptoms of depression and hopelessness. Moreover, regression analysis revealed hopelessness to be a significant positive predictor of symptoms of depression. Once again, the present finding of the significant relationship between symptoms of depression and hopelessness is consistent with findings from previous research. For example, Horwitz et al. (2017), in a study on 59 adolescents aged between 14 and 19 years, who screened positive for being at risk for attempting suicide, indicated that hopelessness emerged as a significant positive predictor of symptoms of depression as well as suicidology. Similarly, MacLeod et al. (2005) reported that hopelessness is the key psychological variable influencing suicidal

behaviour, and that the relationship between depression and suicidality is mediated by hopelessness. Measuring hopelessness according to the Beck Hopelessness Scale (BHS) gives a clear indication that the underlying factors contributing to hopelessness is the patient's overwhelming perception that he or she has no or little control over the outcome of personal expectations, their own future and their immediate circumstances. According to the findings in the present study, this lack of control operated as a significant predictor of symptoms of depression.

Also consistent with the hypothesis, the present findings show a significant positive correlation between symptoms of anxiety and hopelessness, with regression analysis revealing hopelessness to be a significant positive predictor of anxiety. MacLeod et al. (2005) found a relationship between symptoms of anxiety and hopelessness in terms of negative future thinking. Increased feelings of hopelessness and negative expectancy of the future result in elevated feelings of anxiousness, as the future may seem unsure and bleak. A study by Cunningham (2006), who used a structural equation model to determine the significance between symptoms of anxiety, depression and hopelessness in 971 adolescents, found that anxiety scores showed a positive correlation with depression and hopelessness scores.

Overall, the findings of the present study, in light of the relevant literature, have indicated that symptoms of depression, anxiety and hopelessness played a major contributing role in the suicidal behaviour of participants. Furthermore, the study's finding that hopelessness is a positive predictor of both anxiety and depression, together with literature suggesting that symptoms of depression predicts suicidal behaviour (Brown et al., 2000; Franklin et al., 2017; Nanayakkara et al., 2013; Steer et al., 1993), confirms the crucial role of hopelessness in suicidal behaviour. This calls for more research on the possible negative predictors of hopelessness. While the present study failed to investigate the correlations between various

coping-strategies and hopelessness, it is highly recommended that future research explore these relationships.

5.2.3 Overall use of coping: Avoidant and support-seeking coping

The present study revealed that the use of the three subscales of the Coping Strategy Indicator consisted of equal use of avoidant coping (38.24%) and social support-seeking coping (38.24%); followed by 17.65% predominantly using problem-solving coping; 2.94% using an equal combination of problem-solving and social support-seeking coping; and 2.94% using an equal combination of problem-solving and avoidant coping strategies. These initial findings are puzzling, when compared to previous research studies as previous research has found that avoidant coping is the predominant coping strategy used by suicidal individuals (Barzilay & Apter, 2014; Bazrafshan et al., 2014; Guerreiro et al., 2015; Marty et al., 2010; Mirkovic et al., 2015).

A closer analysis of the findings, however, reveal that of the severely depressed individuals in the sample group, the majority (60%) made use of avoidant coping. This finding is valuable in that it not only suggests a correlation between depression and avoidant coping, it also indicates that less depressed individuals are more likely to use social support-seeking coping. Indeed, regression analyses confirmed these findings in that the present study indicated a significant positive correlation between symptoms of depression and avoidant coping, and found a significant negative correlation between symptoms of depression and the social support-seeking coping strategy.

Interestingly, Steeger, Gondoli and Morrissey (2013) found the relationship between avoidant coping and depressive symptoms to be bidirectional. The study also found that maladaptive behaviour or emotional outcomes emerge as a result of using avoidant cognitive and behavioural coping when faced with a challenge or threat. Similarly, Felton and Revenson

(1984) reported on a mutually reinforcing cycle between avoidant coping and emotional distress; and that a history of depressive symptoms could prevent or inhibit effective coping. Furthermore, an association was found between reliance on avoidant coping and depressive symptoms (Felton & Revenson, 1984), with these symptoms reportedly inducing feelings of disappointment and creating an environment of frustration.

The finding that a negative correlation exists between symptoms of depression and social support-seeking coping is supported by literature (Carlson & Miller, 2017; Somhlaba & Wait, 2009). Somhlaba and Wait reported that social isolation has been associated with feelings of depression (2009). Similarly, it could be argued that perceived social support creates a sense of belonging and an environment where the individual feels safe and possibly able to make use of the available social support networks for enlisting the needed support, which in turn can have a diminishing effect on feelings of depression and isolation.

5.2.4 The stress-coping model

It is insightful to interpret the relationship between symptoms of depression and avoidant coping, in relation to Lazarus and Folkman's stress-coping model. Their model suggests an active striving for balance, or homeostasis. When a state of balance or homeostasis is under threat, the individual assesses his or her available resources to adequately remove the stressor, in order to return to a state of homeostasis once again. When the individual is exposed to overloaded emotional distress, with inadequate resources, avoidant coping usually follows, resulting in maladaptive behaviour patterns (Lazarus & Folkman, 1984).

On the basis of the stress-coping model, it is possible that when faced with a stressor, the individual assesses his or her situation and perhaps realises that he or she does not possess the necessary skills or resources to solve (or to "fight") his or her problem or stressor. This

could result in the individual avoiding (“flight”) his or her situation permanently by trying to end his or her suffering by attempting suicide.

5.2.5 Anxiety and perceived social support

Consistent with the hypothesis, a significant negative correlation was found between social support appraisal and symptoms of anxiety. Moreover, social support appraisal emerged as a significant negative predictor of symptoms of anxiety. Research supports the finding that poor social support has been associated with increased feelings of anxiety (Cohen et al., 1988; Lee et al., 2014; Mahmoud, 2011; Tsuchihashi-Makaya et al., 2009). A recent study by Mahmoud (2011), on 257 undergraduate students, established a negative relationship between social support and anxiety and found that support received from loved ones (by means of guidance and reassurance) assists with the adaptation to stressful encounters. Moreover, it was determined that poor social support can aggravate stress and anxiety.

Similarly, a study by Ogundipe et al. (2015) found that the support from friends and family creates a sense of belonging and reassurance which has a diminishing effect on anxiety levels. Similarly, poor social support creates feelings of isolation, which in turn is associated with depression and ultimately suicidality (Ogundipe et al., 2015). Against this background, it makes sense that, in the present study, diminished perceptions of social support from significant others were associated with participants’ heightened anxiety. To this effect, the general experience of limited availability of social support (and diminished avenues for enlisting support from the existing social networks) could have evoked a great deal of constant worry, apprehension and heightened uncertainty about what the future holds for the participants.

Ultimately, this sequence of emotions support Farberow and Shneidman’s (1961) Communication Theory. The theory suggests that as a result of debilitating stress and limited social support – as a cry for help to loved ones – the individual often engages in suicidal

behaviour as a manner of seeking loved-ones' attention. A lack of social support is associated with a sense of longing and isolation. This sense of isolation often inhibits the individual from physically communicating their emotional needs or distress to loved ones, thus engaging in suicidal behaviour and attempting suicide, as a cry for help. Lee et al. (2014) found that perceived social support had an inhibiting effect on depressive symptoms, and that perceived social support could be associated with feelings of self-worth, belonging and security. Similarly, in a study by Savi Çakar and Karataş (2012), a significant positive relationship was established between self-esteem, perceived social support and hopelessness.

The finding that only 50% of participants indicated that their intention was to die, offers further support for Farberow and Shneidman's Communication Theory. It is possible that in an attempt to convey the degree of the individual's emotional distress, he or she resorts to suicidal behaviour as a mean of communication. In some cases, it could be possible that the individuals themselves do not understand their own feelings or mental distress, and consequently also don't possess the verbal capacity to convey this distress – as they do not understand it themselves. Also noteworthy, the present study found that 79.4% of participants indicated to be of "average" or "good" mental health – clearly indicating a lack of understanding of their emotional state. An argument could therefore be made that these individuals do not possess the skills to adequately evaluate their own feelings and emotional state and possibly also do not possess the ability to verbalise their distress. It could therefore be argued that in an attempt for an outward expression of their inward distress, they resort to suicidal behaviour as means of communication.

5.2.6 Coping and perceived social support

Findings from the present study show a significant positive correlation between perceived social support and the social support-seeking coping strategy. In addition, this coping strategy

emerged as a significant positive predictor of perceived social support. Similarly, a study by Ognibene and Collins (1998) of 81 participants, indicated that individuals that perceived to have access to social support from loved ones sought more social support when confronted with stress. Findings of the present study indicate that the more the individual interacted in social support-seeking coping, the more his or her perception of available social support was positively reinforced. The majority of participants (61.8%) in this study, however, did not engage in social support-seeking coping which explains their lower perception of social support. Subsequently, the participants experienced a lack of support and sense of belonging as well as feelings of isolation and loneliness.

While the avoidant coping strategy was significantly negatively correlated with perceived social support (at bivariate level), when regression analyses were conducted, the avoidant coping strategy emerged as a not-significant predictor of perceived social support. A study by Seiffge-Krenke (2006) indicated that individuals using avoidant coping had less of a need to engage in social support. The findings of the present study indicate that the participants' engagement with avoidant coping, contributed to their perceived lack of social support. The combination of these factors intensify feelings of isolation, hopelessness and anxiety. The predisposition to avoid stressors coupled with the perception of lacking social support, contributes to the individual's overall avoidant behaviour. Once again, it can be argued that engaging in non-fatal suicidal behaviour becomes an avoidant strategy which serves as a mechanism to deal with life stressors.

In conclusion, it has been established that anxiety predicts depression, which in turn predicts suicide. The use of social support-seeking coping is positively related to perceived social support, which in turn is negatively related to anxiety. A case could be made for the importance of social support-seeking coping along with its positive correlation to social appraisal, in addressing symptoms of depression and anxiety that could lead to suicide.

5.3 Implications for intervention

The findings of the present study can be helpful for psychologists, social workers and all other mental health professionals dealing with suicidal individuals, specifically within the rural communities of South Africa. It also has significance given the limited literature and scholarly work on suicidal behaviour within the rural context.

The majority of participants (85.3%) were between the ages of 15 and 34 years and intervention programmes should be structured to adequately address the challenges that this age group typically experiences. The age group between 25 and 34 years is typically associated with emotional and economic uncertainty, as this is the time during which tertiary studies are completed, employment is sought, one might enter the labour market, find a life partner and/or start a family. For many, this can be a stressful experience. One could argue that as a result of environmental stressors, such as poverty and unemployment, feelings of hopelessness about the future could increase during this time and possibly contribute to suicidal behaviour.

The present study also indicated that the majority of participants were first-time attempters and considered themselves to be of average mental health, clearly indicating a lack of insight into their mental well-being. Therefore, attention should be given to awareness programmes that educate community members on mental health issues.

The predominance of youth and adolescent attempters (85.3% of this age group in the present study) illustrates the need for these intervention programmes in youth centres, high schools and tertiary educational institutions. High schools should develop and implement educational programmes for learners on the dangers of attempted suicide, the effect of untreated stressors, the consequences of avoidant coping and the crucial role of social support in general psychological well-being. Psycho-educational programmes aimed at helping those already under duress should be centred on equipping them with skills for identifying their

distressed and conflicted emotions (so as to be able to seek social support and professional help as soon as it is needed), and identifying and solidifying those social ties and important relationships from whom emotional relief could be obtained (and from whom support could be enlisted) in times of need.

Moreover, the educational community outreach programmes should have a specific focus on the identification and development of positive and constructive coping skills. The fact that 38% of the participants made use of the avoidant coping strategies – against the backdrop of the high prevalence of symptoms of depression (*with 73.53% of all participants presenting with symptoms of at least mild depression*), symptoms of anxiety (*with 67.65% of the participants presenting with at least mild anxiety*) and symptoms of hopelessness (*with 55.89% of participants presenting with at least mild levels of hopelessness*) – highlights the urgency for psycho-education for emotionally vulnerable individuals to incorporate healthy adaptive coping skills. Knowing how to deal with a stressor can considerably reduce stressful circumstances (Blonna, 2005).

At the community level, projects should be initiated to educate community members on the symptoms of depression, anxiety and hopelessness. In communities confronted with poverty, gangsterism and crime, the debilitating effect of depression and anxiety are often unidentified and left untreated. Special attention should be given to the development of effective coping strategies and communication skills. Communities should also be educated on the positive influence of social support. As a possible preventative measure, follow-up meetings and group sessions could be initialised for discharged individuals that attempted non-fatal suicidal behaviour. Hospitals could facilitate group sessions, where these individuals could get together on a weekly or monthly basis, serve as a support structure for one another and discuss their feelings and stressors with each other. These sessions could be facilitated by

mental health workers who would help guide these individuals to implement positive coping mechanisms and identify symptoms of stress.

Research shows that a previous episode of non-fatal suicidal behaviour is considered the biggest risk factor for repeated attempts (WHO, 2014). For this reason, closer attention should be given to second-time (and, generally, repeat-) attempters, as they represent a particularly vulnerable group. Hospital staff should also be educated on the influence of stress, coping and social support on suicidal behaviour.

5.4 Recommendations and conclusion

5.4.1 Strengths of the study

The present study used the stress-coping model and communication theory as a basis for understanding the relationship between stress, coping and perceived social support in patients admitted to a rural Western Cape hospital following attempted suicide. The strengths of the present study are briefly discussed below.

Firstly, by interviewing suicidal individuals, the study was explorative by nature and resulted in first-hand experience and understanding of the influence of stress, coping and social support on suicidal behaviour. Subsequently, the study was not inferential, but rather a true account of the suicidal individual's perspective and experience. Consequently, the study's findings could help structure prevention and intervention programmes to be implemented by mental health workers.

Secondly, limited research has been done in rural communities on the psychological functioning of suicidal individuals in terms of stress, coping and perceived social support. Therefore the findings of the present study are valuable in that they contribute to and expand

knowledge and understanding of the psychological functioning of individuals engaging in non-fatal suicidal behaviour in the rural Western Cape.

5.4.2 Limitations of the study and recommendations for future research

The present study encountered the following limitations. Firstly, for the purpose of this study, a quantitative research design was selected in order to quantify stress, coping and social support. While this enabled the quantification of the statistical relationships between variables, it meant that the subjective experiences of suicidal individuals regarding their suicidal behaviour was not explored qualitatively. Therefore, future research should consider exploring the phenomenon of non-fatal suicidal behaviour by means of either qualitative research designs or a mixed-methods approach in order to gain a better understanding of the environmental and personal stressors that individuals engaging in non-fatal suicidal behaviour often struggle with before and after attempting to take their own lives.

Secondly, given the cross-sectional nature of the study's design, it was impossible to ascertain whether the experience of stress (symptoms of depression, anxiety and hopelessness), coping and perceived social support found in the study was illustrative of the experience of suicidal individuals more generally when faced with acutely stressful encounters, or whether these were specific to individuals during the time immediately following an episode of non-fatal suicidal behaviour. Therefore, future research should consider using longitudinal research designs in order to observe the manifestation of stress, coping and perceived social support at different times – and help identify those times in which intervention would most likely benefit emotionally vulnerable individuals.

Thirdly, and finally, the study was limited to a sample size of 34 participants. While it is expected that studies on suicidal individuals would generally yield smaller samples, it still remains a shortcoming as findings from such a sample cannot be generalized to the broader

South African population. In order to generalize findings to the greater South African population, further research would be required with larger sample sizes.

5.4.3 Concluding remarks

To conclude, literature indicates an increase in suicidal behaviour globally, warranting further research. The underlying psychological factors influencing suicidal behaviour should be a public health concern, and more attention should be given to the increasing prevalence of suicidal behaviour. The present study aimed to provide some understanding into the psychological functioning of suicidal individuals in a rural context. Despite being limited by a small sample size, the study does provide insight into the predominant coping strategies, perceived social support and stress levels of suicidal individuals.

The study found participants to have various levels of depression, anxiety and hopelessness. The correlations between these were consistent with previous research in that depression was found to be positively correlated with anxiety and hopelessness. Furthermore, hopelessness was also found to be a positive predictor of depression.

The study also established a negative correlation between anxiety and social support appraisal. In turn, social support appraisal has emerged as a significant negative predictor of anxiety.

The study found that while avoidant coping negatively predicts social appraisal, social-support seeking positively predicts social appraisal. Another notable finding was that social-support seeking and social appraisal are negatively correlated to anxiety and depression. Upon further investigation, the study also found a positive correlation between avoidant coping and severe depression.

An important finding of this study for the implementation of treatment and prevention programs is the important role of social support-seeking coping due to it being negatively correlated with depression, which is a risk factor for episodes of non-fatal suicidal behaviour. The insight obtained in this study can aid psychologists, social workers and other mental health workers to effectively structure prevention and intervention programs to address the maladaptive coping mechanisms and stress levels of people in the community.

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APPENDICES

Appendix A: Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

AGE:

PT. NO.:

GENDER:

 1 MALE 2 FEMALE

RACE:

 1 WHITE 2 AFRICAN 3 COLOURED 4 ASIAN 5 OTHER

PRIMARY LANGUAGE:

 1 ENGLISH 2 AFRIKAANS 3 XHOSA 4 OTHER

MARITAL STATUS:

 1 SINGLE 2 IN A RELATIONSHIP 3 ENGAGED 4 MARRIED 5 DIVORCED 6 WIDOWED

NUMBER OF DEPENDANTS:

 0 1 2 3 4 MORE

EDUCATIONAL LEVEL

 1 NO FORMAL EDUCATION 2 GRADE 1-3 3 GRADE 4-7 4 GRADE 8-10 5 GRADE 11-12 6 DIPLOMA 7 DEGREE

OCCUPATION:

1	UNEMPLOYED	2	EMPLOYED: (SPECIFY)
3	SCHOLAR	4	STUDENT

GROSS FAMILY MONTHLY INCOME:

1	R1 - R2,000	2	R2,001- R5,000	3	R5,001- R8,000	4	R8,001- R10,000
5	R10,001- R15,000	6	R15,001- MORE				

NUMBER OF SUICIDE ATTEMPTS (INCL THIS ATTEMPT):

1	2	3	4	MORE
---	---	---	---	------

METHOD OF ATTEMPTED SUICIDE (THIS ATTEMPT):

1	OVERDOSE	2	INHALATION	3	SHOOTING	4	HANGING
5	CUTTING	6	OTHER (SPECIFY):	7	MULTIPLE (SPECIFY):		

WAS IT YOUR INTENTION TO DIE?

1	YES	2	NO	IF NO, SPECIFY:
---	-----	---	----	-----------------

ARE YOU GOING TO ATTEMPT SUICIDE AGAIN?

1	YES	2	NO	3	UNSURE
---	-----	---	----	---	--------

HOW WOULD YOU RATE YOUR OVERALL MENTAL HEALTH?

1	GOOD	2	AVERAGE	3	POOR
---	------	---	---------	---	------

Appendix B: Beck Depression Inventory – Second Edition (BDI-II)

BECK DEPRESSION INVENTORY SECOND EDITION (BDI-II)



[Redacted]

1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]

[Redacted]

1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]

[Redacted]

1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]

[Redacted]

1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]

[Redacted]

1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]
1	1	[Redacted]

[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



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	[Redacted]
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[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[Redacted]

	[Redacted]
	[Redacted]
	[Redacted]
	[Redacted]



[REDACTED]

█	█	[REDACTED]
█	█	[REDACTED]
█	█	[REDACTED]
█	█	[REDACTED]



[REDACTED]

█	█	[REDACTED]
█	█	[REDACTED]
█	█	[REDACTED]
█	█	[REDACTED]



Appendix D: Beck Hopelessness Scale (BHS)

BECK HOPELESSNESS SCALE (BHS)			
1		1	1
2		1	1
3		1	1
4		1	1
5		1	1
6		1	1
7		1	1
8		1	1
9		1	1
10		1	1
11		1	1
12		1	1
13		1	1
14		1	1
15		1	1
16		1	1
17		1	1
18		1	1
19		1	1
20		1	1
		1	1
		1	1

Appendix E: Coping Strategy Indicator (CSI)

COPING STRATEGY INDICATOR (CSI)

[REDACTED]

	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Appendix F: Social Support Appraisal Scale (SSA)

SOCIAL SUPPORT APPRAISAL SCALE (SSA)

[Redacted text]

		1	2	3	4
1	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix G: Informed consent form (English)



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF THE STUDY: *The psychological functioning of patients admitted to a rural Western Cape hospital following attempted suicide: Stress, coping and perceived social support.*

You are asked to participate in a study conducted by Mrs Carla de Clerk, Hons (BA) Psychology, HPCSA Registered Counsellor (PRC 0015997), a master's student in psychology, Stellenbosch University, who is supervised by Dr. N. Z. Somhlaba. The results of the research project will contribute towards my thesis for the Masters degree in Psychology. Moreover, I have special interest in finding out more about how individuals who have tried to take their own lives (commit suicide) feel and think about their lives, in order to produce and share knowledge about how suicidal individuals can be better helped to improve their emotional well-being.

You were selected as a possible participant in this study because you were admitted to the rural Western Cape hospital [REDACTED] following attempted suicide.

1. PURPOSE OF THE STUDY

The purpose of the study is to establish the nature of the link between the stress experienced by individuals who attempt to commit suicide (in other words, their depression, anxiety and loss of hope in their lives), the manner in which they cope with the stress experienced, and ways in which they view social support from family, friends, and other important relationships. All this information relates in particular to individuals (like yourself) who have been admitted [REDACTED] following attempted suicide.

2. PROCEDURES

If you volunteer to participate in this study, you will be asked to do the following things:

Answer a series of questions given to you about:

1. Yourself and the life around you (otherwise known as demographic information);
2. Your emotional state (relating to whether or not you are depressed). To help provide us with information in this regard, questions about your level of depression will be asked;
3. Your state of being anxious (being fearful or being worried, and whether you can be described as anxious or not). To help provide us with information in this regard, a set of questions about you level of anxiety will be asked;
4. Your state of loss of hope (relating to whether you can be described as someone who has lost hope or not). To help provide us with information in this regard, I will be asking you about your level of hopelessness will be asked;

5. The ways in which you cope with stresses in life. To help provide us with information in this regard, questions about your level of overall coping will be asked;
6. The manner in which you view social support from family, friends and other important relationships. To help provide us with information in this regard, a set of questions about how you view these relationships will be asked.

All participants will be interviewed by the researcher and the series of questions will be answered during this interview. One contact session will be made with the researcher and the interview will take approximately 1 hour to complete. In the event that emotional distress makes it necessary to stop the interview, and we need to refer you to someone who helps you with feeling better, this will be done after I have consulted with you. A second interview to enable us to continue where we left off may be arranged with you, if you wish to continue answering the questions. All interviews will be conducted in the hospital.

3. POTENTIAL RISKS AND DISCOMFORTS

Answering the series of questions that I will be asking you might result in you feeling a little sadder, more depressed, more hopeless or more anxious, if you were already experiencing these feelings. It is important that I let you know that not all people interviewed for this study will feel the same. In the event that these feelings and thoughts do occur, and I am of the view that special attention is needed, I will refer you to a psychologist / social worker (someone who deals with helping people overcome their emotional problems and helps them feel better) who can help you. Should you have these thoughts and feelings, and you do not wish to continue answering the questions I have for you, you are welcome to let me know so that I can give you a chance to stop answering the questions, without you needing to explain why you wish to stop. Since all the people who help people deal with emotional problems are based at [REDACTED], I will make arrangements with any of the following people to help you in this regard:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

As already indicated above, I have a special interest in finding out more about how people who have tried to take their own lives (commit suicide) feel and think about their lives, in order to produce and share knowledge about how suicidal people can be better helped to improve their emotional well-being. This study will help to provide information that is important for finding ways of helping people with thoughts and feelings about committing suicide, feel better so that they do not reach a point of wanting to attempt suicide. A potential benefit for participating might be that you will be feeling better by sharing your thoughts and feelings with someone. Apart from this potential benefit there will be no direct benefit to you as a participant.

5. PAYMENT FOR PARTICIPATION

Participants will not receive payment and will participate on a voluntary basis.

6. CONFIDENTIALITY AND ANONYMITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Anonymity will be maintained by means of assigning a number to your name and thereafter reference to your name will not be made, but will only be made to the patient's given number. In other words, nobody will be able to see which of the questionnaires belong to you. We will use a number to identify each questionnaire and not your name. The list of given numbers associated with the names of people who participated in the study (by answering the questions) will be kept by the researcher in electronically and it will be password protected and only accessible to the researcher.

Interviews may be audio recorded and you has the right to listen to and request for changes to be made to the tapes. The tapes will be used for reviewing purposes and will only be accessed by the researcher. Results may be used for making the information known in other platforms and places where information collected through studies like the one I am working on (which requires me to ask you questions) is made known, and by keeping the information that you shared with me safe at all times.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. If a situation arises in which the individual is becoming too emotional and distressed as a result of participation, the participant will be referred for counseling. On the basis of the counselor's feedback after referral, participation may continue or be withdrawn.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Researcher:

[REDACTED]

Supervisor:

[REDACTED]

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE
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The information above was described to the participant by Carla de Clerk in [Afrikaans/English/Xhosa/other] and the participant is in command of this language or it was satisfactorily translated to *me / him / her. I / the participant* were given the opportunity to ask questions and these questions were answered to *my / his / her* satisfaction.

The participant hereby consent voluntarily to participate in this study / I hereby consent that the participant may participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ and/or [his/her] representative _____. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [Afrikaans/*English/*Xhosa/*Other] and [no translator was used/this conversation was translated into _____ by _____].

Signature of Investigator

Date

Appendix H: Informed consent form (Afrikaans)



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UNIVERSITEIT VAN STELLENBOSCH TOESTEMMING TOT DEELNAME IN NAVORSING

TITEL VAN DIE STUDIE: *Die sielkundige funksionering van pasiente opgeneem in 'n landelike Wes-Kaapse hospitaal weens 'n self-moord poging. Die rol van stress, hantering en ervaring van sosiale ondersteuning.*

Jy word uitgenooi om deel te neem aan 'n studie uitgevoer deur Mev. Carla de Clerk, Hons (BA) Sielkunde, HPCSA Geregisteerde Berader (PRC 0015997), n Meerstersgraad student in Sielkunde, Universiteit van Stellenbosch, onder leiding van my supervisor Dr. N. Z. Somhlaba. Die resultate van die navorsingsprojek sal bydra tot my tesis vir die Meestersgraad in Sielkunde. Verder het ek 'n spesiale belangstelling om meer uit te vind oor hoe individue wat poog om hul eie lewens te neem (selfmoord poging) voel en dink oor hulle lewens, om uiteindelik kennis te produseer en te deel oor hoe individue wat selfmoordneigings het beter gehelp word om hul emosionele welstand te verbeter.

Jy is gekies as 'n moontlike kandidaat in hierdie studie omdat jy opgeneem is in 'n landelike Wes-Kaapse hospitaal in [REDACTED] as gevolg van jou selfmoord poging.

1. DOEL VAN DIE STUDIE:

Die doel van die studie is om vas te stel wat die aard van die verhouding is tussen die ervaring van stres deur individue wat poog om selfmoord te pleeg (in ander woorde, hul depressie, angstigheid en hopeloosheid in hul lewens), die manier waarin hulle die stres ervaring hanteer, asook die manier waarop hulle sosiale ondersteuning van vriende, familie en ander belangrike verhoudings sien en ervaar. Al hierdie inligting hou verband spesifiek met individue (soos jouself) wie opgeneem is in [REDACTED] weens 'n selfmoord poging.

2. PROSEDURES:

As jy vrywillig deelnaam aan hierdie studie, gaan jy gevra word om die volgende te doen:

Jy gaan 'n reeks vrae moet antwoord wat aan jou gegee word aangaande:

1. Jouself en die lewe rondom jou (andersins bekend as demografiese inligting);
2. Jou emosionele toestand (met betrekking tot of jy depressief is of nie). Om ons te help inligting inwin hieroor, sal vrae gevra word oor jou vlak van depressie;
3. Jou vlak van angstigheid (vreesvol of bekommerd wees, en of jy beskryf kan word as angstig of nie). Om vir ons inligting hierrondom te verskaf, gaan 'n paar vrae gevra word oor jou vlak van angstigheid;

4. Jou stand van verlies en hoop (met betrekking tot of jy kan beskryf word as iemand wat hoop verloor het of nie). Om ons te voorsien van inligting hieroor, sal ek jou vra oor jou vlak van wanhoop.
5. Die manier waarop jy die spanning in jou lewe hanteer. Om inligting hieroor te bekom, sal vrae oor jou afgemene hantering hiermee gevra word;
6. Die wyse waarop jy jou sosiale ondersteuning van vriende, familie en ander belangrike verhoudings sien. Om ons te help om inligting hieroor in te win, sal 'n reeks vrae gevra word oor hoe jy hierdie verhoudings sien.

Alle deelnemers sal ondervra word deur die navorser en 'n reeks van vrae sal gedurende die onderhoud beantwoord word. Een kontak sessie sal gemaak word met die navorser en die onderhoud sal ongeveer 1 uur neem om te voltooi. In 'n geval waar emosionele ontsteltenis dit sou nodig maak om die onderhoud te staak, en ek jou moet verwys na iemand wat jou kan help om beter te voel, sal 'n tweede onderhoud gereel word, indien jy sou wou voortgaan met jou deelname in hierdie studie. Alle onderhoude sal gevoer word in die Hospitaal.

3. MOONTLIKE RISIKOS EN ONGERIEF

Deur die reeks vrae te beantwoord wat ek aan jou gaan vra, mag jy dalk 'n bietjie meer hardseer, depressief, hopeloos of angstig begin voel, as jy reeds hierdie gevoelens ervaar het. Dit is belangrik dat jy verstaan dat nie alle mense wat deelneem aan hierdie studie dieselfde gaan voel nie. Sou jy enige van hierdie negatiewe emosies en / of gedagtes ervaar, en ek van mening is dat jy verdere ondersteuning benodig, sal ek jou verwys na 'n sielkundige / maatskaplike werker (iemand wat mense met emosionele probleme help en te laat beter voel) sodat die persoon jou kan help om beter te voel. Sou jy egter hierdie negatiewe emosies en / of gedagtes ervaar en verkies om nie met die studie voort te gaan nie, is jy vry om my te laat weet en die studie sal gestaak word sonder enige negatiewe gevolge. Aangesien al die persone wat jou gaan help om emosioneel beter te voel werksaam is [REDACTED], sal 'n afspraak vir jou gereel word met enige van die volgende persone:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

4. POTENTIELE VOORDELE AAN SUBJEK EN / OF GEMEENSKAP

Soos reeds aangedui, het ek 'n spesiale belangstelling om meer uit te vind oor hoe mense wat probeer het om hul eie lewens te neem (selfmoord poging), voel en dink oor hul lewens, ten einde kennis te produseer en deel oor hoe om hierdie persone beter te help om hul emosionele welstand te verbeter. Hierdie studie sal help om belangrike inligting te verskaf vir die vind van nuwe maniere om mense te help wat poog om selfmoord te pleeg, om sodoende toekomstige selfmoord pogings te probeer vermy. 'n Potensiele voordeel van jou deelname kan moontlik wees dat jy emosioneel beter kan voel deur jou gedagtes en gevoelens met iemand te deel. Behalwe hierdie moontlike voordeel sal daar geen ander direkte voordeel vir jou deelname wees nie.

5. BETALING VIR DEELNAME:

Deelnemers sal geen betaling ontvang nie en deelname is op 'n vrywillige basis.

6. KONFIDENSIALITEIT EN ANONIMITEIT:

Enige inligting wat verkry word deur hierdie studie en moontlik met jou geïdentifiseer kan word sal vertroulik bly en slegs openbaar gemaak word met jou toestemming of as deur die wet vereis. Anonimiteit sal gehandhaaf word deur middel van 'n getal aan jou naam toe te ken en daarna sal verwysing slegs na jou nommer gemaak word en nie na jou naam nie. Met ander woorde, niemand sal in staat wees om te sien watter vraelys aan jou behoort nie. Die lys van syfers toegeken aan elke kandidaat wat deelgeneem het aan die studie (deur die vrae te beantwoord) sal elektronies gehou word deur die navorser en dit sal wagwoord-beskermd wees en slegs toeganklik wees vir die navorser.

Klank opnames mag geneem word van onderhoude en jy het die reg om daarna te luister en te versoek om veranderinge te maak aan die opnames. Die opnames sal gebruik word vir nasien doeleindes en sal slegs toeganklik wees vir die navorser. Die resultate van hierdie studie as geheel kan bekend gemaak word op ander platforms waar soortgelyke studies hul inligting bekend maak en deel, maar jou persoonlike inligting wat jy met my gedeel sal veilig gehou word te alle tye.

7. DEELNAME EN ONTTREKING:

Jy kan kies of jy wil deelneem aan hierdie studie. As jy aan hierdie studie wil deelneem, kan jy op enige tyd onttrek sonder enige negatiewe gevolge. Jy mag ook weier om enige van die vrae te beantwoord en steeds deel te bly van die studie. Die ondersoeker mag jou onttrek van hierdie navorsing as 'n situasie opduik wat dit sou regverdig. As 'n situasie opduik waarin jy te emosioneel of ontsteld sou raak as gevolg van jou deelname, sal jy verwys word vir berading. Op grond van die berader se terugvoer, kan deelname voorgesit of gestop word.

8. IDENTIFIKASIE VAN ONDERSOEKERS:

Indien jy enige vrae of bekommernisse het oor die navorsing, voel asb. vry om die volgende persone te kontak:

Navorsers:

[Redacted contact information for researchers]

Supervisor:

[Redacted contact information for supervisor]

9. REGTE VAN DIE NAVORSINGSSUBJEK:

Jy kan jou toestemming onttrek op enige tyd en deelname staak sonder enige nagevolge. Jy doen nie afstand van enige wetlike eise of regte as gevolg van jou deelname aan hierdie studie nie. As jy vrae het oor jou regte as 'n onderwerp, kontak Me. Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] by die Afdeling Navorsingsontwikkeling.

HANDTEKENING VAN NAVORSINGSSUBJEK OF WETTIGE VERTEENWOORDIGER
--

Die inligting hierbo was beskryf en verduidelik aan die deelnemer deur Carla de Clerk in [Afrikaans/English/Xhosa/other] en die deelnemer is in beheer van hierdie taal of dit was voldoende vertolk aan my/hom/haar. Ek / die deelnemer was die geleentheid gebied om vrae te vra en die vrae is voldoende aan my / hom / haar beantwoord.

Die deelnemer stem hiermee vrywillig in om deel te neem in hierdie studie / Ek stem hiermee in dat die deelnemer in die studie mag deelneem. Ek is 'n afskrif van hierdie vorm gegee.

Naam van Subjek / Deelnemer

Naam van Wettige Verteenwoordiger (indien van toepassing)

**Handtekening van Subjek /
Deelnemer of Wettige Verteenwoordiger**

Datum

HANDTEKENING VAN ONDERSOEKER

Ek verklaar dat ek die inligting in hierdie dokument verduidelik het aan _____ en/of [sy/haar] verteenwoordiger _____. [Hy/Sy] was aangemoedig en genoeg tyd gegee om my enige vrae te vra. Hierdie gesprek was gevoer in [Afrikaans/*English/*Xhosa/*Other] en [geen tolk was gebruik/die gesprek was vertolk na _____ deur _____].

Handtekening van ondersoeker

Datum

Appendix I: Informed consent form (Xhosa)

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STELLENBOSCH UNIVERSITY
IMVUME YOKUTHATHA INXAXHEBA KUPHONONONGO

ISIHLOKO SOPHONONONGO : Ukusebenza kwengqondo yezigulane ezilaliswe kwisibhedlele esisemaphandleni saseNtshona Koloni emva kokuzama ukuzibulala : Indima yokucinezeleka, ukumelana kunye nenkxaso yoluntu.

Uyacelwa ukuba uthathe inxaxheba kuphononongo olwenziwa nguNksz Carla C de Clark Hons (BA) Psychology, HPCSA Umcebisi Obhalisiweyo (PRC 0015997), umfundi wesidanga sesibini kwizifundo ngengqondo kwiYunivesithi yaseStellenbosch, ongaphantsi kweliso likagqira uN. Z. Somhlaba. Iziphumo zeprojekthi yophononongo ziza kunikela kwizifundo zam zesiDanga sesibini kwi-Psychology. Ngaphezu koko, ndinomdla okhethekileyo wokufumana ngakumbi ngendlela umntu ngamnye oye wazama ukuzibulala ngayo (azibulale) avakalelwa nacinga ngayo ngobomi bakhe, ukuze sivelise size sabelane ngolwazi malunga ngendlela abantu abafuna ukuzibulala abanokuncedwa ngayo ukuze baphucule indlela abavakalelwa ngayo.

Uye wakhethwa njengomntu osenokuthatha inxaxheba kolu phononongo kuba uye walaliswa kwisibhedlele sasemaphandleni saseNtshona Koloni [REDACTED] emva kokuba uzame ukuzibulala.

10. INJONGO YOPHONONONGO:

Injongo yolu phononongo kukwazi unxulumano olukhoyo phakathi konxinzelelo olufunyanwa ngumntu ozama ukuzibulala (ngamanye amazwi, uxinzelelo lwabo, unxunguphalo nokungabi nathemba kubomi babo), indlela abajamelana ngayo nonxinzelelo lwengqondo, neendlela abayijonga ngayo inkxaso yosapho, abahlobo, nolunye ulwalamano olusondeleyo. Yonke le nkcazelo iphathelele ngokukodwa kubantu (abafana nawe) abalaliswe kwisibhedlele [REDACTED]

11. INKQUBO:

Ukuba ukhetha ukuthatha inxaxheba kolu phononongo, uza kucelwa ukuba wenze ezi zinto zilandelayo: Uphendule imibuzo eliqela oyinikiweyo malunga:

1. Nawe nangempilo oyiphilayo (eyaziwa njengeenkukacha mayelana nawe);
2. Ubume bendlela ovakalelwa ngayo (ephathelele enoba uxinzelekile okanye akunjalo). . Ukuze sifumane inkcazelo kule nkalo, uza kubuzwa imibuzo malunga neqondo lokuxinzeleka kwakho;
3. Ubume bokuxhalaba kwakho (ukoyika okanye ukukhathazeka, kwaye enoba ungachazwa njengomntu oxhalabileyo kusini na). Ukusinceda sifumane inkcazelo kule nkalo, kuza kubuzwa imibuzo eliqela ngeqondo lokuxhalaba kwakho;
4. Ubume bengqondo yakho mayelana nokuphelelwa lithemba (ngokuphathelele enoba ungachazwa njengomntu ophelwe lithemba okanye akunjalo). Ukusinceda sifumane inkcazelo kule nkalo, ndiza kukubuzwa imibuzo ngeqondo lakho lokungabi nathemba;

5. Iindlela omelana ngazo noxinzelelo lwengqondo (stress) ebomini. Ukusinceda sifumane inkcazelo kule nkalo, kuza kubuzwa imibuzo ephathelele iqondo lokumelana kwakho;
6. Indlela olujonga ngayo uncedo olufumana kusapho, abahlobo nabye abantu osondeleyo kubo. Ukusinceda sifumane inkcazelo kule nkalo, kuza kubuzwa imibuzo eliqela ngendlela olujonga ngayo olu lwalamano.

Bonke abathathi-nxaxheba baza kubuzwa imibuzo ngumphandi yaye imibuzo iza kuphendulwa ebudeni bodliwano-ndlebe. Iseshoni yoqhagamshelwano iza kwenziwa nomphandi yaye udliwano-ndlebe luza kuthatha malunga neyure e-1 ukuze igqitywe. Kwimeko yaxa uxinzelelo lwengqondo lwenza kunyanzeleke ukuba lumiswe udliwano-ndlebe, yaye kudingeka ukuba sikuthumele kumntu oza kukunceda uzive ngcono, oku kuza kwenziwa emva kokuba ndiye ndadibana nawe. Udliwano-ndlebe lwesibini ukuze siqhubeke luza kucwangciswa kunye nawe, ukuba unqwenela ukuqhubeka nokuphendula imibuzo. Lonke udliwano-ndlebe luza kuqhutshelwa esibhedlele.

12. IMINGCIPHEKO ESENOKUBAKHO NOKUNGAKHULULEKI

Ngokuphendula imibuzo eliqela endikubuzwa yona kusenokukhokelela ekubeni uzive udakumbile ngakumbi, uxinzelekile ngakumbi, ungenathemba nangakumbi okanye uxhalabile ngakumbi, ukuba ubusele uvakalelwa njalo ngaphambili. Kubalulekile ukuba ndikwazise ukuba asingabo bonke abantu ababuzwayo kolu phando abaziva ngokufanayo. Kwimeko yaxa ezi mvakalelo nezi ngcinga kwenzeka zibekho, yaye ndibona ukuba ungancedakala ngoncedo olukhethekileyo, ndiza kukuthumela kugqirha wengqondo / unontlalontle (umntu onceda abantu abaneengxaki zeemvakalelo yaye ebanceda bazive ngcono) kwaye onako ukukunceda. Ukuba kuyenzeka ufikelwe zezi ngcinga nezi mvakalelo, kwaye akunqweneli ukuqhubeka nokuphendula imibuzo endinayo, uvumelekile ukuba undazise ukuze ndikunike ithuba lokuyeka ukuphendula imibuzo, ngaphandle kokunika izizathu.. Njengoko bonke abantu abanceda abantu bajamelane neengxaki zendlela abavakalelwa ngayo bekwisiBhedlele [REDACTED] ndiza kwenza amalungiselelo kunye naye nawuphi nan a umntu kwaba balandelayo ukuze bakuncede kule nkalo:

[REDACTED]

13. IINGENELO EZISENOKUBAKHO KUBALINGWA KUNYE/OKANYE KULUNTU

Njengoko kubonisiwe ngasentla, ndinomdla okhethekileyo wokufumanisa ngakumbi indlela abantu abaye bazama ukuthatha ubomi babo (ukuzibulala) abavakalelwa ngayo ngobomi babo, ukuze kuveliswe kuze kwabelwane ngolwazi malunga ngendlela abantu abazama ukuzibulala abanokuncedwa ngayo ukuphucula indlela abavakalelwa ngayo. Olu phononongo luza kunceda ukunikela inkcazelo ebalulekileyo yokufumanisa iindlela zokunceda abantu abaneengcinga neemvakalelo zokuzibulala, bazive ngcono ukuze bangafikeleli kwinqanaba lokufuna ukuzibulala. Ingenelo esenokubakho ngokuthatha inxaxheba kukuba uza kuziva ngcono ngokwabelana ngeengcinga neemvakalelo zakho nomnye umntu. Ngaphandle kwale ngenelo akusayi kubakho ngenelo ingqalileyo kuwe njengomthathi-nxaxheba.

14. INTLAWULO NGOKUTHATHA INXAXHEBA:

Abathathi-nxaxheba abasayi kuhlawulwa yaye baya kuthatha inxaxheba ngokuzithandela.

15. IMFIHLELO NOKUNGAZIWA NGEGAMA:

Nayiphi na inkcazelo efunyenwe ngokuphathelele olu phononongo yaye esenokukuchaza iza kuhlala iyimfihlo yaye iza kuchazwa kuphela ngemvume yakho okanye njegoko kuyimfuneko ngokomthetho. Ukungaziwa kuza kugcinwa ngokwabela inombolo kwigama lakho emva koko ukubhekisela kwigama lakho akusayi kwenziwa, kodwa kuza kwenziwa kuphela kwinqombolo enikwe isigulane. Ngamanye amagama, akakho umntu oza kukwazi ukubona ukuba liliphi iphepha limibuzo elilelakho. Siza kusebenzisa inombolo ukuchonga iphepha lemibuzo ngalinye hayi igama lakho. Uluhlu lweenombolo ezinikelweyo ezinxulumene namagama abantu abathathe inxaxheba kuphononongo (ngokuphendula imibuzo) luza kugcinwa ngumphathi nge-elektroniki yaye luza kukhuselwa ngephaswedi yaye luza kufikelelwa ngumphathi kuphela.

Udliwano-ndlebe lusenokushicilelwa yaye unayo imvume yokuphulaphula kwaye ucele ukuba kwenziwe utshintsho kwitheyipu. Iitheyipu ziza kusetyenziselwa iinjongo zokuhlola yaye ziza kufikelelwa ngumphandi kuphela. Iziphumo zisenokusetyenziswa ukwenza inkcazelo ifumaneko kwamanye amajelo neendawo apho inkcazelo iqokelelwa ngophononongo njengolu ndisebenza kulo (olufuna ndikubuze imibuzo), nangokugcina inkcazelo ondichazele yona ikhuselekile ngalo lonke ixesha.

16. UKUTHATHA INXAXHEBA NOKURHOXA

Usenokukhetha ukuba koluphononongo okanye ungabi kulo. Ukuba ukhetha ukuba kuphononongo, unako ukurhoxa nanini na ngaphandle kweziphumo ezibi kuwe. Kwakhona usenokukhetha ukungayiphenduli nayiphi na imibuzo ongafuniyo ukuyiphendula kodwa uqhubeke ukuphononongo. Umphandi usenokurhoxisa kuphando ukuba iimeko zinyanzelisa njalo. Ukuba kubakho imeko yaya umthathi-nxaxheba esiya ngokubaxunguphala kakhulu ngenxa yokuthatha inxaxheba, umthathi-nxaxheba uza kuthunyelwa kumcebisi. Ngokusekelwe kwingxelo yomcebisi, ukuthatha inxaxheba kusenokuqhubeka okanye kurhoxiswe.

17. UKUCHAZWA KWABAPHANDI

Ukuba unemibuzo okanye izinto ezikuxhalabisayo malunga nophando, zive ukhululekile ukuqhagamshela:

Umphandi:

[Redacted]
[Redacted]
[Redacted]
[Redacted]
carladeclerk@live.co.za

Umphathi:

[Redacted]
[Redacted]
[Redacted]

18. AMALUNGELO ABALINGWA BOPHANDO

Unako ukurhoxisa imvume yakho nanini na uze uyeke ukuqhubeka ukuthatha inxaxheba ngaphandle kokuhlululwa. Awuhluthwa ilungelo lakho lomthetho okanye imbuyekezo ngokuba yinxenye yolu

phononongo lophando. Ukuba unemibuzo mayelana namalungelo akho njengomlingwa wophando, qhagamshela uNks Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] kwiCandelo loPhuhliso loPhando.

UTYOBELO LOMLINGWA WOPHANDO OKANYE UMMELI OSEMTHETHWENI
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Inkcazelo engasentla icaciselwe umthathi-nxaxheba nguCarla de Clerk [ngesiBhulu/isiNgesi/isiXhosa/olunye] yaye umthathi-nxaxheba ulazi kakuhle olu lwimi okanye iye yaguqulelwa ngokwanelisayo kum./kuye. Mna / umthathi-nxaxheba uye wanikwa ithuba lokubuzo imibuzo yaye le mibuzo iye yaphendulwa kum / kuye/ ngokwanelisayo.

Umthathi-nxaxheba unikezela imvume enganyanzelwa ukuba abe yinxenye *kolu phononongo* / ndinikezela imvume yokuba umthathi-nxaxheba angathatha inxaxheba kolu phononongo. Ndinikwe ikopi yale fomu.

Igama loMlingwa/loMthathi-nxaxheba

Igama loMmeli Osemthethweni (ukuba kuyimfuneko)

Utyobelo loMlingwa/loMthathi-nxaxheba okanye uMmeli Osemthethweni

Umhla

UTYOBELO LOMPHANDI

Ndiyaqinisekisa ukuba ndiyicacisile inkcazelo enikelwe kolu xwebhu kukunye nommeli wakhe u..... Uye wanikwa ixesha elaneleyo lokuba andibuze nayiphi na imibuzo. Le ncoko iye yaqhutywa [ngesiBhulu/*isiNgesi/*isiXhosa/*Olunye] yaye [akukhange kusetyenziswe umguquleli/le ncoko iye yaguqulelwa ngesi _____ ngu _____].

Utyobelo loMphandi

Umhla

Appendix J: Ascent form (English)



PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM



TITLE OF THE RESEARCH PROJECT:

The psychological functioning of patients admitted to rural Western Cape hospital following attempted suicide: The role of stress, coping and perceived social support.

RESEARCHERS NAME(S): Carla C. de Clerk

ADDRESS: [REDACTED]

CONTACT NUMBER: [REDACTED]

What is RESEARCH?

Research is something we do to find **NEW KNOWLEDGE** about the way things (and people) work. We use research projects or studies to help us find out more about children and teenagers and the things that affect their lives, their schools, their families and their health. We do this to try and make the world a better place!

What is this research project all about?

The research project will be focusing on people who have been admitted to hospital for an attempt to end their lives (attempted suicide). These individuals will be asked to participate in the research project and, if they agree to take part, they need to answer various questions about themselves, specifically their feelings and thoughts about themselves. The results from these set of questions will be used to explain the nature of stress that people who have tried to end their lives experience, the ways in which they cope with their life challenges and manner in which they view their social support from friends, family and other important relationships..

Why have I been invited to take part in this research project?

You have been asked to participate in the study because you have been admitted to [REDACTED] following your attempt at taking your own life (trying to commit suicide). Your answers about your experiences, thoughts and feelings will help me to understand how you felt at the time when you made an attempt to end your life, and to understand what support you may need to overcome the problems you experience.

Who is doing the research?

Mrs Carla C. de Clerk, who is a student at Stellenbosch University studying for her Masters Degree in Psychology.

What will happen to me in this study?

You will be asked a couple of questions relating to your stress (depression, anxiety and hopelessness, to get a sense of how you experience these), how you cope with the challenges in your life, and how you view your social support from friends, family and other relationships. You are free to ask any questions, during and after the questions have been asked, to ask any questions if you are not sure about anything relating to the study.

Can anything bad happen to me?

Answering the series of questions I ask you might result in you feeling a little sadder, more depressed, more hopeless or more anxious, if you were already experiencing these feelings. It is important that I let you know that not all people interviewed for this study will feel the same. In the event that these feelings and thoughts do occur, and I am of the view that special attention is needed, I will refer you to a professional who helps people with emotional problems and helps them feel better and who can help you. Should you have these thoughts and feelings, and you do not wish to continue answering the questions I have for you, you are welcome to let me know so that I can give you a chance to stop answering the questions, without you needing to explain why you wish to stop.

Can anything good happen to me?

You will not receive any direct benefit from answering the series of questions.

Will anyone know I am in the study?

The only people that will know you participated in this study will be myself as a researcher. Any information you give in the interview will be kept only by the researcher.

**Who can I talk to about the study?**

If you would like to talk to anybody regarding the study you can contact the following persons:

Mrs. Carla de Clerk (Researcher): [REDACTED]
carladeclerk@live.co.za

Dr. N. Z. Somhlaba (Supervisor): [REDACTED]
nzs@sun.ac.za

What if I do not want to do this?

Participation is voluntary and should you not wish to answer any of the questions I have for you, or you wish to stop answering them while you had initially agreed to answering them, you will be free to let me know and stop at any stage during the research, without any explanation required.

Do you understand this research study and are you willing to take part in it?

 YES

 NO

Has the researcher answered all your questions?

 YES

 NO

Do you understand that you can STOP being in the study at any time?

 YES

 NO

Signature of Child

Date

Appendix K: Ascent form (Afrikaans)



DEELNAME INLIGTINGSBLAD EN INSTEMMINGS VORM



TITEL VAN DIE NAVORSINGSPROJEK:

Die sielkundige funksionering van pasiënte wat opgeneem is in 'n landelike Wes-Kaapse hospitaal weens 'n self-moord poging. Die rol van stress, hantering en ervaring van sosiale ondersteuning.

NAVORSER SE NAAM: Carla C. de Clerk

ADRES: [REDACTED]

KONTAK NOMMER [REDACTED]

Wat is NAVORSING?

Navorsing is iets wat ons doen om **NUWE KENNIS** te vind oor die maniere waarop dinge (en mense) werk. Ons gebruik navorsingsprojekte (of studies) om ons te help om meer uit te vind oor kinders en tieners en die dinge wat hulle lewens, skool, families en gesondheid affekteer. Ons doen dit om te probeer om die wêreld 'n beter plek te maak!

Wat behels hierdie navorsingsprojek?

Hierdie navorsingsprojek gaan fokus op mense wat opgeneem is in die hospitaal omdat hulle hul eie lewens probeer neem het (selfmoord poging). Hierdie persone gaan gevra word om deel te neem aan die navorsingsprojek, en, as hulle sou instem, moet hulle 'n paar vrae beantwoord oor hulself, spesifiek oor hul gevoelens en gedagtes oor hulself. Die resultate van hierdie vrae sal gebruik word om 'n verduideliking te gee oor die stres wat mense ervaar wat probeer om hul eie lewens te beëindig, die maniere waarop hulle hul lewensuitdagings hanteer asook die manier waarop hulle die sosiale ondersteuning van vriende, familie en belangrike verhoudings sien en ervaar.

Hoekom is ek uitgenooi om deel te neem in hierdie navorsingsprojek?

Jy is uitgenooi om deel te neem aan hierdie studie omdat jy opgeneem is in [REDACTED] nadat jy probeer het om jou eie lewe te neem (selfmoord poging). Jou antwoorde op die vrae oor jou ervarings, gedagtes en gevoelens gaan my help om te verstaan hoe jy gevoel het op die tyd toe hy besluit het om jou lewe te beëindig. Jou insette gaan my ook help om te verstaan watter ondersteuning jy dalk mag nodig hê om die probleme wat jy ervaar, te oorkom.

Wie gaan die navorsing doen?

Mev. Carla C. de Clerk, 'n student is aan die Universiteit van Stellenbosch wat tans besig is met haar Meestersgraad in Sielkunde.

Wat gaan met my gebeur in hierdie studie?

Jy gaan 'n paar vrae moet beantwoord wat handel oor jou stres (depressie, angstigheid en hopeloosheid, om 'n gevoel te kry oor hoe jy dit ervaar), hoe jy die uitdagings in jou lewe hanteer, asook hoe jy die sosiale ondersteuning van vriende, familie en ander verhoudings ervaar. Sou jy enige vrae hê rakende die studie is jy vry om gedurende en na afloop van die sessie jou vrae te vra.

Kan enigiets sleg met my gebeur?

Deur die vrae te beantwoord wat aan jou gevra gaan word, kan jy moontlik 'n bietjie meer hardseer, depressief, hopeloos of angstig begin voel, as jy dalk reeds hierdie gevoelens ervaar het. Dit is belangrik dat jy verstaan dat nie almal wat deelneem aan hierdie studie dieselfde gaan voel nie. Sou jy egter hierdie gevoelens en gedagtes ervaar, en ek van mening is dat jy verdere aandag en hulp sou benodig, sal ek jou verwys na 'n professionele persoon wat mense help met emosionele probleme om jou te laat beter voel. Sou jy hierdie gedagtes en gevoelens hê, en jy wil nie verder voortgaan met die onderhoud nie, is jy vry om my daarvan in kennis te stel en sal die onderhoud gestop word sonder dat jy 'n verduideliking hoef te gee hoekom jy nie wil voortgaan nie. .

Kan enigiets goed met my gebeur?

Jy gaan geen direkte voordeel ontvang deur die vrae van die onderhoud te beantwoord nie.

Gaan enigiemand weet ek het deelgeneem aan hierdie studie?

Die enigste persoon wat gaan weet dat jy deelgeneem het aan hierdie studie is ek, die navorser. Enige inligting wat jy vir my gee gedurende die onderhoud gaan slegs gehou word deur die navorser.

**Met wie kan ek praat oor die studie?**

Sou jy graag met iemand wou gesels oor die studie kan jy die volgende persone kontak:

Mev.. Carla de Clerk (Navorser): [Redacted]
carladeclerk@live.co.za

Dr. N. Z. Somhlaba (Supervisor): [Redacted]
nzs@sun.ac.za

Wat as ek nie wil deelneem nie?

Deelname is vrywillig en sou jy nie die vrae wou beantwoord nie, of jy wil op enige tyd gedurende die onderhoud stop, is jy vry om my in kennis te stel en die navorsing sal onmiddelik gestop word sonder dat jy enige verduideliking hoef te gee.

Verstaan jy hierdie navorsingstudie en is jy gewillig om deel te neem?

JA	NEE
----	-----

Het die navorser al jou vrae beantwoord?

JA	NEE
----	-----

Verstaan jy dat jy op enige oomblik kan STOP met jou deelname in hierdie studie?

JA	NEE
----	-----

Handtekening van Kind

Datum

Appendix L: Ascent form (Xhosa)



IPHETSHANA LENKCAZELO LOMTHATHI-NXAHEBA NEFOMU YEMVUME



ISIHLOKO SEPROJEKTHI YOPHANDO:

Ukusebenza ngokwengqondo kwezigulane ezilaliswe kwisibhedlele sasemaphandleni eNtshona Koloni emva kokuzama ukuzibulala : Indima yokucinezeleka, ukumelana kunye nenkxaso yoluntu.

IGAMA LOMPHANDI : Carla C. de Clerk

IDILESI : [REDACTED]

INOMBOLO YOQHAGAMSHELWANO : [REDACTED]

Yintoni UPHANDO?

Ukuphanda kwenziwa ukuze kufumanike **ULWAZI OLUTSHA** ngendlela izinto (nabantu) abasebenza ngazo. Sisebenzisa uphando okanye uphononongo ukuze sifumanise kabanzi ngabantwana nolutsha kunye nezinto ezibathintayo ngokwasempilweni, izikolo abafunda kuzo, iintsapho zabo kunye nezempilo zabo. Senza konke oku ukuze sizame ukwenza ihlabathi libe ngcono!

Ingantoni le projekthi yophando?

Olu phando luzakuqwalaselana nabantu abalaliswe esibhedlele emva kokuzama ukuthatha ubomi babo (ukuzama ukuzibulalka). Izigulane ziza kucelwa ukuba zithabathe inxaxheba kwiprojekthi yophando, ukuba ziyavuma ukuba yinxenye yophando, baza kuphendula imibuzo emayelana nabo, igxininise kwiimvakalelo zabo kunye neengcinga zabo. Iziphumo zale mibuzo ziza kusetyenziswa ukuze kucaciswe izinga loxinezeleko lwabantu abakhe bazama ukuzibulala, kunye nendlela yokuphila abazifumana bekuyo, indlela abamelana ngayo neengxaki abajongene nazo, nendlela abathi baqonde ngayo uncedo abalunikwa ngobahlobo babo, usapho kunye nabo basondelene nabo ekuhlaleni..

Kutheni ndiye ndamenywa ukuba ndithathe inxaxheba kule projekthi yophando?

Ucelwe ukuba ube ngomnye wabathabatha inxaxheba kolu phononongo kuba ungomnye wezigulane ezilaliswe kwisibhedlele [REDACTED] emva kokuzama ukuzibulala. Iimpendulo zakho ngokwamava akho, iingcinga kunye neemvakalelo zakho ziza kundinceda ndifumanise ulwazi lokuba uzifumanise unjani ngexesha ubuzama ukuzibulala, nokuthi ndiqondisise ukuba luncedo olunjani oludingayo ukuze ukwazi ukumelana neengxaki omelene nazo.

NGUBANI OWENZA OLU PHANDO ?

UNks Carla C. de Clerk. Owenza isifundo zakhe zesiDanga zesibini kwiYunivesithi yaseStellenbosch, efunda isifundo ngokusebenza kwengqondo (Masters degree in Psychology).

Yintoni eza kwenzeka kum kolu phando?

Uza kubuzwa imibuzo enxulumene noxinezelelo lwakho, (ucinzelelo, ukuxhalaba kunye nokungabi nathemba kwakhokuzi ndiqikelele ukuba uzifumana njani ezi mpawu), nendlela ohlangabezana ngayo noce lomngeni ebomini bakho, nendlela oyijongan gayo inkxaso oyifumana kubahlobo, usapho nabanye abantu osondelene nabo. Uvumelekile ukuba ubuze nayiphi na imibuzo, ebudeni nasemva kokuba ubuzwe imibuzo, ukuba ubuze nayiphi na imibuzo ukuba akuqinisekanga ngayo nantoni na ephathelele uphando.

Ngaba ikhona into embi enokwenzeka kum?

Ngokuphendula imibuzo eliqela endikubuzi yona kusenokukhokelela ekubeni uzive udakumbile ngakumbi, ucinzelekile ngakumbi, ungenathemba nangakumbi okanye uxhalabile ngakumbi, ukuba ubusele uvakalelwa njalo ngaphambili. Kubalulekile ukuba ndikwazise ukuba asibo bonke abantu ababuzwayo kolu phando abaziva ngokufanayo. Kwimeko yaxa ezi mvakalelo nezi ngcinga kwenzeka zibekho, yaye ndibona ukuba ungancedakala ngoncedo olukhethekileyo, ndiza kukuthumela kwingcali enceda abantu abaneengxaki zeemvakalelo yaye ebanceda bazive ngcono kwaye onako ukukunceda. Ukuba kuyenzeka ufikelwe zezi ngcinga nezi mvakalelo, kwaye akunqweneli ukuqhubeka nokuphendula imibuzo endinayo, uvumelekile ukuba undazise ukuze ndikunike ithuba lokuyeka ukuphendula imibuzo, ngaphandle kokunika izizathu.

Ngaba ikhona into entle enokwenzeka kum?

Awusayi kufumana ngenelo ingqalileyo ngokuphendula le mibuzo iliqela.

Ngaba ukhona omnye umntu oza kukwazi ukuba ndikolu phando?

Mnye kuphela umntu oza kuba nolwazi lokuba uthabathe inxaxheba kolu phando ndim njengomphandi. Lonke ulwazi oza kulunikezela kolu phando luza kuba selugcinweni lwam kuphela.



Ndingathetha nabani malunga nophando?

Ukuba unqwenela ukuthetha nomntu mayelana nolu phando, ungaqhagamshelana naba bantu balandelayo :

UNks Carla de Clark (Umphandi): [REDACTED]
carladeclerk@live.co.za

UGqr N.Z Somhlaba (Umphathi): [REDACTED]
[REDACTED]

Kuthekani ukuba andifuni ukuthatha inxaxheba?

Ukuba yinxenye yolu phando kuxhomekeke kuwe yaye ukuba akunqweneli ukuphendula nawuphi na umbuzo endinawo, okanye unqwenela ukuyeka ukuyiphendula nangona ubuye wavuma ukuyiphendula ekuqaleni, uza kuvumeleka ukuba undazise uze uyeke nanini na ebudeni bophando, ngaphandle kokufuneka unikele ingcaciso.

Ngaba uyaluqonda olu phononongo lophando yaye ukulungele ukuthatha inxaxheba?

ewe

hayi

Ngaba umphandi uye wayiphendula yonke imibuzo yakho?

ewe

hayi

Ngaba uyaqonda ukuba unako UKUYEKA ukuthatha inxaxheba kuphononongo nanini na?

ewe

hayi

Utyobelo loMntwana

Umhla

Appendix M: Stellenbosch University, Research Ethics Committee, Letter of ethics clearance

Appendix N: Department of Health, Letter of approval for research