Attempted Suicide Among South African Adolescents Living in a Low Resource Environment: Contested Meanings, Lived Experience, and Expressed Support Needs

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DECLARATION

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ABSTRACT

Adolescent suicide is a serious public health concern, yet we do not understand the reasons South African adolescents give for their suicide attempts and the meanings they attach to their behaviour. Nor do we know how the adolescents' caregivers and clinicians perceive their attempts, or how these experiences and understandings are framed by the socio-cultural context. The aim of this research was to provide a contextualised understanding of the phenomenon of suicide attempts by South African adolescents living in a low resource environment. I used a multiperspectival research design situated within a theoretical framework of hermeneutic phenomenology. All participants were recruited via the Child and Adolescent Mental Health unit of a large psychiatric hospital located in Cape Town. In-depth semi-structured interviews were conducted with 10 adolescents, their caregivers (n=10), and the clinicians who treated them (n=9). The adolescents also took photographs to illustrate their experience, and these were discussed during a second interview using the technique of photo-elicitation. I analysed data using Interpretative Phenomenological Analysis. All participants foregrounded the relational context of the adolescents' suicide attempts, especially relationships with family members, which were described as both a mitigating and contributing factor to the suicide attempt. The adolescents explained how caregivers' failure to acknowledge sexual and physical abuse, which they perceived as betrayal, led to emotional disconnection and subsequently, to precipitating a suicide attempt. In contrast, adolescents said that attachment to younger siblings and pets ameliorated their suicidality. The adolescents recounted how bonding with other suicidal peers reduced feelings of isolation, but that they also learned about suicidal behaviours from each other. Participants also spoke about how the adolescents' suicide attempts were shaped by the socio-economic context, including exposure to poverty and high levels of violence. Both caregivers and clinicians described feelings of anxiety, powerlessness, and helplessness elicited by the adolescents' suicidality, echoing the powerlessness reported by the adolescents. Participants did not endorse a purely psychiatric understanding of adolescent suicidal behaviour; instead they described the adolescents' suicide attempts as an escape from pain, or an attempt to alleviate perceived economic burdensomeness. The adolescents experienced admission to a psychiatric hospital as providing safety, but also as exacerbating a loss of autonomy. Participants discussed how improved connectedness, belonging, communication, and validation of the adolescents' experiences, to counter the adolescents' sense of isolation and invisibility, were important for support after the

attempt, and for the prevention of adolescent suicide. The participants' accounts of the adolescents' suicide attempts were incongruent with existing theories of suicidal behaviour, highlighting the need for adolescent specific, contextualised theories of suicidal behaviour. These findings also suggest that adolescent suicide prevention cannot solely be the responsibility of the mental health care sector, that the wellbeing of caregivers is essential for adolescent suicide prevention, and they emphasise the importance of adolescent-specific services that enhance feelings of autonomy. Potential areas for future research in the field of adolescent suicide prevention include the role of siblings, pets, and feelings of betrayal.

Keywords: Suicide attempt, adolescents, South Africa, Interpretative Phenomenological Analysis, photo-elicitation, multiperspectival research design, critical suicidology

OPSOMMING

Selfmoord onder adolessente is ’n kommerwekkende openbare gesondheidsbelang, maar ons verstaan nie die redes wat Suid-Afrikaanse adolessente vir hul selfmoordpogings bied asook die betekenisse wat hulle aan hul gedrag heg nie. Ons weet verder ook nie hoe die adolessente se voogde en klinici hul pogings verstaan of hoe hierdie ervarings en insigte deur die sosio-kulturele konteks geraam word nie. Die doel van hierdie navorsing was om ’n gekontekstualiseerde begrip van die verskynsel van selfmoordpogings deur Suid-Afrikaanse adolessente woonagtig in ’n lae hulpbron-omgewing te bied. Ek het gebruik gemaak van ’n multi-perspektiewelike navorsingsontwerp binne die teoretiese raamwerk van hermeneutiese fenomenologie. Al die deelnemers is gewerf via die Geestesgesondheidseenheid vir kinders en adolessente van ’n groot psigiatriese hospitaal in Kaapstad. In-diepte semi-gestruktureerde onderhoude is gevoer met 10 adolessente, hul voogde (n=10), en die klinici wie hulle behandel het (n=9). Die adolessente het ook foto’s geneem om hul ervaring te illustreer, wat tydens ’n tweede onderhoud bespreek is met behulp van die foto-ontlokkingstegniek. Ek het data geanaliseer met behulp van Interpretatiewe Fenomenologiese Analise. Al die deelnemers het klem geplaas op die verhoudingskonteks van die adolessente se selfmoordpogings, veral verhoudings met familielede, wat as beide ’n versagtende en bydraende faktor tot die selfmoordpoging beskryf is. Die adolessente het verduidelik dat die voogde se versuiming om seksuele en fisieke mishandeling te erken – wat hulle as verraad beskou het – gelei het tot emosionele afkoppeling en gevolglik tot ’n selfmoordpoging. In teenstelling hiermee het adolessente beweer dat gehegtheid aan jonger broers en susters asook troeteldiere hul selfmoordneigings verlig het. Die adolessente het vertel hoe die saambinding met ander in ’n portuurgroep met selfmoordneigings hul gevoelens van isolasie verminder het, maar dat hulle ook van selfmoordgedrag by mekaar geleer het. Deelnemers het ook gepraat oor die maniere waarop die adolessente se selfmoordpogings beïnvloed was deur die sosio-ekonomiese konteks, insluitend hul blootstelling aan armoede en hoë vlakke van geweld. Beide voogde en klinici het beskryf hoe gevoelens van angs, magteloosheid en hulpeloosheid ontlok was deur die adolessente se selfmoordneigings. Dit word verder weerspieël in die magteloosheid wat deur die adolessente gerapporteer is. Deelnemers het nie ’n suiwer psigiatriese begrip van selfmoordgedrag by adolessente beaam nie; hulle het eerder die adolessente se selfmoordpogings beskryf as ’n ontsnapping van pyn, of ’n poging om hul waargenome bydrae tot huishoudelike ekonomiese las te verlig. Die adolessente het die opname in ’n psigiatriese

hospitaal as ’n bron van veiligheid ervaar, maar ook as ’n verlies van outonomiteit. Deelnemers het bespreek hoe verbeterde verbondenheid, aanvaarding, kommunikasie en geldigmaking van die ervarings van die adolessente dien as teenwerking tot die adolessente se gevoel van isolasie en onsigbaarheid. Hulle beaam verder dat hierdie faktore belangrik was vir ondersteuning ná die poging, asook vir die voorkoming van selfmoord onder adolessente. Die deelnemers se verhale van die adolessente se selfmoordpogings was strydig met bestaande teorieë van selfmoordgedrag, wat sodoende die behoefte aan adolessente-spesifieke, gekontekstualiseerde teorieë van selfmoordgedrag beklemtoon. Hierdie bevindinge dui ook eerstens daarop dat adolessente-selfmoordvoorkoming nie alleenlik die verantwoordelikheid van die geestesgesondheidsektor kan wees nie, dat die welstand van voogde tweedens noodsaaklik is vir adolessente-selfmoordvoorkoming, en dit beklemtoon laastens die belangrikheid van adolessente-spesifieke dienste wat die gevoel van outonomie versterk. Die rol van broers en susters, troeteldiere, en gevoelens van verraad word geïdentifiseer as potensiële terreine vir toekomstige navorsing in die veld van selfmoordvoorkoming onder adolessente.

Sleutelwoorde: selfmoordpoging, adolessente, Suid-Afrika, Interpretatiewe Fenomenologiese Analise, foto-ontlokking, multi-perspektiewelike navorsingsontwerp, kritieke selfmoordstudie

STATEMENT REGARDING SCHOLARSHIP

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LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
ACEs	Adverse childhood experiences
BPD	Borderline personality disorder
CAMH	Child and adolescent mental health
CAMHS	Child and adolescent mental health services
DBT	Dialectical behaviour therapy
DSH	Deliberate self-harm
GDP	Gross domestic product
HCPs	Health care professionals
IPA	Interpretative Phenomenological Analysis
IPV	Interpersonal violence
IPTS	Interpersonal Theory of Suicide
LGBT	Lesbian, gay, bisexual, and transgender
LMICs	Low-and middle-income countries
n	Number of cases in the sub-sample
NGO	Non-governmental organisation
NSSI	Non-suicidal self-injury
NSSIB	Non-suicidal self-injurious behaviour
PAR	Population attributable risk
PTSD	Post-traumatic stress disorder
SASSA	South African Social Security Agency
SD	Standard deviation
WHO	World Health Organisation
wOR	Weighted mean odds ratio
YRBS	Youth Risk Behaviour Survey

CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

Working as a clinical psychologist in the Child and Adolescent Mental Health (CAMH) unit of a psychiatric hospital in Cape Town over a period of 21 months, I was struck by the number of adolescents presenting with self-harming and other suicidal behaviours. Most of the adolescents are from the surrounding "Cape Flats", an area that conjures up images of gangsterism, substance use, and poverty. Talking to these adolescents, it became clear that their suicidal acts could not be neatly contained within the psychiatric terminology of "major depressive disorder", other psychiatric diagnostic terms, or as a symptom of mental illness. The adolescents spoke about their strained relationships with parents and peers, as well as feelings of despondency often linked to their daily struggles. I started to question the adequacy of the services we offered to the suicidal adolescents and their families. Although we could focus on providing the necessary psychological and psychiatric support, we were unable to resolve the financial stress, violence, and trauma that seemed intertwined with the adolescents' presentation. I also started to question the implicit expectation that mental health professionals were responsible for preventing adolescent suicide, and the pressure this placed on clinicians.

Wanting both to understand the nuances of suicidal behaviours among adolescents, and to improve the delivery of services at the CAMH unit, I turned to the literature. Most of the literature concerns quantitative studies, which while useful at eliciting associations, do not delve into the nuances or meanings associated with such behaviour. There is a comparative lack of qualitative research, especially in South Africa, which asks the people whose suicidal behaviour is being studied for their own understanding or interpretation of it. The "lived experience" of these adolescents and the meaning inherent in their behaviour seems key to understanding their actions. I acknowledge that meaning is created and that the same action can be differently interpreted by various actors. For this reason, while the focus of the research is on the adolescents' perspective, the research also elicits the perspectives of caregivers and health care professionals (hereafter referred to as clinicians) regarding the adolescents' suicide attempts. This allows for the exploration of contested meanings and provides a

multiperspectival, contextualised view of the phenomenon of adolescent suicide attempts. I acknowledge that my own biases have influenced the interpretation of the collected data, and this adds another layer of complexity to the interpreted meaning attached to the adolescents' suicide attempts. To summarise, this research explores the phenomenon of suicide attempts by adolescents residing in a resource constrained area of Cape Town. It achieves this by exploring the lived experience of adolescents who have attempted[1] suicide, as well as the lived experiences of their caregivers and clinicians.

1.2 SUICIDAL BEHAVIOUR IN SOUTH AFRICA

Suicidal behaviour is recognised as a priority condition in the World Health Organisation's (WHO) Mental Health Gap Action Programme (WHO, 2014a), with the reduction of suicide mortality being an indicator in the United Nations Sustainable Development Goals (WHO, 2019). Estimates of South African suicide rates widely fluctuate, due to underreporting, and to deaths being misclassified or assigned as having unknown causes (Bantjes & Kagee, 2013; Kootbodien et al., 2020; Mars et al., 2014; WHO, 2014a, 2019). For example, analysis of South African death certificate information from 1997 to 2016 estimated rates of suicide per 100,000 as 2.07 for men and 0.49 for women (Kootbodien et al., 2020), while a review of publications approximated the mean annual suicide rate for South Africa at 17.2 per 100,000 population (Mars et al., 2014). The WHO estimated the age-standardised suicide rate for South Africa in 2016 at 12.8 per 100,000, which is higher than the global average of 10.5 per 100,000 (WHO, 2019). While the global age-standardised suicide rate has decreased by 9.8% between 2010 and 2016 (WHO, 2019), this downward trend does not appear to apply to South Africa (Kootbodien et al., 2020).

Globally, suicide is the second most common cause of death among youth aged 15 to 29 years (WHO, 2014a) and the third leading cause of death for 15 to 19 year olds (WHO, 2019). Among these adolescents, the number of global deaths is similar for males and females, although suicide is the second leading cause of death for girls, and third for boys (WHO, 2019). South African data suggests that those aged 15 to 29 years have the highest probability of dying by suicide when compared to other age groups, accounting for 42.7% of suicides. Hanging is the

[1] The use of the word "attempted" is considered pejorative by some authors (e.g., Silverman, 2006). This is not my intention. I discuss the rationale for using the phrase "suicide attempt" in section 1.4.2 of this chapter.

most common method of suicide used by males in this age group (15 to 29 years), while females mainly choose poisoning (closely followed by hanging) (Kootbodien et al., 2020). Specific estimates for South African adolescents aged 13 to 18 years are difficult to obtain, due to a lack of systematic data collection by age group (Bantjes & Kagee, 2013). Local estimates suggest that about 9.5% of non-natural deaths amongst South African youth are due to suicide (Schlebusch, 2012), although statistics are frequently unreliable (Shilubane et al., 2013). Stigma, or fear of reprisal or hospitalisation, may also curtail accurate self-reporting (M. M. Silverman, 2011).

Estimates from the most recent national South African Youth Risk Behaviour Survey (YRBS) suggest that nationally 17.8% of high school students attempted suicide during the 6 months preceding the survey, with a third of those requiring medical treatment for their attempt (Reddy et al., 2013). This is in line with the estimate of 20.6% among school-going adolescents from a variety of low-and middle-income countries (LMICs) in the Africa region (Liu et al., 2018). These prevalence rates are much higher than those reported for youth in most international studies (e.g., Jeong et al., 2020; Kokkevi et al., 2012; Nock et al., 2013) and should be interpreted with caution. Globally, the prevalence of suicide attempts is consistently much lower than that of suicidal ideation (e.g., Borges et al., 2010; Jeong et al., 2020; Nock et al., 2013), yet the South African YRBS found similar rates for both. Both the YRBS (Reddy et al., 2013) and the study by Liu and colleagues (2018) used single item questions to determine the prevalence of suicide attempts, and it is possible that there were difficulties with the translation of concepts into African languages, thereby blurring the distinction between types of suicidal behaviour (including ideation). A South African community-based study in turn indicated that during the preceding month 3.2% of adolescents had attempted suicide, 5.8% planned an attempt, and 7.2% reported ideation (Cluver et al., 2015). Yet, there are no large-scale population based studies, as the YRBS only included school going adolescents attending grades 8 to 11 (Reddy et al., 2013). We therefore do not know what the population-based rate of suicide attempts among South African adolescents is, some of whom may not be attending school. In 2016, 32.1% of the youth living in the City of Cape Town had not completed secondary schooling (Statistics South Africa, 2017). This is pertinent as many older adolescents are not attending school, and therefore we do not know the extent of suicidal behaviour among this group. These statistics may be particularly relevant in low resource communities such as those where this research took place.

1.3 CONTEXT OF THE RESEARCH

This study was conducted in the CAMH unit of a large psychiatric hospital located in the Cape Town area of the Western Cape province of South Africa. The hospital was established during apartheid to serve "Coloured"[2] psychiatric patients, and it continues to serve a mostly uninsured black[2] population. The majority of patients are from the suburbs of Mitchells Plain and Khayelitsha, which form part of the Cape Metropolitan district, although the hospital also has a large rural drainage area. In addition to a total of 722 inpatient beds, the hospital also offers ambulatory services in the domains of Child and Adolescent Psychiatry, Intellectual Disability Services, General Adult Psychiatry and Forensic Psychiatry (University of Cape Town, 2020a).

The suburbs of Mitchells Plain and Khayelitsha are commonly referred to as part of the "Cape Flats", an area that has been colloquially described as the "dumping ground of apartheid" (e.g., Williams, n.d.). People of colour were forcibly relocated to this area, situated on the outskirts of the central city district, under apartheid's Group Areas Act (Mabin, 1992). The suburbs of the Cape Flats continue to reflect apartheid's racial segregation. Mitchells Plain's community remains mainly "Coloured" and Afrikaans and English speaking, while Khayelitsha consist of a predominantly isiXhosa-speaking, "Black"[2] African population (Statistics South Africa, 2011). The "Cape Flats" are plagued by high levels of poverty, crime, gangsterism, and violence. Both Mitchells Plain and Khayelitsha were among the top five South African precincts for contact crimes, including murder and sexual offences, during the 2018/2019 police reporting period. Mitchells Plain also reported the highest levels of drug-related crime in the country (South African Police Service, 2019).

[2] The terms "Coloured", "Black", and "White" mirror the racial classifications used during apartheid. Despite their origin, they continue to be commonly used terms in contemporary South Africa (Posel, 2001). I acknowledge that race is a social construct. I am using these terms to reflect their shared understanding, as used in the local context. In South Africa, "Black" and "African" are used interchangeably, although "black" is also used to refer to all people of colour (thereby including "African, "Coloured", "Asian", and "Indian"). "Coloured" is used to designate a diverse group of people with mixed racial heritage. In this thesis, I use "Black" (with a capital B) to refer to "African" people, and "black" (with a small b) to refer to all people of colour. Socio-economic inequalities in South Africa continue disproportionally to burden black communities.

There is a chronic shortfall of mental health services for children and adolescents in South Africa (Lund et al., 2009). Only 1.4% of outpatient mental health services and 1% of beds in psychiatric hospitals are reserved exclusively for children and adolescents (Lund et al., 2010). Yet, children and adolescents aged 19 and younger make up 38.8% of the South African population (Statistics South Africa, 2012). Expert consensus estimates the annual prevalence rates of mental health disorders amongst children and adolescents in the Western Cape at around 17% (Kleintjes et al., 2006). Rates may be elevated amongst the population serviced by the CAMH unit in this study, as local adolescents who are materially disadvantaged and belong to historically disadvantaged groups tend to suffer from higher levels of mental illness (Das-Munshi et al., 2016), with the majority of diagnoses consisting of general anxiety disorder, post-traumatic stress disorder, and major depressive disorder (Kleintjes et al., 2006). In addition, a large proportion of adolescents visiting the CAMH unit have a history of substance use; with the use of substances among adolescents residing in Mitchells Plain elevated above national and international levels (Hamdulay & Mash, 2011). The mismatch between the need for and provision of mental health services has implications for the workload of clinicians working in the CAMH unit at the hospital where this research was based.

The CAMH unit consists of both inpatient adolescent units (for ages 13 to 18) and an outpatient service for all children up to the age of 18. Patients with complex psychiatric presentations, that cannot be addressed at a primary (i.e., local clinic) or secondary level of health care (i.e., district hospital), are referred to the CAMH unit. While referrals to the inpatient unit are taken from across the Western Cape province, the catchment area for ambulatory services consists primarily of Mitchells Plain and Khayelitsha. Although ambulatory services are provided for some other rural catchment areas, only those patients residing in Mitchells Plain and Khayelitsha were included in this study.

1.4 DEFINITIONS OF KEY CONSTRUCTS

There is a lack of agreed nomenclature regarding suicidal behaviours (Posner et al., 2014). Similarly, a definition of adolescence based on chronological age is contested (e.g., Mandarino, 2014). The inconsistent use of terminology can have negative implications for both research and health service delivery, and it is therefore necessary to provide clear definitions for the purposes of this study.

1.4.1 Adolescence

The WHO defines adolescence as the transitional period in human growth and development that occurs after childhood and before adulthood, between the ages of 10 and 19 years (WHO, 2014b). Yet, a definition of adolescence based on a chronological age bracket is contested (Mandarino, 2014). Instead the transition to adulthood is marked by the fulfilment of developmental tasks, which are specific to their socio-cultural context (Arnett, 1997; Sawyer et al., 2012). Western conceptualisations emphasise goals such as individuation from parents, including financial independence and moving out of home (Arnett, 1997). Yet, given economic necessities and the need for further education, many authors argue that in the 21st century adolescence has expanded well into the 20s (Mandarino, 2014; Patton & Viner, 2007). Although the end of adolescence cannot be strictly defined by chronological age, access to mental health services for children and adolescents commonly ends at the age of 18. Those over the age of 18 years are required to access adult services. This can lead to a discontinuity of services, a rupture in therapeutic relationships, and developmentally inappropriate services. Some adolescents may discontinue accessing mental health services altogether (Mandarino, 2014).

The CAMH unit at the hospital where this research was based consists of both inpatient adolescent units and an outpatient Child and Family Unit. The inpatient unit admits adolescents between the ages of 13 and 18 years, while the outpatient unit has an upper age limit of 18 years. For practical reasons, the definition of adolescence for this study will therefore be as follows (adapted from WHO, 2014b):

> *Adolescence*: The period in human growth and development that occurs after childhood and before adulthood, from ages 13 to 18.

1.4.2 Suicide Attempt and Interrupted Attempt

Suicidal behaviours are conceptualised as existing on a continuum (Nock et al., 2008; Sveticic & De Leo, 2012). They encompass a range of behaviours from less severe forms, such as suicidal ideation, through to intentional self-harming behaviours that result in death (Posner et al., 2014; Sveticic & De Leo, 2012). Epidemiological studies demonstrate the generally decreasing prevalence of suicidal behaviours across this continuum, with suicidal ideation

being much more common than suicide attempts and suicide the least prevalent outcome (Bertolote et al., 2005; Nock et al., 2008). Yet, a lack of consensus regarding nomenclature makes it difficult to evaluate research, as different definitions and inclusion criteria result in heterogenous groupings, making comparisons difficult. Clinical communication, accurate mortality and morbidity statistics, and prevention efforts are also adversely affected by a lack of standard nomenclature (De Leo et al., 2006; O'Carroll et al., 1996; Posner et al., 2014; M. M. Silverman, 2011). It is therefore essential to define what I mean when I refer to including adolescents who have *attempted suicide* or engaged in an *interrupted attempt* in this study.

The word "attempted" in the context of suicide is considered pejorative by some authors, as it is seen to imply failure (e.g., Silverman, 2006), with an international move toward using the term "non-fatal suicidal behaviour" to denote any non-lethal self-directed violence where there was non-zero intent to die. I have however chosen to use the term "suicide attempt" in this thesis, because it is a commonly used description and is therefore more accessible to research participants and potential future readers of this work who are situated outside of the suicidology field. Additionally, I also decided against the term "non-fatal suicidal behaviour" as it encompasses a broader range of suicidal behaviours, including suicidal ideation, preparatory acts, and suicide attempts (Mościcki, 2014). I wanted to narrow the focus, as research has demonstrated differences in experience and motivations between those individuals who attempt suicide and those who engage solely in non-suicidal self-injury (NSSI) (Brausch & Gutierrez, 2010; Taliaferro et al., 2019) or experience suicidal ideation but do not act on their thoughts (Kim et al., 2015; Wetherall et al., 2018). Yet, I acknowledge that it is difficult to draw this distinction at times.

1.4.2.1 Three Components of a Suicide Attempt

Agency, intent, and expected outcome are the three components that dominate classification systems when distinguishing a suicide attempt from other non-suicidal self-injurious behaviours (NSSIBs) (De Leo et al., 2006; Posner et al., 2014). These components are discussed next.

Agency. Agency denotes that the suicide attempt was self-initiated, although it does not necessarily have to be self-inflicted. For example, an individual may provoke a person with the expectation of being fatally wounded. This act would be regarded as self-initiated, but not self-inflicted. A suicide attempt can be active in nature, such as for example swallowing poison or hanging oneself, or passive, such as refusing to eat (Posner et al., 2014).

Intent. Intent refers to the desire for death as an outcome and is key to distinguishing a suicide attempt from accidental or non-suicidal self-harm (Posner et al., 2014). Yet judging whether intent was present is challenging. Patients at times minimise or deny the intent of their actions, for reasons which may include shame or stigma; while it is possible that others may exaggerate the lethality of their actions (Osafo et al., 2015; M. M. Silverman, 2011). The question of whether a suicide attempt took place or not allows for subjective interpretation, which may result in the inclusion of a diverse group of people, ranging from those with superficial lacerations to those who engage in acts with a high probability of lethality (Kidd, 2003). As stated by Rosenberg and colleagues (1988, p.1446): "With respect to intent, absence of evidence is not evidence of absence".

There is seldom a single impetus underlying a suicide attempt, with various motivations contributing to the behaviour. Ambivalence around dying is common (Berk & Asarnow, 2015). The concept of non-zero stated or inferred intent is therefore key when assessing intent. If there is any part of the individual that wanted to die, intent can be assumed. Intent may also be inferred by the lethality of the method employed, even if intent is denied by the individual (e.g., the individual shoots him or herself in the head, but survives) (O'Carroll et al., 1996; Posner et al., 2014). The lack of operationalisation of the concept of intent however in practice leads to low levels of agreement amongst professionals when classifying an act as a suicide attempt or not (Wagner et al., 2002).

Expected Outcome. The person attempting suicide must believe that death is a potential outcome of the action. Even if the behaviour does not have a high degree of lethality, if the person believes that it could result in death, this aspect defining a suicide attempt is met (Posner et al., 2014). A suicide attempt may or may not result in injury (O'Carroll et al., 1996).

1.4.3 Definitions for the Purposes of this Research

For the purposes of this research, only adolescents who were perceived to have engaged in a *suicide attempt* or *interrupted attempt*, during the preceding 6 months, were included. These terms can be subsumed within the category of suicidal behaviours with a non-zero intent to die (Posner et al., 2014). The definitions for the purposes of this study are adapted from Posner and colleagues (2014, p.18):

> *Suicide attempt*: A nonfatal self-directed potentially injurious behaviour with any intent to die (either explicit or implicit) as a result of the behaviour

> *Interrupted attempt*: A person takes steps toward making a suicide attempt but is stopped by another person prior to any injury or potential injury

A suicide attempt does not necessarily result in harm or injury, although the potential for harm exists. It also requires a non-zero intent to die. It is critical to note that the concerned person may have held ambivalent feelings towards dying, but if there was any intent or desire to die associated with the act it is regarded as a suicide attempt (Posner et al., 2014). Intent, as discussed above, is often unclear and for the purposes of the study we therefore allow for both explicit and implicit intent. If a patient states that there was any part of them that wanted to die, intent is met. Similarly, a clinician may infer intent by the method employed or the characteristics of the behaviour, even if intent is denied by the patient. An interrupted attempt assumes that no injury occurred, but that if the person had not been interrupted by another person a suicide attempt would have followed (Posner et al., 2014). For this study, an interrupted attempt would not include a self-aborted attempt, but an attempt that was interrupted by another person or circumstance (e.g., family member unexpectedly arriving home early as the individual was preparing for the suicidal act). This research therefore does not include adolescents who have *solely* engaged in NSSIB, or who engaged in preparatory acts which did not result in a suicide attempt. I acknowledge that these distinctions may not always be clear. For the purposes of this study, an adolescent meets the inclusion criteria if the adolescent or the clinician perceive the act as a suicide attempt or interrupted attempt.

1.5 THE RELEVANCE OF QUALITATIVE RESEARCH FOR SUICIDE PREVENTION AND RESEARCH

While the predominant use of quantitative research methodology in suicidology has provided explanations of the associations between risk factors and suicidal behaviour, it falls short in truly demonstrating in-depth understanding of the phenomenon (Hjelmeland & Knizek, 2011). Multiple motives may underlie suicidal behaviour, both conscious and unconscious, which cannot be reduced to a few factors. Suicide attempts are complex acts, and although individuals may share similar socio-demographic and psychiatric characteristics, the underlying psychology and motives of the attempt may differ (Berk & Asarnow, 2015). Qualitative research based on first-person accounts (such as done in this study) allows for a nuanced understanding of phenomena such as suicide attempts, by exploring the lived experience of those affected. Suicide also occurs within a socio-cultural, political, and historical context, which is difficult to quantify (Hjelmeland, 2016). The need for local qualitative studies has therefore been highlighted in order to understand the complexities of suicidal behaviour and the interplay with the socio-cultural context (Mars et al., 2014). This in-depth and contextualised understanding is necessary to inform context sensitive and culturally informed suicide prevention strategies. Qualitative research is also useful as an advocacy tool, by creating awareness of experiences by those living them (Larkin et al., 2019). Yet, qualitative research reliant on first-person narratives also has several limitations. These include the inability to attribute causality (Coyle, 2007; Larkin et al., 2019) and the potential unreliability of autobiographical accounts (Bantjes & Swartz, 2019; Gardner, 2001), a point to which I will return in section 9.3 of the final chapter of this thesis.

1.6 RATIONALE FOR THE STUDY

Despite the public health concern posed by suicide, there is a lack of research into suicidal behaviours among South African adolescents. We do not understand the reasons local adolescents give for their suicide attempts and the meanings they attach to their behaviour. Nor do we know how the adolescents' caregivers and clinicians perceive their attempts, and how these experiences and understandings are framed by the local context. Yet, research demonstrates that past suicide attempts predict future attempts among adolescents (Asarnow et al., 2017; Roberts et al., 2010). Past suicide attempts are also strong predictors of subsequent death by suicide (Bostwick et al., 2016; Owens et al., 2002). An in-depth contextualised

understanding of adolescent suicide attempts is therefore an essential first step, which will aid in furthering research into the prevention of suicide amongst our youth and inform service delivery. This is the first South African and African study that examines the phenomenon of suicide attempts among a cohort of adolescents from the views of the adolescents, their caregivers, and clinicians. The multiperspectival design of this study aims to provide a more comprehensive and nuanced understanding than if only one group's perspective were considered.

1.7 RESEARCH AIM AND QUESTIONS

1.7.1 Research Aim

This research aims to provide a contextualised understanding of the phenomenon of suicide attempts by South African adolescents living in a low resource environment. To achieve this aim, the perspectives and lived experiences of three different groups of participants were elicited. These include the adolescents who attempted suicide, their caregivers, and the clinicians who worked with them. I hope that a contextualised and nuanced understanding of the adolescents' suicide attempts can inform future work by the clinicians in the CAMH unit in which this research was conducted. I also hope that this research will influence discussions and decisions related to service delivery and efforts at adolescent suicide prevention in local (or similar) contexts.

1.7.2 Research Questions

The following research questions contribute to the study's aim of providing a contextualised understanding of the phenomenon of suicide attempts by South African adolescents residing in a low resource area of Cape Town. The research questions are addressed by primarily exploring the lived experience of the adolescents who attempted suicide. However, in order to provide a more complete understanding, the perspectives and experiences of these adolescents' caregivers and clinicians were also elicited. The first five questions will therefore apply to the adolescents, caregivers, and clinicians, while the sixth question pertains only to the adolescents:

i. How do participants understand the adolescents' suicide attempts?
ii. What is the socio-cultural context in which adolescents in low resource environments attempt suicide?
iii. What, if anything, do participants think may have averted the adolescent's suicide attempt?
iv. What ideas do participants have for youth suicide prevention?
v. What are the participants' expressed support needs?
vi. What were this group of adolescents' experiences of receiving mental health support services after their suicide attempt?

1.8 A BRIEF OVERVIEW OF THE THESIS

In this chapter I outline the background to and context of this research. The terminology for the study is defined. I explain the rationale for the study, its research aim, and questions.

Chapter 2 starts with an overview of the mainstream literature concerning adolescent suicide attempts and examines the limitations of dominant biomedical conceptualisations. I present a narrative literature review of the lived experiences of suicidal adolescents, their caregivers, and clinicians. The chapter ends with an overview of theories of suicidal behaviour.

In Chapter 3 I describe the chosen methodology for this research. I outline the theoretical framework of hermeneutic phenomenology and describe the use of Interpretative Phenomenological Analysis. The procedures of recruitment, data collection, and data analysis are detailed. I discuss the ethical considerations, the steps undertaken to ensure the quality of the research, and my positioning as researcher.

I present the findings of the research in chapters 4 to 6. Chapter 4 outlines the findings for the adolescents, Chapter 5 for the caregivers, and Chapter 6 for the clinicians.

In Chapter 7 I synthesise and interpret the findings from the three findings chapters and discuss their implications in view of the existing literature.

In Chapter 8 I reflect on my experience of the overall research process, and its apparent impact on the participants.

In Chapter 9 I provide a summation of this study's findings and discuss the limitations of the research. I describe the implications for service delivery and make suggestions for future research.

CHAPTER 2
LITERATURE REVIEW

I begin by exploring the mainstream literature (i.e., quantitative research conducted with a risk factor paradigm), with a focus on adolescent suicide and suicide attempts. This is followed by a discussion of the limitations of mainstream suicidology research, including an overview of critical suicidology. A narrative literature review of qualitative studies examining the experiences of adolescents who have attempted suicide, as well as their caregivers and clinicians, is provided. Finally, a summary of theories of suicidal behaviour is presented.

2.1 AN OVERVIEW OF THE MAINSTREAM SUICIDOLOGY LITERATURE

The mainstream literature consists of predominantly quantitative research. As far as possible, I have focused on including meta-analyses, systematic reviews, and where available, longitudinal and prospective studies. I have focused on research exploring adolescent suicide and suicide attempts, and therefore excluded research that exclusively focused on other suicidal behaviours, such as suicidal ideation and NSSI. Biological explanations of adolescent suicide and suicide attempts were also excluded as my research is explicitly situated within a psychological and socio-cultural paradigm, and limitations of space preclude me from discussing all potential biological explanations for suicide. For an overview of the epidemiology of adolescent suicide, please refer to section 1.2 of Chapter 1.

2.1.1 Risk Factors for Adolescent Suicide and Suicide Attempts

2.1.1.1 Demographic Risk Factors

Sex and Age. It is well known that the global age-standardised suicide rate is higher for males than females, although the difference is less pronounced in low- and middle-income countries (LMICs) (WHO, 2019). Yet recent statistics suggest that the number of global suicide deaths are similar for male and female adolescents aged 15 to 19 years old (WHO, 2019), although rates differ cross-nationally (Glenn et al., 2020). In South Africa, the suicide rate remains higher for males than females across age groups, including adolescents (Kootbodien et al., 2020). Female adolescents attempt suicide more frequently than males, both internationally

(Cha et al., 2018) and across LMICs (Liu et al., 2018). Yet, there is no difference in rates of attempted suicide by sex for the Africa region (Liu et al., 2018). Similarly, a representative school-based survey among South African adolescents found no difference in the rate of suicide attempts between females and males (Reddy et al., 2013), although a community-based prospective study (including adolescents who were not enrolled in school) found a higher rate of attempts among females than males (Cluver et al., 2015). Older adolescents are more likely to attempt suicide than their younger counterparts (Chu et al., 2017; Liu et al., 2018; Reddy et al., 2013).

Minority Groups. Globally, minority groups are at increased risk of suicide and suicide attempts. Indigenous adolescents have disproportionally high suicide rates (Dickson et al., 2019; Glenn et al., 2020), which may be partially attributed to economic disadvantage, as well as to identity confusion arising from the effects of colonisation (Beautrais & Fergusson, 2006). Adolescents who identify as transgender, homosexual, or bisexual also have an increased risk of attempted suicide when compared to heterosexual peers (di Giacomo et al., 2018; Hatzenbuehler, 2011). This may be due to the greater degree of victimisation experienced by LGBT youth (Duncan & Hatzenbuehler, 2014; Hatzenbuehler, 2011) .

2.1.1.2 Psychological Risk Factors

Meta-analyses and longitudinal studies have demonstrated that mental illness increases the risk for both suicide (Gili et al., 2019) and suicide attempts (Gili et al., 2019; Jakobsen et al., 2011; Miché et al., 2018) in adolescents. The risk of a suicide attempt increases proportionally with the number of psychiatric diagnoses (Gili et al., 2019), for both first (Miché et al., 2018) and repeat attempts (Jakobsen et al., 2011). The risk of suicide among adolescents with a mental disorder is particularly high, with an estimated odds ratio of 10.83 (Gili et al., 2019).

When specific mental disorders are analysed in terms of their risk for suicide attempts among adolescents, the results are more ambiguous. Longitudinal studies suggest that depressive disorders (Miché et al., 2018; Nrugham et al., 2008b), post-traumatic stress disorder (PTSD) (Miché et al., 2018), marijuana use (Roberts et al., 2010), and nicotine dependence, but not alcohol use disorder (Miché et al., 2018) predict suicide attempts among adolescents. In a

prospective study with South African adolescents, alcohol or drug misuse was not predictive of suicidal behaviour (Cluver et al., 2015). Large-scale cross-sectional studies also demonstrate positive associations between anxiety (Liu et al., 2018; Shayo & Lawala, 2019), substance use (Carvalho et al., 2019; Liu et al., 2018), and suicide attempts, although causality cannot be implied. A meta-analysis of longitudinal population-based studies found that only affective disorders predicted suicide attempts among adolescents (Gili et al., 2019). Negative affective processes such as loneliness (Liu et al., 2018; Shayo & Lawala, 2019), worthlessness, and hopelessness (Nrugham et al., 2008b) have also been associated with suicide attempts among adolescents. Finally, there is strong evidence that previous suicide attempts are predictive of future suicide attempts among teenagers, as demonstrated by prospective longitudinal studies (Asarnow et al., 2017; Nrugham et al., 2008a; Roberts et al., 2010)

2.1.1.3 Environmental Risk Factors

Familial Factors. The suicide of a family member has been associated with an increased risk of suicide and suicide attempts among adolescents (Frey & Cerel, 2015), including South African teenagers (Vawda, 2012). Two longitudinal American studies found that the suicide attempt of a family member or caregiver predicted suicide attempts among adolescents (Abrutyn & Mueller, 2014; Roberts et al., 2010).

Some research suggests that parental psychiatric diagnosis may be associated with adolescents' suicide attempts. For example, parental depression was a predictor of future suicide attempts among male adolescents (Asarnow et al., 2017). Children and adolescents were also less likely to engage in a repeat attempt, if their parents received treatment for their own psychiatric diagnoses after the adolescents' first suicide attempt (Jakobsen et al., 2011), although causality cannot be attributed.

Poor familial relationships have been associated with adolescent suicide attempts (Liu et al., 2018). Family conflict was associated with suicide attempts among South African adolescents (Madu & Matla, 2004; Pillay & Wassenaar, 1997), and conflict with parents often immediately precipitated the suicidal behaviour (Pillay & Wassenaar, 1997). Connectedness with parents

on the other hand appears to be protective, lowering the risk of suicide attempts (Conner et al., 2016; Shayo & Lawala, 2019).

Interpersonal Violence. Interpersonal violence (IPV), including child sexual and physical abuse, bullying, community and dating violence, is associated with both increased suicide attempts and suicide among adolescents and young adults (Castellví et al., 2017; Cha et al., 2018; Evans et al., 2005; Miller et al., 2013). Research suggests an additive effect on risk for suicide attempts, when more than one form of child maltreatment occurs (Miller et al., 2013). A meta-analysis of population-based studies found that any form of interpersonal violence during childhood increases the risk of suicide 10-fold for those aged between 12 and 19 years of age, when compared to non-exposed peers (Castellví et al., 2017).

Adverse Childhood Experiences. Adverse childhood experiences (ACEs) increase the risk of suicide attempts throughout the lifespan (Bruwer et al., 2014; Cluver et al., 2015; Dube et al., 2001). This association was apparent in a prospective study with South African adolescents, which defined ACEs as including physical, sexual and emotional abuse, domestic violence, loss of parent due to AIDS-related illness or homicide, community violence exposure, and food insecurity. Even when controlling for socio-demographics and baseline suicidality those adolescents with five or more ACEs were three times more likely to attempt suicide than those with no ACEs (Cluver et al., 2015). The South African Stress and Health Study found that the impact of ACEs varies over the life course. For example, sexual abuse in childhood was significantly associated with suicide attempts during childhood and adolescence, but not during later years (Bruwer et al., 2014).

Bullying. Bullying, including cyberbullying, by peers is associated with an increased risk of suicide attempts among adolescents (John et al., 2018; Katsaras et al., 2018; Liu et al., 2018; van Geel et al., 2014). A meta-analysis found bullying to be the form of interpersonal violence contributing the most to suicide attempts among adolescents, with a population attributable risk (PAR) of 22% (Castellví et al., 2017). Perpetrators of bullying (including cyberbullying) also face an increased risk of suicidal behaviours, although to a lesser extent than victims (John et al., 2018; Katsaras et al., 2018). Those adolescents who are both bullies and victims are at greatest risk for suicide attempts (Holt et al., 2015; Katsaras et al., 2018). These associations

held when a meta-analysis was conducted on adolescents who had no psychiatric comorbidities, did not use drugs, and were not sexual minorities (Katsaras et al., 2018).

Peer and School Connectedness. Connectedness to peers and school seems to be a protective factor for adolescents (Czyz et al., 2012; Gunn et al., 2018). Gunn and colleagues (2018) found that an increased sense of school connectedness protected adolescents with suicidal ideation from engaging in a suicide attempt. Inpatient suicidal adolescents who reported an improvement in peer connectedness were half as likely to attempt suicide in the year post discharge (Czyz et al., 2012). A meta-analysis of cross-sectional studies also found that school absenteeism, a possible measure of social exclusion, was associated with increased self-harm (regardless of intent) among adolescents (Epstein et al., 2019). Yet longitudinal data from a nationally representative sample of American adolescents found that exposure to friends who had attempted suicide appeared to trigger suicidal thoughts and attempts among adolescents (Abrutyn & Mueller, 2014).

Food Insecurity. Food insecurity is associated with suicide attempts among adolescents (Koyanagi et al., 2019; Shayo & Lawala, 2019), including in a large-scale study across 40 LMICs (Liu et al., 2018). However, no association is detected between GDP per capita and adolescent suicide attempts (Koyanagi et al., 2019; Liu et al., 2018). Rather, the degree of social inequality in a country may play a role, with stronger associations between suicide attempts and food insecurity in countries with a lower prevalence of severe food insecurity (Koyanagi et al., 2019).

2.1.2 Prevention and Treatment of Adolescent Suicide and Suicide Attempts

The effects for most interventions targeting adolescents with self-harm are unknown (Hawton et al., 2015; Morken et al., 2020; Ougrin et al., 2015; Robinson et al., 2018). This is attributed to a lack of high-quality intervention studies for adolescents, and a lack of statistical power due to high attrition rates and insufficient sample sizes in research (Hawton et al., 2015; Ougrin et al., 2015; Robinson et al., 2018). Furthermore, few intervention studies are conducted in LMICs (Robinson et al., 2018).

Universal school-based interventions seem to offer potential for the prevention of suicide attempts among adolescents (Morken et al., 2020; Robinson et al., 2018). Moderate evidence suggests that school-based interventions prevent suicide attempts among adolescents in the short term, and possibly the long term (Morken et al., 2020), although these programmes need to be sustained in order for the effects to last (Asarnow & Mehlum, 2019). Universal school-based interventions that have shown the greatest promise in reducing suicide attempts among adolescents include Signs of Suicide, the Youth Aware of Mental Health programme, and the Good Behavior Game (Katz et al., 2013; Singer et al., 2019). Signs of Suicide teaches students the warning signs of suicide, and encourages them to seek assistance for themselves or a friend exhibiting these signs (Schilling et al., 2016). Youth Aware of Mental Health focuses on mental health awareness and the skills needed to cope with adverse life events, using interactive workshops and teaching (Wasserman et al., 2015). The Good Behaviour Game is implemented at elementary school level, focusing on social integration and acceptance through classroom-based teamwork that aims to reduce aggressive and disruptive behaviour. Although not specifically targeting suicidal behaviour, this intervention reduced suicide attempts throughout childhood, adolescence, and into early adulthood (Wilcox et al., 2008).

There is insufficient evidence to support the standalone screening of adolescents for suicide risk (Morken et al., 2020). Furthermore, a systematic review found that there is no screening tool that is a sufficiently accurate predictor of suicide risk among adolescents (Harris et al., 2019). Gatekeeper training programmes for teachers and parents also have no evidence for reducing suicide attempts in adolescents, although they did improve suicide literacy (Torok et al., 2019).

Restricting access to means is an effective manner of preventing suicides among adults (Mann et al., 2005; Milner et al., 2017), although no reviews are specific to adolescents (Morken et al., 2020). Reporting on celebrity suicides, but not general suicides, has been associated with an increase of suicide in the general population (Niederkrotenthaler et al., 2020; Stack, 2005). Although media guidelines exist (WHO, 2017), further research is required to evaluate the effectiveness of particular guidelines (Stack, 2020). Research is needed to test online interventions for youth (Perry et al., 2016; Robinson et al., 2018).

There is mixed evidence for the effectiveness of clinical interventions in reducing repetition of self-harm (including suicide attempts) among youth. While Robinson and colleagues (2018) found little evidence in support, once low-quality studies had been removed from the meta-analysis, a review by Ougrin and colleagues (2015) did find evidence in support thereof. Dialectical behaviour therapy (DBT) is the treatment modality with the most support for reducing self-harm and suicide attempts in adolescents, with a number of randomised control trials supporting its efficacy (Hawton et al., 2015; McCauley et al., 2018; Mehlum et al., 2016; Morken et al., 2020; Ougrin et al., 2015; Tebbett-Mock et al., 2020). Although mentalisation based therapy also offers some potential, it is based on a single randomised control trial (Hawton et al., 2015; Ougrin et al., 2015).

Overall, multi-modal and multi-level interventions in community settings, including school settings, show the most promise in the prevention of suicide and suicide attempts among both youth (Robinson et al., 2018), and the general population (Hofstra et al., 2020). Treatment that combines individual treatment with a strong family component, as well as interventions that address the psychosocial environment and enhance the ability of adults to support adolescents, show the greatest promise (Asarnow & Mehlum, 2019).

2.1.3 Limitations of the Mainstream Literature

In the absence of experimental designs, the risk factors discussed cannot be causally linked to suicidal behaviours. Instead they are either correlates of suicidal behaviour (for cross-sectional designs) or risk factors for future suicidal behaviour (for longitudinal and prospective studies) (Cha et al., 2018). Many of the studies are also limited by heterogenous samples and were not able to account fully for the impact of confounding factors. Although the literature highlights the importance of environmental factors for increasing risk for suicide and suicide attempts among adolescents, the focus of interventions largely remains on the individual adolescent, and often involves creating awareness of or treatment for mental health problems. Secondly, the risk factors discussed are not unique to suicidal adolescents, but are common to distressed youth (Wagner et al., 2003). Most psychosocial risk factors have a nonspecific outcome, with a cumulation of risk factors increasing the probability of suicide attempts among teenagers (Roberts et al., 2010). Yet most interventions, except for the Good Behaviour Game, focus specifically on reducing suicidal behaviour. It has therefore been suggested that interventions

should rather address multiple risk and protective factors, which are likely to reduce a variety of risky behaviours, including suicidal behaviour (Roberts et al., 2010). For those interventions that are promising, it is unclear as to what the effective therapeutic mechanisms are that underlie them (Hawton et al., 2015; Ougrin et al., 2015).

2.2 CRITICAL SUICIDOLOGY: CHALLENGING DOMINANT BIOMEDICAL CONCEPTUALISATIONS OF SUICIDE

The dominant, contemporary conceptualisation of suicide as a symptom of psychopathology and as something that has its origins within the individual has been challenged by a number of authors, who have pointed to the socio-cultural dimensions of suicidal behaviour (Hjelmeland & Knizek, 2017; Marsh, 2010, 2016; White, 2016, 2017; White & Morris, 2019). This rethinking of suicide and critique of suicide prevention situated within a psychiatric model has been termed critical suicidology (Kral et al., 2017; White, 2017). Critical suicidology acknowledges that suicide, and the understanding thereof, is located within a historical and cultural frame, and cannot be considered a static or universal entity devoid of context. For example, the Western understanding of suicide has historically shifted from one of sin and crime, to one of pathology (Hecht, 2013; Marsh, 2010). Critical suicidologists therefore challenge assumptions made by the dominant conceptualisation of suicide. These assumptions are that: 1) "Suicide is pathological", 2) "Suicidology is science", and 3) "Suicide is individual" (Marsh, 2016, p.16-17). By questioning these assumptions, critical suicidologists hope to embrace more creative approaches to suicide and suicide prevention, while drawing on the expertise of those with lived experience (White, 2017).

2.2.1 Querying Mental Disorder as the Main Causal Factor in Suicide

Critical suicidologists question the assumption that mental disorders are the key causal factors in most suicides (e.g., Hjelmeland & Knizek, 2017). Shneidman (1992) notes that although there may be a strong association between mental disorders and suicide, causality cannot be implied, and the majority of people with mental disorders do not suicide. Critical suicidologists highlight that studies conducted in non-Western settings have found much lower incidences of mental disorders in suicides than those in the West (e.g., Cho et al., 2016; Mars et al., 2014; Zhang et al., 2010). In their meta-analysis, Cho and colleagues (2016) found a lower prevalence

of mental disorders (69.6%) among suicides in East Asia than those in North America (88.2%). Other research estimated the prevalence of mental illness in suicides as 48% among rural Chinese (Zhang et al., 2010), while Choo and colleagues (2019) only diagnosed 25% of patients admitted to the emergency department of a hospital in Singapore following a suicide attempt with a mental illness. Some authors hypothesise that these lower prevalence rates may be due to an underdiagnosis of mental illness, due to factors such as fear of stigma (Choo et al., 2019). Yet others note the relevance of socio-economic, cultural, and social context when considering geographical variations in suicide rates (Cho et al., 2016; Zhang et al., 2010).

2.2.2 The Over-Reliance on Quantitative Research

Critical suicidologists critique the dominance of quantitative research in suicidology, which is focused predominantly on risk factors and epidemiology. Quantitative research excludes socio-cultural context (which cannot be quantified) and negates the complexity of relational human beings (Hjelmeland, 2016). It is therefore argued that qualitative research is required to enhance understanding of what makes people suicidal (Hjelmeland, 2016). Psychological autopsy studies, which form a large part of the evidence base implying a causal link between suicide and mental illness, have been critiqued for their methodological flaws (Hjelmeland, 2016; Hjelmeland et al., 2012). One of the main arguments is that psychiatric diagnoses cannot be reliably assigned by interviewing other people, often long after the suicide (Hjelmeland, 2016; Hjelmeland et al., 2012).

2.2.3 Psychiatric Power and Its Impact on Solutions for Addressing Suicide

Conceptualising suicide as an individual state of pathology restricts solutions to medical and psychiatric ones and sidelines economic, historical, and socio-political power relations (Marsh, 2010; White, 2016). In Marsh's (2010) Foucauldian analysis of suicide, he examines how the conceptualisation of suicide as a pathological state has led to the consolidation of psychiatric power. Understanding suicide as a medical truth has led to psychiatric practices of confinement of individuals deemed to be dangerous to themselves and others. Yet the act of watching, examining, and keeping detailed case notes of these patients has produced knowledge that justifies these practices. Marsh refers to these as the "circular relations of power-to-knowledge and knowledge-to-power" (2010, p.225). This medicalisation of suicide has created a power

imbalance between the clinician and suicidal patient and informed their role conceptualisations. It also places a burden on clinicians (White, 2016), who are expected to have the power to prevent suicides. The medicalisation of suicide also excludes alternative ways of understanding, such as for example, suicide as resistance (Marsh, 2010).

2.2.4 Impact of Biomedical Conceptualisations of Suicide on Prevention Programmes

The biomedical conceptualisation of suicide has led to youth prevention programmes that are authoritative, regarding teenagers as passive recipients of adult expertise (White, 2012, 2016). Teenagers are taught to equate suicide with mental illness, and told to inform an adult if they notice signs of suicide displayed by themselves or others (e.g., Schilling et al., 2016; Wyman et al., 2010). White (2012, 2016) argues that these conceptualisations disregard contexts, including the possible unavailability of adults who can be trusted, and negate the experiences and insight of the youth.

2.2.5 Alternative Ways of Conceptualising Suicide

Those situated outside the medical field have often challenged the psychiatric framing of suicide. Suicide has instead been regarded as a form of protest and communication (Cheikh et al., 2011; Park & Lester, 2009; Staples & Widger, 2012; Waters, 2015). This protest may be against social, political or economic conditions, when other forms of communication have failed (e.g., Park & Lester, 2009; Waters, 2015). For example, Kizza and colleagues (2012) examined how the suicides of young Ugandan women were situated within the historical context of a protracted civil war. Women maturing during the war were not socialised into the traditional role of being subordinate to men, resulting in power struggles between married couples in a patriarchal society. Feelings of loss of control, and a protest against expected gender norms, appeared to be tied up with the young women's suicides. In summary, by questioning what Marsh (2010) refers to as a "compulsory ontology of pathology" (p.219), critical suicidologists hope to introduce more diverse ways of thinking about and working with suicide, and those impacted by it.

I am interested in the psychological and socio-cultural context in which the adolescents in this study attempted suicide and question a purely psychiatric or bio-medical understanding of

suicidal behaviour. This research and its aim of providing a contextualised understanding of the phenomenon of adolescent suicide attempts therefore align with the assumptions of critical suicidology discussed in this section. Yet, I acknowledge that the divide between the bio-medical and the contextual is itself an artificial construct. By emphasising a contextualised understanding, I am not negating the importance of psychiatric factors in adolescent suicide attempts.

2.3 THE LIVED EXPERIENCE OF SUICIDAL ADOLESCENTS, THEIR CAREGIVERS, AND CLINICIANS

This section provides a narrative literature review of qualitative research which examines the experiences of adolescents who have attempted suicide, their caregivers or parents, and the clinicians who work with these adolescents. Studies were included if the suicidal adolescents were aged between 13 and 18 years, although studies in which the age range overlaps with this age span were included. Due to the inconsistent use of terminology in research publications, I included literature that referred to either "suicide attempt", "deliberate self-harm" (DSH), or "self-harm", and grammatical variants thereof. European and British research frequently refers to self-harm or deliberate self-harm, regardless of the intent to die, and includes instances where adolescents have overdosed or harmed themselves to a degree that requires medical treatment. I excluded literature that solely focused on NSSI.

The following databases were searched for relevant, peer-reviewed qualitative publications: Academic Search Premier, Africa-Wide Information, CINAHL, MEDLINE, ScienceDirect, and GoogleScholar. References listed in articles were also consulted for additional literature. This narrative section of the literature review was updated until the 16 April 2020, with no restriction placed on articles' date of publication. Regarding the search strategies detailed below, TI stands for terms that were required to be included in the title of the article, while SU refers to subject terms. Some databases do not have SU as a qualifier; in these cases, the title, abstract, and keywords were searched. The search strategies were as follows:

i. For literature on the adolescents' experience: TI (adolescen* or teen* or children or youth or young) AND TI (suicid* or self harm or self-harm) AND SU qualitative;

ii. For literature on the caregivers' experience: TI (parent or famil* or care* or mother or father) AND TI (adolescen* or teen* or children or youth or young) AND TI (suicid* or self harm or self-harm) AND SU qualitative;
iii. For literature on the clinicians' experience: TI (clinician or professional or nurse or doctor or staff) AND TI (adolescen* or teen* or children or youth or young) AND TI (suicid* or self harm or self-harm) AND SU qualitative.

Three qualitative systematic reviews have explored the experiences and perceptions of adolescents who have attempted suicide (Grimmond et al., 2019; Lachal et al., 2015; Nicolopoulos et al., 2018). Nicolopoulos and colleagues (2018) focused on qualitative studies exploring motivations for attempting suicide among youth aged 12 to 25 years and included 17 studies in their review. The other two reviews incorporated the perspectives of youth, parents, and health care professionals. Lachal et al. (2015) identified 31 qualitative studies published between 1990 and 2014, that elicited the perspectives of youth aged 9 to 30 years, who had attempted suicide. Grimmond et al.'s (2019) review included a total of 27 qualitative studies published up until October 2018. Of these 27 studies, 14 elicited the perspectives of youth aged 25 or younger, who had attempted suicide. However, Grimmond et al.'s (2019) write-up did not distinguish among the perspectives of the various groups, and also incorporated opinions about suicide by non-suicidal youth.

2.3.1 The Experiences of Adolescents Who Have Attempted Suicide

Suicidal adolescents describe being in distress. This includes feelings of despair, irritability, worthlessness, and low self-esteem (Beekrum et al., 2011; Grimmond et al., 2019; Lachal et al., 2015). Feelings of hopelessness, worthlessness, helplessness, and shame were frequently described as catalysts at the time of the attempt (Nicolopoulos et al., 2018). Yet suicidal adolescents frequently express ambiguity around their suicide attempts (Beekrum et al., 2011; Holliday & Vandermause, 2015; Zayas et al., 2010). The desire to escape from pain and suffering is often described as the motivation for the attempt, rather than necessarily a desire to die (Holliday & Vandermause, 2015; Nicolopoulos et al., 2018; Orri et al., 2014).

Relational difficulties are central to the experiences of adolescents who have attempted suicide (Grimmond et al., 2019; Lachal et al., 2015; Latakienė & Skruibis, 2015; O'Brien et al., 2019).

Feeling rejected, unloved, alone, and misunderstood were common experiences preceding adolescents' suicide attempts (Holliday & Vandermause, 2015; Nicolopoulos et al., 2018; Orri et al., 2014; Shilubane et al., 2012). Suicidal adolescents report feeling disconnected from others, believing that they are alone in their experience of suffering (Holliday & Vandermause, 2015). Revenge has also been described as a motivation for attempting suicide by Italian adolescents. They hoped that their suicide attempt would elicit guilty feelings in important others, by making them aware of their mistakes (Orri et al., 2014). Grandclerc and colleagues (2019) interpret adolescents' accounts of their suicide attempts as hoping to provoke a reaction and to "always be present in the other person's head" (p.8).

Relationships with parents and families are particularly pertinent in adolescents' narratives about their suicide attempts (Grimmond et al., 2019; Lachal et al., 2015; O'Brien et al., 2019; Rice & Tan, 2017; Shilubane et al., 2012; Wadman et al., 2018; Zayas et al., 2010). Fractured families, conflict with family members, distancing from parents, and instability in the adolescent-parent relationship are described as critical concerns by suicidal adolescents (Beekrum et al., 2011; Lachal et al., 2015; Nicolopoulos et al., 2018). Conflict with parents sometimes arises due to a clash between socio-cultural norms and the adolescents' desire for greater autonomy (Keyvanara & Haghshenas, 2011; Yang, 2012). For example, suicidal Iranian adolescents reported restrictions on dating, and strict expectations of gender roles, which led to conflict with their families (Keyvanara & Haghshenas, 2011). Black South African adolescents also describe favouritism by their mothers towards their siblings, which they connect with feelings of rejection and their suicide attempts (Shilubane et al., 2012). Some adolescents ascribe their suicide attempts to violence within the family, as well as sexual and physical abuse (Aspaslan, 2003; Grimmond et al., 2019; Nicolopoulos et al., 2018; Rice & Tan, 2017). The failure of parents to protect the adolescent from this abuse has also been mentioned as influencing the suicide attempt (Zayas et al., 2010). Problematic alcohol or other drug use by parents, as well as parental disapproval of romantic relationships, have been mentioned by South African adolescents as contributing factors for their suicide attempts (Aspaslan, 2003). In addition, British adolescents relate how they learned suicidal behaviour through exposure to familial self-harm, where the definition of self-harm did not distinguish between suicidal and non-suicidal intent (Smith-Gowling et al., 2018). South African adolescents of Indian origin also reported unrealistically high parental expectations and a family history of attempted or completed suicide as factors in their attempts (Beekrum et al., 2011).

Other common experiences of adolescents who have attempted suicide include rejection by the peer group, feeling different, being bullied, and discrimination due to sexual orientation (Lachal et al., 2015; Zayas et al., 2010). A failure to fit into the peer group or to conform to perceived societal ideals elicits feelings of shame, anger, and guilt (Lachal et al., 2015). The resulting sense of isolation and rejection is described as a contributing factor in the suicidal behaviour (Grimmond et al., 2019). Yet self-harming behaviour is also learned from peers, with one adolescent stating that the cumulative exposure to self-harm normalised the behaviour (Smith-Gowling et al., 2018). Some adolescents find a sense of belonging by identifying with alternative subcultures (Trnka et al., 2018). However, these subcultures may endorse suicidal behaviour, with adolescents who identify with the emo subculture reporting a high degree of acceptance of suicide and NSSI (Trnka et al., 2018).

Descriptions of relationships with families and peers, and the feelings these elicit, dominate adolescents' accounts of their suicide attempts. Yet, some adolescents have also mentioned the influence of the community and socio-economic factors. For example, both poverty and the experience of prejudice towards adolescents belonging to a minority culture have been identified as influencing their suicidal behaviour (Grimmond et al., 2019). Some adolescents directly attributed their suicide attempt to poverty, reasoning that their death would reduce the financial burden for their family (Keyvanara & Haghshenas, 2011; Nicolopoulos et al., 2018). When talking about their suicide attempts, some South African adolescents related how rumours or false accusations by community members resulted in feeling hopeless and sad (Shilubane et al., 2012). Young people have also emphasised the role of the wider community in recovery and prevention of suicidal behaviour. The need to include young people in the community was stressed (Grimmond et al., 2019).

Suicide attempts are described as enabling communication of distress (Grandclerc et al., 2019; Grimmond et al., 2019; Holliday & Vandermause, 2015; Lachal et al., 2015). Communication difficulties with parents are commonly reported (Beekrum et al., 2011; Lachal et al., 2015), and are often interlinked with poor relationships with parents (Grimmond et al., 2019). Vietnamese adolescents described engaging in suicidal communication prior to their attempt, often through non-verbal and indirect means, but that this behaviour was difficult for others to interpret (Wasserman et al., 2008). American adolescents who were admitted to an emergency

unit after a suicide attempt reported difficulty in talking to others about their suffering, and that the attempt was a way to communicate the emotional pain they were experiencing. Yet this motivation was frequently not conscious at the time of the attempt, only being made sense of during the process of reflecting on their experience (Holliday & Vandermause, 2015). The difficulty in vocalising distress has also been described by other adolescents attending a CAMH unit. These adolescents found it helpful when other people voiced their concern about the adolescents' wellbeing (Hassett & Isbister, 2017). Holliday and Vandermause (2015) posit that the suicide attempt should therefore be interpreted as a "cry of pain" (p.172), rather than as attention seeking behaviour, which frequently has negative connotations.

One of the themes that predominates across qualitative studies concerning adolescents who have attempted suicide is a loss of control over their lives, and a bid to regain that control via the suicidal act (Lachal et al., 2015; Nicolopoulos et al., 2018; Orri et al., 2014). In addition, a loss of control is also described at the time of the suicidal act (Grandclerc et al., 2019). Grandclerc and colleagues (2019) interpreted the adolescents' description of their suicide attempts as an attempt to control, or master, death. They posit that adolescence presents a stage in which individuals are grappling with the reality of mortality, while still aware of the feeling of immortality present in childhood. Adolescents relate that they regain a sense of control over their lives when they start to understand themselves, often through talking with others, such as therapists, peers, and community members (Lachal et al., 2015).

Adolescents report mixed experiences about their interaction with mental health support services following suicidal behaviour (Gilmour et al., 2019). Those with beneficial experiences attributed this to a positive interaction with clinicians (Gilmour et al., 2019; Idenfors et al., 2015; McAndrew & Warne, 2014). In contrast, those with less favourable impressions report not feeling listened to by staff, and being patronised (Gilmour et al., 2019; Wadman et al., 2018). Adolescents describe wanting to be taken seriously, to be listened to, and treated with respect (Gilmour et al., 2019). British adolescents report feeling let-down by CAMHS, recounting long waiting lists, an inadequate number of sessions, and feeling dismissed by the service. This was summarized in one young's person description of CAMHS, as "just empty promises really" (Wadman et al., 2018, p.126). Regarding their experiences on inpatient adolescent mental health units, adolescents describe the exposure to others' self-harm as

traumatising. They describe the transmission of self-harming behaviour in the ward, with instances of self-harm at times triggering others to do the same. They also report learning new, and at times, surreptitious techniques of self-harming (Smith-Gowling et al., 2018). Yet, adolescents have also described benefitting from sharing their experience with peers in a similar situation (McAndrew & Warne, 2014; Smith-Gowling et al., 2018).

Some adolescents distinguish their life "before and after the attempt" (Holliday & Vandermause, 2015, p.170). Adolescent narratives illustrate that the suicide attempt either enabled recovery from suicidality through an improvement in familial relationships after the attempt (Holliday & Vandermause, 2015; Orri et al., 2014; Zayas et al., 2010), or did not lead to any changes, thereby reinforcing feelings of distress (Orri et al., 2014). Adolescents recount how the suicidal crisis led them to realise that others did (and had) cared for them, and/ or it allowed them to re-establish connections with people important to them (Holliday & Vandermause, 2015). The attempt also facilitated communication and efforts at mutual understanding, thereby enabling improvements in familial relationships (Orri et al., 2014). South African female adolescents of Indian heritage describe how their overdosing attempts frequently led to an improvement in interpersonal relationships, when other forms of communication had failed. They also report learning about the possible interpersonal effectiveness of suicidal behaviour, by observing how suicidal behaviour by family or friends had led to the desired changes in the behaviour of important others (Beekrum et al., 2011). Ultimately, a recovery from suicidal behaviour is described by adolescents as being intertwined with improvements in the communication and relationships with parents and feeling understood by those around them (Lachal et al., 2015; Orri et al., 2014). Adolescents describe connection with other people, and the availability of others who would listen to them, as allowing them to recover from suicidality (Holliday & Vandermause, 2015). South African adolescents have stated that they require greater parental support following their suicide attempts (Aspaslan, 2003). Adolescents also describe the importance of their relationships with clinicians, in particular the need for the clinician to offer unconditional support and understanding (Lachal et al., 2015). Health care providers were also described as being able to assist with the re-establishment of connections to the important people in the adolescents' lives (Holliday & Vandermause, 2015).

2.3.2 The Experiences of Parents and Caregivers

There is a lack of qualitative data exploring the perceptions and experiences of family members of adolescents who have attempted suicide (Chiang et al., 2015; Lachal et al., 2015). A systematic review of qualitative studies, published between 1990 and 2014, only elicited seven studies that examined the perspectives of parents (Lachal et al., 2015). Existing research predominantly focuses on those parents whose children have died from suicide, rather than those whose teenagers have survived suicide attempts (Lachal et al., 2015). No relevant qualitative studies conducted in South Africa were found.

Parents describe their child's suicide attempt as a double trauma, referring to both the trauma of the attempt and the ongoing impact on the family (Buus et al., 2014). Feelings of powerlessness and helplessness (Buus et al., 2014; Daly, 2005; Lachal et al., 2015; McLaughlin et al., 2014), as well as anger (Byrne et al., 2008; Lachal et al., 2015; Raphael et al., 2006), are commonly reported by parents and caregivers. They describe losing trust in their child, and that the parent-child relationship is altered following their child's deliberate self-harm (Byrne et al., 2008). Hate and blame towards the suicidal adolescent were also described by parents. These feelings were attributed to the adverse impact that the suicidal behaviour had on the family's wellbeing (Buus et al., 2014). Some mothers described feeling rejected by their suicidal adolescents, and admitted that at times they wished their child had never been born (Daly, 2005).

Parents describe a disruption of family dynamics, with the suicidal behaviour becoming the focal point within the family (Byrne et al., 2008). In a Danish study, many parents reported being manipulated by their suicidal children. They described giving into demands due to their feelings of guilt and the fear of a repeat attempt (Buus et al., 2014). Parents have also reported difficulty maintaining discipline, fearing that saying or doing the wrong thing would trigger suicidal behaviour (Byrne et al., 2008; Raphael et al., 2006). They also describe how the suicidal adolescent would "play the parents off against each other" (Buus et al., 2014, p.828). Mothers reported "walking on eggshells" in order to avoid an argument, which they feared may provoke suicidal behaviour (Daly, 2005, p.26). They also described emotionally distancing themselves from their adolescents in order to protect themselves from the pain of a repeat attempt (Daly, 2005).

Caregivers struggle to balance the demands of their everyday lives with caring for the suicidal youth (Dempsey et al., 2019). They fear future attempts, which often leads to monitoring their children's behaviour (Buus et al., 2014; Byrne et al., 2008; Daly, 2005). For example, parents have described sleeping outside their children's bedroom door (Buus et al., 2014; Ferrey et al., 2016). The ongoing anxiety and hypervigilance experienced by caregivers and family members was described as related to a decline in their own physical and mental health (Ferrey et al., 2016; McLaughlin et al., 2014; Raphael et al., 2006). Some report difficulty in maintaining full-time work, due to concern about their children, leading to financial strain; in addition to the detrimental impact on their marriages (Ferrey et al., 2016).

Parents of suicidal adolescents express feelings of guilt, believing that they had somehow failed in their role as parents (Buus et al., 2014; Byrne et al., 2008; Curtis et al., 2018; Daly, 2005; Ferrey et al., 2016; Lachal et al., 2015), or for not realising sooner that their child was unwell (Dempsey et al., 2019). At the same time, Buus and colleagues observed how parents attempted to portray themselves as responsible and adequate parents through their narratives (Buus et al., 2014). Parents also expressed guilt towards their other children, stating that they were neglected due to the overwhelming focus on the suicidal adolescent (Buus et al., 2014; Daly, 2005). Although there is a lack of research exploring the lived experience of siblings, parents describe how siblings express both anger and resentment, as well as support and overprotectiveness, towards their suicidal siblings (Ferrey et al., 2016). Some parents report that their non-suicidal children hide the suicidal behaviour of siblings from peers to avoid stigma (Ferrey et al., 2016).

Feelings of shame (Buus et al., 2014; Dempsey et al., 2019; McLaughlin et al., 2014) and isolation (Buus et al., 2014; Byrne et al., 2008; Dempsey et al., 2019; Ferrey et al., 2016; Lachal et al., 2015; McLaughlin et al., 2014) are common. Parents worry about what others may think (Buus et al., 2014; Ferrey et al., 2016), and report concern that other people may believe that there was something amiss in the family (Buus et al., 2014). In addition, caregivers report how at times the suicidal person specifically asks them not to tell anyone about their suicidality, and this placed them in a position of not wanting to break their trust (McLaughlin et al., 2014).

Family members' reactions to the attempted suicide of a relative are situated within the cultural attitudes towards suicide. For example, in Ghana suicide is still largely regarded as a crime and a sin. The stigma of an attempted suicide is carried by relatives, who regard it as a social injury. Family members report feelings of anger and shame after the attempted suicide of a relative, and are reluctant to seek support outside of the nuclear family due to fear of stigma (Asare-Doku et al., 2017). Although feelings of shame and isolation are also reported in Western contexts, parents were able to receive support by meeting with other parents in the same situation (Buus et al., 2014; Daly, 2005; Dempsey et al., 2019).

Caregivers have expressed the need for improved guidance by mental health services on how to better manage suicidal crises, as well as the young person in their care (Byrne et al., 2008; Curtis et al., 2018; Dempsey et al., 2019). Some expressed anxiety due to long waiting times in accessing CAMHS' appointments (Byrne et al., 2008). Parents also indicated a need for support groups with other caregivers who were grappling with similar experiences (Byrne et al., 2008; Ferrey et al., 2016). They preferred meeting with strangers, so that information would not be shared with mutual acquaintances or family members (Ferrey et al., 2016).

2.3.3 The Experiences of Health Care Professionals Working with Suicidal Adolescents

Most of the research exploring the attitudes of health care professionals working with suicidal adolescents is quantitative in nature, with attitudinal scales being commonly employed. Lachal and colleagues' (2015) systematic review only identified six qualitative studies that identified the experiences of health care professionals working with suicidal adolescents, and none of these were conducted in South Africa.

In their meta-synthesis of qualitative studies, Lachal and colleagues (2015) emphasise that health care professionals frequently experience an incomprehension of the youth's suicidal behaviour, and that this affects empathy. The lack or difficulty in understanding adolescents' suicidal behaviour has been described by clinicians across contexts, from doctors and nurses working in primary care settings in Nicaragua (Obando Medina et al., 2014) to British clinicians working in a variety of medical and specialist settings (M. Anderson et al., 2003; Rouski et al., 2017). Clinicians describe comparing their own differing experiences of

adolescence with those of the teenagers they treat, and how this related to their difficulty in understanding the suicidal behaviour (M. Anderson et al., 2003).

Clinicians working with suicidal youth describe the emotional toll it takes on them, reporting feelings of helplessness, impotence, and anger (Lachal et al., 2015). They report how they initially felt overwhelmed when working with suicidal youth, but that over time they became desensitised in order to cope (Rouski et al., 2017). Feelings of frustration and a sense of inadequacy are also described (M. Anderson et al., 2003; Obando Medina et al., 2014), with clinicians believing that they do not have the skills to engage with suicidal adolescents (M. Anderson et al., 2003). Nurses and doctors working in primary health care settings in Nicaragua describe reluctance to work with suicidal adolescence due to their feelings of incompetence (Obando Medina et al., 2014). This in turn results in "avoiding the 'hot potato'", a metaphor used to depict the phenomenon of re-referring suicidal adolescents to other practitioners (Obando Medina et al., 2014, p.6). In addition, clinicians report feeling responsible for stopping suicidal behaviour, and that they experienced a sense of failure if they were unable to do so (Rouski et al., 2017). Some describe adopting a parental role towards suicidal adolescents (Rouski et al., 2017). The sense of helplessness experienced by clinicians also extends to interaction with the parents of suicidal adolescents, who are at times experienced as resistant to intervention or treatment (Lachal et al., 2015; Slovak & Singer, 2012).

Suicide attempts are perceived as a communicative act by many health care professionals (M. Anderson et al., 2005; Lachal et al., 2015). Some clinicians describe how adolescents use suicidal behaviour to demonstrate feelings that went unheard or could not be expressed in other ways. Yet, the message communicated by the act is regarded as complex. At times it is seen as a punitive act towards another, or one that may be used to influence the family as a whole (M. Anderson et al., 2005). One nurse understood suicidal behaviour as attention seeking behaviour, the only way in which adolescents were able to receive attention (Matel-Anderson & Bekhet, 2016). Clinicians report that post-attempt the adolescents convey a need for attention and commitment by both their families and their health care workers (Lachal et al., 2015). Despite identifying an ability to communicate and express feelings as protective against future suicide attempts (Matel-Anderson & Bekhet, 2016), clinicians also describe their own difficulties in communicating with suicidal adolescents (Obando Medina et al., 2014) .

Psychiatric nurses have attributed adolescents' suicidal behaviour to unstable households, lack of parental bonding, and traumatic childhood histories. In addition, bullying, cognitive distortions such as concrete thinking, and easy access to means of harm were identified as risk factors for suicidal behaviour. These nurses suggest that improved connection with others, faith, and hope for the future will protect against further suicide attempts. They also express the importance of treating the whole person, and decreasing stigma around mental illness (Matel-Anderson & Bekhet, 2016).

Clinicians believe that the exposure to suicidal acts by others in their environment, whether family or friends, influenced the adolescents to engage in suicidal behaviours (M. Anderson et al., 2005). Clinicians working on adolescent inpatient units describe the contagious nature of suicidal behaviour, and how this leaves them feeling vulnerable and frustrated (Rouski et al., 2017). Adolescents on inpatient wards are also described as both colluding and competing with each other in terms of their suicidal behaviour (M. Anderson et al., 2005). Mixing suicidal adolescents with other children has been raised as a concern by paediatric nurses, who are worried about the impact on non-suicidal patients (M. Anderson et al., 2003). Apart from direct exposure to the suicidal behaviour of others, some clinicians believe that media promotes an idealised image of those youths who rebel via suicide and that this may be a contributing factor (Lachal et al., 2015). Yet, the influence of media is seen to occur alongside encountering others engaging in this behaviour, rather than in isolation (M. Anderson et al., 2005).

Clinicians regard lack of time as a barrier to providing effective services to suicidal adolescents (M. Anderson et al., 2003; Obando Medina et al., 2014). Yet when they did find time to engage with the adolescents, clinicians expressed doubt about the effectiveness of their interventions (M. Anderson et al., 2003). Lack of time is also described as a barrier to clinical supervision, which is desired by many health professionals working with suicidal adolescents (Rouski et al., 2017). Instead, clinicians often rely on the informal support provided by colleagues (Rouski et al., 2017). Other barriers identified by clinicians include a lack of privacy (Obando Medina et al., 2014) and a lack of clarity about risk management plans in the unit, which results in uncertainty among clinicians (Rouski et al., 2017).

Clinicians request specialised training to enable them to work with suicidal adolescents (Lachal et al., 2015; Matel-Anderson & Bekhet, 2016; Obando Medina et al., 2014). They also express the need for better discharge preparation, the importance of treating the whole person, and decreasing stigma around mental illness (Matel-Anderson & Bekhet, 2016). Health professionals in Nicaragua suggest that group activities for adolescents in the community may be beneficial, and stressed that responsibility could not solely be that of the health sector (Obando Medina et al., 2014).

2.3.4 Summary of Experiences

The experience of distress is common to adolescents who have attempted suicide, as well as to their parents, and treating health professionals. Both adolescents and caregivers experience feelings of rejection and being misunderstood by one another, while a sense of helplessness and impotence is common to both parents and health professionals. Problematic relationships with parents and families are central to the adolescents' narratives, and these are described as being situated in and influenced by socio-cultural and economic contexts.

2.4 THEORIES AND CONCEPTUALISATIONS OF SUICIDAL BEHAVIOUR

This section provides an overview of theories of suicidal behaviour. It does not aim to be exhaustive and excludes biological theories and those that exclusively focus on explaining NSSI. There is a lack of theories that specifically try to explain suicide attempts among adolescents. In most instances, existing theories were created with an adult population in mind.

2.4.1 Durkheim's Theory of Suicide

Durkheim's (1897/1951) seminal work on suicide has influenced subsequent psychological theories (Rudd et al., 2009), and therefore a brief overview is provided. Rather than focusing on the individual, Durkheim's (1897/1951) theory explains suicide at a societal level, attempting to account for epidemiological shifts in suicide rates across time and place. Durkheim considered social forces, namely social integration and moral regulation, as influencing suicide. Moral regulation describes the degree to which society regulates the behaviours and beliefs of individuals, through laws and societal norms. Durkheim proposed

that extremes of either social integration or moral regulation could result in suicide. A person who lacks connection and integration with society may engage in *egoistic* suicide, while *altruistic* suicide may result if a person is too socially integrated. With *altruistic* suicide a person sacrifices themselves for the good of the group or a cause. *Anomic* suicide results when a person fails to find a sense of meaning or purpose in society and is more frequent during times of economic turmoil. *Fatalistic* suicide in turn results from excessive moral regulation, characteristic of oppressive societies (Durkheim, 1897/1951; Rudd et al., 2009; Selby et al., 2014).

Durkheim's theory has been critiqued for the mutual exclusivity of his aetiological categories of suicide, and for equating a single cause with a single effect. It therefore negates the possibility of a multicausal theory, which incorporates cultural beliefs and individual attributes alongside social factors (Hamlin & Brym, 2006). Spangler (1979) considers Durkheim's theory as primarily a critique of modern society. While Durkheim's theory considers the broader milieu, it negates individual agency and meaning-making.

2.4.2 The Role of Hopelessness in Suicide

Beck and colleagues emphasise the importance of cognition, and that a person's perception of and interpretation of reality is central to understanding suicidal behaviour (Beck, 1986; Weishaar & Beck, 1992). *Hopelessness* is regarded as pervasive in a suicidal person's thinking about the self, the world, and the future; and as predictive of eventual suicide (Beck, 1986; Beck et al., 1989). Wenzel and Beck (2008) later developed a more comprehensive cognitive model of suicidal behaviour. In summary, this cognitive model proposes that suicidal behaviour results when a suicidal schema is activated. There are many different types of suicidal schemas, although the two main ones are those related to chronic hopelessness and perceived unbearability. Wenzel and Beck (2008) distinguish between trait and state hopelessness, acknowledging that trait hopelessness (a longstanding, stable trait) cannot account for all instances of suicidal behaviour, and is most applicable to those people who premeditate their attempts and have a high intent to die. All suicidal schemas however result in state hopelessness (the degree of hopelessness at any moment in time). Suicidal schema can be activated by dispositional vulnerability factors, cognitive processes associated with psychiatric disturbance, and life stress. Dispositional vulnerability factors include longer-standing characteristics such

as impulsivity, problem solving deficits, an overgeneral memory style, a trait-like maladaptive coping style, and personality variables such as perfectionism and neuroticism. These are hypothesised to create life stress, to exacerbate psychiatric disturbance, and to reduce coping ability during a suicidal crisis. Suicidal ideation arises when state hopelessness is present alongside biased information processing, such as attentional fixation on suicide-relevant cues. A suicide attempt occurs when the individual is no longer able to tolerate the despair resulting from this state (Wenzel & Beck, 2008). Cognitive therapy is proposed to alter a suicidal person's negative cognitions and suicidal schema, and thereby alleviate the sense of hopelessness (Beck, 1986; Weishaar & Beck, 1992; Wenzel & Beck, 2008).

Beck and colleagues' research indicates that hopelessness predicts suicide in psychiatric patients (Beck et al., 1990; Beck et al., 1989), and that it is more strongly correlated to suicidal intent than depression (Beck et al., 1975). In a meta-analysis of longitudinal studies examining the effect of depression and hopelessness on suicide risk, hopelessness was found to be the strongest predictor of suicide (wOR=1.98), while a diagnosis of major depressive disorder was most predictive of suicide attempts (wOR=2.38) (Ribeiro et al., 2018). Yet, the effects were much weaker than expected, and the authors caution against solely relying on the presence of depression and hopelessness when assessing suicidal risk. Although cognition certainly plays a role in the experience of hopelessness, the question remains as to what aspects of the person's world and environment may have contributed to this state.

2.4.3 Suicide as Escape from the Self

Baumeister's theory (1990) suggests that people attempt suicide in order to achieve oblivion, and thereby a loss of consciousness of their painful affect and life situation. The escape theory postulates six steps, which need to be met, for a person to attempt suicide. These are: 1.) Current reality fails to meet the individual's expectations. This may be due to unrealistically high expectations, or recent setbacks or failures; 2.) The person blames the self for these negative outcomes, i.e., stable internal attributions are made; 3.) High aversive self-awareness results in the person perceiving the self as inadequate, guilty, or incompetent; 4.) The person experiences negative affect due to unfavourably comparing themselves with the expected standards; 5) The individual tries to escape into a "numb state of cognitive deconstruction" (p.91), through cognitive rigidity and a restrictive focus on the present. However, this is not sufficient to end

the painful thoughts and feelings; 6.) The deconstructed mental state reduces inhibitions, including those related to attempting suicide. The individual attempts suicide to escape from awareness of their current problems and the insinuations about the self (Baumeister, 1990).

Baumeister acknowledges that his theory cannot and does not aim to explain all psychological processes resulting in suicide attempts. Escape theory aims to explain suicide *attempts*, not their outcome. Baumeister describes that even if the person survives their attempt, it often results in a temporary removal from painful circumstances, for example through hospitalisation or access to emotional support (Baumeister, 1990). Escape theory is difficult to test in its entirety, due to the sequence of steps involved, and lacks sufficient empirical research (Selby et al., 2014).

2.4.4 The Role of Emotional Dysregulation in Suicidal Behaviour

Linehan (1993) posits that emotional dysregulation is a factor leading to suicidal behaviour. Although Linehan developed her conceptualisation in relation to people with borderline personality disorder (BPD), it can be applied to understanding suicide in general (Selby et al., 2014). Linehan proposes that suicidal behaviour results from an interaction of emotional invalidation and emotional dysregulation. Emotional invalidation occurs when a person's internal experiences are repeatedly criticised or trivialised, and they are punished for communicating these experiences or feelings. In addition, extreme displays of emotion are intermittently reinforced. Linehan also suggests that emotional dysregulation arises from biological vulnerabilities, which lead to an intense experiencing of emotions and a heightened sensitivity to distressing stimuli. A strong negative affect arises out of the interaction between emotional invalidation and emotional dysregulation, and suicidal behaviour is used to manage the emotional distress. Suicide, and suicide attempts, are a desperate attempt to permanently end the person's emotional pain (Linehan, 1993; Selby et al., 2014).

Based on her theory of emotional dysregulation, Linehan developed dialectical behaviour therapy (DBT) to target the suicidal behaviour of people with BPD (Linehan, 2015). Research has demonstrated that DBT reduces self-harm and suicide attempts in adolescents, although evidence is of low certainty (Hawton et al., 2015; McCauley et al., 2018; Mehlum et al., 2016;

Morken et al., 2020; Ougrin et al., 2015; Tebbett-Mock et al., 2020). Overall, few studies have directly explored the link between emotional dysregulation and suicide. Linehan's theory has also been criticised, as only a minority of people who experience emotional dysregulation attempt suicide (Selby et al., 2014).

2.4.5 Suicide and Psychache

Shneidman (1998) hypothesises that a person attempts suicide to end or escape from *psychache. Psychache* is described as a psychological pain that has become unbearable and is associated with painful emotions such as guilt, shame, hopelessness, and humiliation (Leenaars, 2010; Shneidman, 1998). Shneidman suggests that frustrated psychological needs maintain psychache. These needs are detailed as "the needs for affiliation, counteraction, defense, inviolacy, shame-avoidance, and succore [*sic*], as well the combined needs for order and understanding" (Shneidman, 1998, p.248). The concept of psychache however does not allude to *why* this state arises, and therefore does not suggest what could be done to minimise the likelihood or intensity of its occurrence.

2.4.6 The Interpersonal Theory of Suicide

The Interpersonal Theory of Suicide is currently one of the most popular, and empirically tested, theories of suicide (Chu et al., 2017; Ma et al., 2016). Joiner and colleagues posit that for an individual to attempt suicide, both a desire for suicide and a capability for suicide are required (Joiner, 2005; van Orden et al., 2010). The desire for suicide arises out of both thwarted belongingness and perceived burdensomeness. Thwarted belongingness is experienced as feeling alone and is linked to a sense of disconnection and lack of reciprocal social support. Perceived burdensomeness describes the person's belief that they are a burden to others, and is linked to feelings of self-hate, and the belief that one is worth more to others dead than alive. The Interpersonal Theory of Suicide proposes that when both thwarted belongingness and perceived burdensomeness are present, and the person feels hopeless about the possibility of change, the desire for suicide manifests. Yet, the desire for suicide is not sufficient for a person to attempt suicide. A person also needs to have the capability to attempt suicide. This capability is acquired through a diminished fear of death and an elevated tolerance

for physical pain. A tolerance for physical pain can be developed through habitual exposure, for example through NSSI (Joiner, 2005; van Orden et al., 2010).

Meta-analyses have produced mixed results regarding the theory's predictive value (Chu et al., 2017; Ma et al., 2016). Joiner's research group demonstrated support for the associations between the three main constructs of the theory (thwarted belongingness, perceived burdensomeness, and capability for suicide) and a history of suicide attempts, although the effect sizes were modest (Chu et al., 2017). With regards to the theory's applicability to adolescents, a review concluded that there was some support for its validity, particularly for the association between acquired capability and suicide attempts in adolescence (Stewart et al., 2017). This association is supported by research, which has found NSSI to be predictive of future suicide attempts among female adolescents (Asarnow et al., 2017), as well as the transition from suicidal ideation to attempts (Mars et al., 2019). Yet, the Interpersonal Theory of Suicide has been criticised as decontexualised and reductionistic (Hjelmeland & Knizek, 2020), although this criticism has been challenged (Smith et al., 2020). Hjelmeland and Knizek (2020) suggest that the theory should rather be named the *intra*-personal theory, as it emphasises the person's *perception* of their sense of burdensomeness and belongingness, and negates the person's structural, political, and cultural contexts.

2.4.7 Truth Danger Theory

Anderson and colleagues provide a psychoanalytic theory of youth suicidal behaviour, based on their work with children and adolescents attending tertiary child and adolescent mental health services (CAMHS) (J. Anderson et al., 2012). They propose that young people who engage in suicidal behaviour are confronted by a "fractured reality" (p.130), in which the youth's perceptions of their experiences and relationships are incompatible with those of the family. This leads to fears of risking valued relationships or of being thought of as mad if the family's version of reality is challenged. Anderson and colleagues (2012) distinguish between the "hidden truth", where families are not openly acknowledging history or aspects of family functioning; and the "raw truth", where family issues are known but uncontained (p.148). By confronting the truth, either the young person or family member is placed in danger. Youth experiencing this "fractured reality" feel as if they are at a "dead end" (p.148). A suicide attempt is understood as an attempt to make changes to their current reality. Anderson and

colleagues (2012) provide examples of presentations, including abuse within the family, and intergenerational transmission of trauma.

2.4.8 Summary of Theories of Suicide

There are similarities and overlaps in these theories. For example, the hopelessness described by Beck and colleagues (1975) is also experienced by those engaging in Durkheim's anomic suicide (Durkheim, 1897/1951), and is felt by those who desire suicide as a result of thwarted belongingness and burdensomeness in Joiner's theory (van Orden et al., 2010). Similarly, the desire to escape from extreme emotional pain via suicide is described by Shneidman's theory of psychache (Shneidman, 1998), Baumeister's escape theory (Baumeister, 1990), and Linehan's theory of emotional dysregulation (Linehan, 1993). None of these theories can fully account for all suicide attempts or suicides, which remain complex and multifactorial phenomena. For example, although hopelessness is experienced by many suicidal people, the majority of hopeless people do not die by suicide (Selby et al., 2014).

Besides the Truth Danger Theory, none of the theories or conceptualisations are adolescent-specific. They were not developed with adolescents in mind, and therefore do not consider how the developmental tasks of adolescence, such as the search for identity, may influence suicidal behaviour. Furthermore, the psychological theories described in this section focus mainly on intrapersonal factors. Although they do acknowledge the interaction with the environment on the individual's cognitions, feelings, and behaviours, the focus and proposed solutions largely remain with the individual. Theories require a degree of simplification and generalisability, yet there is a risk that power dynamics, political, and social realities are ignored. Contextual considerations including the role of parent-adolescent relationships, bullying, and child abuse are largely sidelined in the existing theories of suicidal behaviour.

2.5 CONCLUSION

The mainstream literature predominantly focuses on risk factors and epidemiology of adolescent suicide and suicide attempts. Although environmental factors are acknowledged as risk factors, prevention and treatment remains focused on the adolescents and their mental health. Yet, in their narratives about the adolescents' suicide attempts, adolescents, as well as

their caregivers and clinicians, prioritise relational difficulties as leading to intolerable distress. Adolescents describe how troubled relationships are situated in and influenced by socio-cultural and economic contexts. Proposed solutions focus on rebuilding relationships and enhancing interpersonal and communal support.

CHAPTER 3
METHODOLOGY

Research design is determined by the questions the researcher seeks to answer (Durrheim, 1999). I therefore begin this chapter by restating the research aim and questions. I then discuss how the research is situated within the theoretical framework of hermeneutic phenomenology, and how this informs the chosen methodology of Interpretative Phenomenological Analysis. I describe the practical procedures followed to answer the research questions, detail the steps taken to ensure the quality of this research, and reflect on the ethical considerations. I also explore my own positioning in relation to the research, and how this may have influenced the research design and interpretation of the data.

3.1 RESEARCH AIM AND QUESTIONS

3.1.1 Research Aim

This study aims to provide a contextualised understanding of the phenomenon of suicide attempts by South African adolescents living in a low resource environment.

3.1.2 Research Questions

The following research questions contribute to the study's aim by primarily exploring the lived experience of the adolescents who attempted suicide. However, in order to provide a more complete understanding, the perspectives and experiences of these adolescents' caregivers and clinicians were also elicited. The first five questions will therefore apply to the adolescents, caregivers, and clinicians, while the sixth question pertains only to the adolescents:

i. How do participants understand the adolescents' suicide attempts?
ii. What is the socio-cultural context in which adolescents in low resource environments attempt suicide?
iii. What, if anything, do participants think may have averted the adolescent's suicide attempt?
iv. What ideas do participants have for youth suicide prevention?

v. What are the participants' expressed support needs?
vi. What were this group of adolescents' experiences of receiving mental health support services after their suicide attempt?

3.2 THEORETICAL FRAMEWORK

This research is situated within the theoretical framework of hermeneutic phenomenology. The phenomenon of the suicide attempt is examined from the participant's point of view, thereby embracing a first-person account, where meaning is created by the individual situated in their world. Yet the research also involves an interpretative component, whereby I (the researcher) am attempting to make sense of the participants' subjective accounts. This conceptualisation fits into a theoretical framework of hermeneutic phenomenology, which embraces both the philosophies of phenomenology and hermeneutics (Eatough & Smith, 2008).

The terms phenomenology and hermeneutics describe philosophical branches of knowledge, which encompass a variety of perspectives (Eatough & Smith, 2017). Broadly speaking, phenomenology is concerned with the study of lived experience, particularly those experiences which are meaningful to us (Smith et al., 2009). It aims to reflect individuals' subjective accounts of an experience, rather than providing an objective representation of the event (Eatough & Smith, 2008; Smith & Eatough, 2007). Hermeneutics in turn focuses on the *interpretation* of experience, and acknowledges that this is always situated in a cultural-historical context and is influenced by the interpreter's pre-understanding (Eatough & Smith, 2008; McLeod, 2001b; Smith et al., 2009).

Heidegger's philosophies of phenomenology and hermeneutics are particularly pertinent to the theoretical framework for this study and inform the methodology of Interpretative Phenomenological Analysis that is used. Heidegger was interested in exploring the experience of person-in-context. He spoke about *Dasein* (Heidegger, 1953/1996), translated as "being-in-the-world" (Heidegger, 1953/1996, p.49), which emphasises our relatedness to the world, and our positioning within a historical, cultural, linguistic, and social context. This moves away from a phenomenology with transcendental aims, often associated with Husserl, which aims to reveal the essence of a phenomenon by attempting to transcend our biases and assumptions about the world. Heidegger in turn focuses more on the existential, and how we make meaning

of our experiences. He emphasises that we cannot be objective observers, as our relatedness is an essential part of our being (Eatough & Smith, 2017; Smith et al., 2009). In Heideggerian phenomenology the individual is regarded as an actor in his or her world, who actively constructs meaning; that is, the individual is not regarded as passive or powerless (Eatough & Smith, 2008; McLeod, 2001a). I also borrow from Merleau-Ponty's phenomenology, which emphasises the *embodied* nature of our experiences. He noted that our bodies are central to our means of interacting and communicating with the world (Smith et al., 2009). The relevance of the body and its acts are pertinent when examining the lived experience of adolescents who have attempted suicide.

The theoretical framework of hermeneutic phenomenology therefore acknowledges the dynamic, active interpretation by the researcher, but ensures that this is foregrounded in the subjective, lived experience of the participants. In the spirit of Heideggerian phenomenology, context and socio-cultural influences are acknowledged as impacting on the individual's meaning-making, as well as on the researcher's interpretation of that meaning. This framework lends itself well to the qualitative methodology of Interpretative Phenomenological Analysis.

3.3 CHOOSING A QUALITATIVE METHODOLOGY

The research aim and questions, as well as the theoretical framework within which this study is positioned, align with a qualitative methodology. This research does not aim to determine empirical, causal laws explaining behaviour, nor to determine the degree of relationships between characteristics, which are both common goals of quantitative research (Thomas, 2003). Rather, qualitative research can be used to delve into in-depth, rich explorations, in order to explore situated meanings and understand peoples' lived experience. Qualitative methodology also tends primarily to use linguistic representation, including linguistic descriptions of other materials such as photographs, whereas quantitative methodology is primarily concerned with numerical representations of reality (Durrheim, 1999; McLeod, 2001a; Thompson & Harper, 2012). A qualitative methodology is therefore well suited to exploring the phenomenon of adolescent suicide attempts, and the contexts in which they occur.

I considered a variety of possible qualitative methodologies. Grounded theory was excluded, as I did not aim to construct a theory explaining adolescents' suicide attempts (Charmaz & Bryant, 2008; Tweed & Charmaz, 2012). I also did not aim to study the role of language use in the construction of the social world, nor to conduct an analysis of interaction, and this excluded both discourse analysis and conversation analysis, respectively (Georgaca & Avdi, 2012; Potter, 2008; ten Have, 2008). Although I considered narrative analysis, I was more interested in the particular accounts surrounding the phenomenon of adolescents' suicide attempts, than analysing the sequencing of events and the narrator's intention and language use that is foregrounded in narrative analysis (Riessman, 2008). In the end, I decided to use Interpretative Phenomenological Analysis (IPA), which aligns with my world view and allows for both phenomenological and interpretative elements. IPA is well suited to the research aim and questions as it allows us to understand how the phenomenon of adolescent suicide attempts is understood within a particular context by particular people. Its epistemological assumptions are discussed next.

3.3.1 Interpretative Phenomenological Analysis

The qualitative methodology selected for this research is Interpretative Phenomenological Analysis (IPA). Situated within hermeneutic phenomenology, IPA emphasises the subjective experience of the participants, while allowing for interpretation of their accounts. It therefore requires a balance between "giving voice" to the participants and "making sense" of the provided material (Larkin & Thompson, 2012, p.101).

IPA has a number of epistemological assumptions:

i) **IPA supposes that an exploration of personal lived experience is required for an understanding of the word.** It tends to focus on those aspects of experience that matter and are meaningful to people. The research participant is therefore regarded as a meaning-making person and expert in their lifeworld (Eatough & Smith, 2017; Larkin & Thompson, 2012).

ii) **IPA acknowledges that both the research participants and researchers are influenced by their own backgrounds, prejudices, and beliefs, and that the knowledge created can therefore only ever be interpretative in nature, rather than reflecting the true nature of reality**. This implies that we are not able to access

experience directly, but via a process of intersubjective meaning-making. The interpretative process can be regarded as a "double hermeneutic" (Smith & Eatough, 2007, p.36), in that the participant attempts to make sense of their lived reality, and the researcher then interprets how the participant is attempting to make sense of their experience. This implies that the researcher needs to be able to reflect on their own assumptions when producing interpretations (Eatough & Smith, 2017; Larkin & Thompson, 2012; Smith & Eatough, 2007; Smith et al., 2009).

iii) **IPA is concerned with the idiographic or particular.** It is concerned with detail, and how a particular phenomenon (such as a suicide attempt) is understood within a particular context by particular people. Analysis therefore involves detailed examination of each case, before considering instances of convergence and divergence across cases (Eatough & Smith, 2017; Larkin & Thompson, 2012; Smith et al., 2009).

IPA has been used in numerous qualitative studies to explore subjective lived experience and meaning-making (e.g., Akotia et al., 2014; Hassett & Isbister, 2017; Latakienė & Skruibis, 2015; McAndrew & Warne, 2014; Orri et al., 2014). Some studies have also used IPA to focus on the embodied experience of individuals, and how the body has been used to communicate and convey meaning to others (Crouch & Wright, 2004; Orri et al., 2014). The essence of IPA is embodied by Smith et al.'s (2009) observation that:

> "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen." (p.37)

3.4 RESEARCH DESIGN

A *multiperspectival* research design is used in this study. Although IPA research tends to focus on one homogenous group of people with a particular shared experience, the addition of a variety of perspectives from different groups of people can provide additional insights into the phenomenon of interest (Larkin et al., 2019). Recently, some researchers have been incorporating multiperspectival approaches into IPA. These include, for example, the different experiences of medical consultations from the perspectives of patients and physicians (Borg Xuereb et al., 2016) and the exploration of therapeutic rupture and repair from the accounts of therapists and their clients (Haskayne et al., 2014). The experiences of groups of people involved in a system may also be suitable to multiperspectival IPA research. For example,

Rostill-Brookes and colleagues (2011) described the experience of foster placement breakdown from the perspectives of the foster children, foster parents, and their allocated social workers. Considering the phenomenon of adolescent suicide attempts from the perspectives of other people, who form part of the adolescents' world (as is done in this study), can contribute to an enhanced understanding through a pluralistic idiography (Larkin et al., 2019).

3.4.1 Sampling and Recruitment of Participants

Purposive sampling was employed to recruit the participants, as it allowed me to choose participants that shared a particular experience and resided within a defined geographical area (Palys, 2008). I aimed to recruit approximately 10 adolescents, 10 caregivers and 10 clinicians. The size of the sample is larger than that traditionally associated with IPA, although not unheard of (Eatough & Smith, 2008; Smith et al., 2009). I wanted to collect sufficient rich data to allow for the possibility of transferability across similar contexts, while not being overwhelmed by data. Although the concept of sampling to saturation is frequently expounded when determining sample size, it has been criticised (O'Reilly & Parker, 2013; Saunders et al., 2018). It is difficult to determine when the point of data saturation has been reached, as there is always the possibility of discovering something novel with additional data (Saunders et al., 2018; Varpio et al., 2017). In the end, the amount of data I collected allowed me to identify dominant themes that were repeated across accounts, while providing nuance.

All participants were recruited via the CAMH unit at the same psychiatric hospital (for a description of the context, please refer to section 1.3 in Chapter 1). I had previously discussed the concept of the study with the head consultant of the CAMH unit, as well as clinical colleagues. Therefore, by the time ethical approval was granted, many of the clinicians were aware of the study's existence. In order to create further awareness about the specifics of the research, I presented at the weekly journal club, which the entire clinical team attends. I was able to address questions and collect contact details from those willing to provide them. Information leaflets were handed out to the staff, and electronic copies were sent via email (Appendix 1).

3.4.1.1 Recruitment of the Adolescents

In order to assist with recruitment, I obtained permission from the CAMH unit to attend the outpatient referral meeting held every Monday morning. I attended these weekly meetings over 10 months from the 08 May 2017 until the 05 March 2018, at which time sufficient participants had been recruited for the study. During the weekly meeting all new referrals are discussed by the clinical team. This allowed me to identify adolescents who possibly met the inclusion criteria for the study, and to record the clinician assigned to their intake assessment. As the demand for services exceeds the capacity of the clinical team, new referrals are placed on a waiting list. Referrals are triaged, so that those deemed to be at highest risk are prioritised for an intake assessment. Referrals are received from local clinics, district hospitals, school doctors, children's homes, and private practitioners. At times, team members are unable to contact the caregivers of the children and adolescents on the waiting list, despite repeated attempts. In these instances, the referring agent is contacted or a letter is sent to the postal address provided. This in itself poses challenges due to the unreliability of the South African postal system (Styan, 2016); and as referrals are frequently made by registrars or trainees who rotate through placements in the public health care system, they are therefore difficult to contact. In other instances, adolescents and caregivers fail to attend scheduled intake assessments. Although social services are informed in instances where the team is concerned about harm to the child or adolescent, in practice many of the children "fall through the cracks". The implication for recruitment was that at times adolescents, who seemed to meet the inclusion criteria based on the information provided in the referral, never accessed the CAMH unit. They could therefore not be recruited for the study, as only those adolescents who were enrolled as patients in the CAMH unit were eligible to partake in the study (see inclusion criteria below). During the 10 months in which I attended the referral meetings, five adolescents on the unit's waiting list appeared to meet inclusion criteria for the study, but never enrolled as patients in the CAMH unit. Staff were unable to contact the caregivers of three of these adolescents, and a further two failed to arrive for scheduled appointments at the hospital.

Once an intake assessment has been completed, the clinician provides feedback at the referral meeting, and a case manager and primary treating clinician (often the same person) are assigned. This feedback provided clarity on whether the adolescent did indeed meet the inclusion criteria. At this point, I liaised with the treating clinician and asked them to inform the adolescent about the study, and to enquire whether the adolescent would be willing to talk

to me further about the possibility of participating. I ensured that I was available to meet potential participants after their clinical appointments, in order to reduce inconvenience and increase chances of recruitment.

In addition to attending the outpatient referral meetings, I also regularly spoke to the consultant from the inpatient services, in order to establish whether there were any adolescents who met the inclusion criteria. Due to their inpatient status, I was able to approach these adolescents at any time outside their scheduled activities to introduce the concept of the research to them. Once the adolescent had expressed interest, I contacted the caregiver to arrange a meeting, usually coinciding with visiting hours, or prior to the adolescent's weekend leave.

I would meet with the adolescents, introduce myself and my role, and talk to them about the study. I made it very clear that participation was voluntary, and that their decision to participate (or not) would have no impact on their health care. All potential participants were provided with an information leaflet and assent form, which summarised our discussion (Appendix 2). They were asked to take this home with them, and to read through it in their own time, before providing assent. In those instances where an adolescent was accompanied by a caregiver, I asked the adolescent whether they preferred to talk to me alone prior to engaging with their caregiver. Therefore, at times I spoke with the adolescent alone, and at other times the initial meeting was a joint one with both the adolescent and their caregiver. Consent was also required from the adolescent's parent, guardian, or caregiver, and a meeting with the relevant person was held. Caregivers were also provided with an information leaflet and consent form, to peruse in their own time (Appendix 3). Only once both assent and consent had been obtained, in both verbal and written form, was the adolescent admitted as a participant to the study. This often required numerous meetings with both the adolescent and their caregiver, and enabled a level of rapport to be established prior to initiation of the official data collection. The intricacies around assent and consent are further discussed in section 3.7.2.

Inclusion and Exclusion Criteria. Adolescents who met the following criteria were eligible to participate in the study: a) 13 to 18 years of age at the time of recruitment; b) either inpatients or outpatients at the hospital's CAMH unit at the time of recruitment; c) attempted suicide, or had their suicide attempt interrupted, during the 6 months preceding recruitment; d) reside in

Mitchells Plain, Khayelitsha, or Philippi; e) should *not* be psychotic at the time of recruitment and able to give assent.

Although the definition of adolescence is a contested one (as discussed in section 1.4.1 of Chapter 1), the CAMH unit does not admit individuals older than 18 years. For this reason, the age range 13 to 18 years was chosen. The rationale behind the requirement that the suicide attempt, or interrupted attempt, should have taken place during the 6 months preceding recruitment, was to ensure that the event and the circumstances surrounding it were still fresh in the adolescent's memory. As the definition of suicide attempt is also a contested one (see section 1.4.2 in Chapter 1), if the clinician or adolescent perceived the act as a suicide attempt, or interrupted attempt, it was sufficient for inclusion. Mitchells Plain, Khayelitsha, and Philippi are the main catchment areas for the outpatient services and are located in proximity to the hospital. The inpatient services also admit patients from rural areas further afield, but in order to ensure homogeneity, the research was restricted to adolescents from the aforementioned areas. Finally, in order to ensure coherent interviews, those individuals who were psychotic at the time of recruitment were excluded from the study.

In total, 13 adolescents were identified as eligible for the study during the recruitment period, and I invited all 13 to participate. Two adolescents declined the invitation, and one adolescent dropped out of the study. The adolescent who discontinued the study also defaulted treatment in the CAMH unit. She failed to return her camera for processing, and despite her caregiver's repeated assurances that he would return the camera, this did not occur. I was concerned that the camera had been lost or stolen, and that the participant was too embarrassed to admit this. I therefore emphasised that if the camera had been lost, another could be provided. I also reassured the caregiver that she could continue to participate in the study, even if she was no longer attending the hospital. Nevertheless, the adolescent was lost to follow-up. In the end, 10 adolescents participated in and completed the study.

3.4.1.2 Recruitment of the Caregivers

Recruited adolescents were each asked to nominate a caregiver for inclusion in the study. Some of the adolescents had minimal or no contact with their biological parents, and therefore a

caregiver could be any adult who had accepted the responsibility of caring for the adolescent. Some adolescents had more than one caregiver, having lived with various extended family members over time. Therefore, the caregiver who had provided consent for the adolescent to participate in the study was not necessarily the same person who was nominated by the adolescent to be interviewed. Caregivers' participation was voluntary, and on two occasions the adolescent's nominated caregiver could not be interviewed. One caregiver declined participation, and in the other instance the parent believed that interviewing the nominated caregiver would cause altercations between other family members. This concern was discussed with the adolescent, and she reconsidered her choice, deciding to nominate one of her parents instead. In the end, in all cases bar one, the caregiver who had provided consent for the adolescent's participation in the study was also the person who was recruited. A total of 10 caregivers were recruited and participated in the study. In many instances I had repeated contact with the recruited caregivers prior to their interview, so that a level of familiarity had been established by the time of the interview.

3.4.1.3 Recruitment of the Clinicians

Each adolescent was asked to nominate a clinician from the CAMH unit, who they believed knew them best. In some cases, adolescents primarily interacted with one clinician in the unit (who became the obvious choice for recruitment), whereas in other instances adolescents had interacted with a variety of clinicians over time. Where possible, I wanted to interview as many different clinicians as possible, irrespective of profession. I ended up interviewing nine different clinicians. One clinician was interviewed in relation to two of the adolescents, as she was the only clinician who regularly interacted with both of them. All of the nine nominated clinicians consented to participating in the research.

3.4.2 Description of Participants

Due to the threat to internal confidentiality in multiperspectival designs (as discussed in section 3.7.3.1), I have decided to provide an aggregated description of each group of participants, rather than providing individual details. Each member of a triad (adolescent, caregiver, and clinician) is known to each other, increasing the likelihood of recognising each other in the write-up. In addition, adolescents encountered each other in the focus group, and possibly in

the CAMH unit; while clinicians work together on a daily basis. Although confidentiality and anonymity cannot be guaranteed, I aim to protect it as far as possible. One aspect of this is to present data at the group level.

3.4.2.1 The Adolescents

Of the 10 adolescents who participated in the study, the majority were female (*n*=7). One person described their gender as "undefined", while the remaining two identified as male. The age range of the adolescents was 13 to 17 years of age at the time of enrolment, with a mean age of 15.80 years (*SD*=1.32 years). The home languages spoken by the adolescents were English (*n*=7), isiXhosa (*n*=2), and Afrikaans (*n*=1). Eight of the adolescents self-identified as "Coloured"[3] and two as "Black"[3]. The majority of adolescents were bilingual, with all of them fluent in English. Two of the adolescents were not attending school at the time of recruitment, although both subsequently returned to school. In terms of sexual orientation, half of the group identified as heterosexual, three as bisexual, and two as pansexual.

All adolescents resided in either Mitchells Plain or Khayelitsha at the time of recruitment, and during the course of the study all of them lived in formal housing (brick houses). One adolescent moved out of Mitchells Plain while the study was underway but continued to participate in the research. Some of the adolescents had previously resided in wendy houses, structures usually built from plywood or metal sheeting and erected in the backyard of a property. One of the adolescents had previously been homeless, living on the street for a period of time. Many of the adolescents shared bedrooms with family members. All of the adolescents had siblings, and all except one lived with at least some of their siblings.

In terms of suicidal behaviour, all of the adolescents had engaged in NSSI. For the majority (*n*=8), the onset of NSSI occurred prior to their first suicide attempt. Most of the adolescents (*n*=8) had repeatedly attempted suicide, with only two of the adolescents having attempted suicide for the first time prior to joining the study. Since their attempt, most adolescents (*n*=8) had received both inpatient and outpatient services at the hospital's CAMH unit, while two of the adolescents had only accessed outpatient services. Two of the adolescents, who had

[3] Please refer to footnote 2 on page 4 in Chapter 1 for a discussion of racial terminology as used in this thesis.

attended a therapeutic inpatient programme in the CAMH unit, prematurely terminated the programme. One adolescent, who had attended the programme on a voluntary basis, discharged herself after a few days, while the other adolescent failed to return from weekend leave. Both subsequently continued with outpatient services, although one of them eventually defaulted treatment.

3.4.2.2 The Caregivers

The majority of interviewed caregivers were female (*n*=8). Their relationship to the adolescents was as follows: mother (*n*=4), father (*n*=2), great aunt (*n*=2), aunt (*n*=1), and grandmother (*n*=1). Most self-identified as "Coloured"[3] (*n*=7), two as "Black"[3], and one as "Indian"[3]. English was the predominant home language (*n*=6), followed by Afrikaans (*n*=2), and isiXhosa (*n*=2). All caregivers spoke more than one language. The majority of caregivers were employed (*n*=7), while three of them were pensioners. Six of the caregivers had obtained their school leaving certificate (Matric), two had not entered secondary schooling (high school), and one caregiver left school early in their high school career. Only one caregiver had obtained a post-secondary education, namely a diploma.

3.4.2.3 The Clinicians

The clinicians were predominantly female (*n*=6). In terms of ethnicity, four identified as "White", three as "Coloured", one as "Black", and one participant did not identify with any of the commonly used categories, classifying herself as "other". Home languages included English (*n*=5), Afrikaans (*n*=3), and isiXhosa (*n*=1). Clinicians represented a variety of professions, namely psychology, social work, medicine, and nursing. Their years of experience varied widely, having worked in their profession for an average of 10.78 years (*SD*=11.78). Many of the clinicians do not live in the community where they work, commuting from the suburbs to the hospital on a daily basis.

3.4.3 Pseudonyms and Abbreviations

All participants were provided with the opportunity of choosing their own pseudonym. All of the adolescents, six of the caregivers, and five of the clinicians did so. Some of the chosen pseudonyms were lengthy, and/or idiosyncratic, and I therefore abbreviated them for improved

readability of this thesis. The abbreviated pseudonyms are depicted in Table 1 alongside the chosen pseudonyms.

Table 1

Abbreviated Versions of Pseudonyms Chosen by Participants

Group	Chosen pseudonym	Abbreviated version
Adolescents	Kimberlyn Andrews	Kimberlyn
	Little Depressed Boy	LDB
	Thick Charlene	TC
Caregivers	Lady Di	LD

3.4.4 Data Collection

I collected all data in the period from the 19 May 2017 to the 12 July 2018. Three methods of data collection were used: in-depth semi-structured interviews, photography, and a focus group. The in-depth semi-structured interview was the main method of collecting data and was used with all three groups of participants, while the use of photography and the focus group was restricted to the adolescent participants. Semi-structured interviews are commonly employed with IPA, as they allow participants to provide a rich account of their experiences; and ensure sufficient flexibility to follow participants' leads, while ensuring that the phenomena of interest are covered (Smith et al., 2009). In constructing the interview schedules (appendices 6 to 9), I developed open-ended questions that encouraged the participants to describe the context in which the suicide attempt had occurred. The interviews began with a general, non-threatening question to ease the participant into the interview process, and to encourage them to talk freely, before tackling more sensitive topics. The initial interview schedules were discussed with my supervisor and redrafted to enhance wording and flow. Specifics of the interviews are detailed in the phases of data collection that follow this introduction. A brief one-page questionnaire was also constructed for each participant, providing a general overview of their demographic information (appendices 10 to 12). Participants were asked to complete the demographic questionnaire at the end of the interview, so that the conversational tone of the interview was not hindered.

Interviews were held in an assigned office in the CAMH unit at the hospital. I had arranged the office to make it more inviting, by hanging pictures, introducing a plant and wall clock, and by setting up a table that contained a kettle, tea, coffee, and snacks for the participants. All interviews were audio recorded. Participants became accustomed to the presence of the recording devices fairly quickly, and their use did not appear to hinder participants' willingness to talk. All interviews, except for one, were conducted in English. One caregiver preferred speaking in Afrikaans and therefore the interview was done in Afrikaans. The offer of an interpreter was made for participants whose home language was isiXhosa, but all preferred to work without an interpreter. For each adolescent-caregiver-clinician triad, the phases of data collection were completed in the order described below.

3.4.4.1 Phase 1: Initial Interview with the Adolescent

A semi-structured in-depth interview was conducted with each adolescent, lasting an average of 62 minutes. I started by asking them to tell me about their life and the people in it. This provided some insight into their daily lives, environment, and self-concept, while setting a conversational tone for the remaining interview. I then asked them to tell me the story of their suicide attempt. Other questions concerned their retrospective understanding of the attempt, what (if anything) may have prevented their attempt, their support needs, and ideas for adolescent suicide prevention (Appendix 6). Apart from the first question, I did not rigidly adhere to a particular order for asking the questions, as these were frequently pre-empted by the adolescent and the answers interwoven in their descriptions. I therefore let the adolescents determine the pace and direction of the discussion, while ensuring that all questions were addressed at some point during the interview. Some of the adolescents struggled with the question, *"How do you understand or make sense of your suicide attempt?"* I therefore started to rephrase this in later interviews, asking them what they thought the reason was that they had attempted suicide. In most instances the question was superfluous, as the adolescents had indirectly answered the question in their accounts of their suicide attempts. Where necessary, I clarified my understanding of their account with them. In hindsight, this question was too direct, and as suggested by Smith et al. (2009) it is preferable to address abstract questions in a "sideways" manner (p.58).

3.4.4.2 Phase 2: Photography

At the end of the first in-depth interview, each adolescent was given a disposable camera. Basic instructions on how to use the camera were provided at this point in time. For example, adolescents were shown how to use the flash, and cautioned to not cover the viewfinder with their finger when taking photographs. A demonstration camera was available in the room, that adolescents were able to practice with. Ethical concerns around photography were discussed. For example, participants were asked to avoid taking photographs of people without their consent, to avoid photographing incidents that may cause embarrassment or shame, and to think about how photographs of people could be taken to preserve their anonymity. Ethical concerns regarding photography are further discussed in section 3.7.4.

The adolescents were provided with the following instruction for the photography, in both verbal and written form: "*Please take photos that will help me understand what contributed to your suicide attempt, and to keeping you alive."* I emphasised that they could take photos of anything that would help me better understand the context of their lives and their suicide attempts. The adolescents were told that they could take any number of photographs, up to the maximum of 27 exposures available on the Fuijifilm disposable camera. They were asked to return the camera as soon as they had completed the photography. On average, adolescents returned the camera after 6 weeks, although the time taken to do so fluctuated between three and 11 weeks. Participants were sent reminders via What's App, and provided with the opportunity to ask any questions about the camera or photography. Adolescents took an average of 10 photos each.

A disposable camera was chosen above a digital one, as it restricted the number of photos that could be taken, and therefore the adolescent had to reflect on what to shoot. It was also not possible to immediately view the photos, and therefore other people, such as parents, could not demand to see the photographs. This afforded the adolescents privacy in their choice of subject matter. The disposable camera was also more cost-effective than a digital camera (for example, if a camera was lost or stolen), and it reduced the risk of the adolescent being mugged for the camera. There was also an incentive to return the camera, in order for the photographs to be developed. Furthermore, four of the adolescents either did not own a cellphone with an inbuilt camera, or only had intermittent access to one, and therefore this alternative was not an option.

The use of the disposable camera was framed as "retro cool", and most of the adolescents seemed excited at the opportunity to use it. Only one adolescent ended up taking photographs on a cellphone instead, which is further discussed in the ethics' section.

A Note on the Use of Photography in the Research. Photo-elicitation, which integrates photographs into the interview process, was used in this study to facilitate data collection from the adolescent participants. In photo-elicitation, the photographs can, but do not have to, be taken by the research participants (Glaw et al., 2017; Harper, 2002; Padgett et al., 2013). I asked the adolescent participants to take photographs, which were then discussed during their second interview. Participant-produced photography has been described as empowering participants as they are able to decide what to photograph, and can thereby influence the research agenda to some extent (Balmer et al., 2015; Burton et al., 2017). Harper (2002) proposes that the use of images accesses a different aspect of human consciousness than words alone are able to, and evokes memories, feelings, and emotions related to the discussion of the photographs. Photo-elicitation allows the participants to share experiences that may have been difficult to verbalise without the aid of the photographs, and has been described as enriching the data (Burton et al., 2017; Reavey & Johnson, 2017; Sibeoni et al., 2017). This in turn may also enhance the relationship between researchers and participants (Pain, 2012). I also hoped that the use of photographs would invite aspects of the adolescents' external lived reality into the hospital and research setting, thereby providing greater context to their descriptions.

Photo-elicitation is often conflated with Photovoice. Both involve collaboration between researchers and participants, and a shared interest in the photographic images (Padgett et al., 2013). Yet Photovoice aims to represent and empower communities, with an agenda based on community-based participatory action and policy reform (Barndt, 2014; Wang & Burris, 1997). Therefore, photographs and the issues they represent are usually shared and discussed in large and small group formats (Padgett et al., 2013; Wang & Burris, 1997). For example, Photovoice has been used to advocate for enhanced community health and to attempt to influence policy makers (Wang, 2006). Photo-elicitation, however, does not require the creation and discussion of photographs to be in the context of community-based participatory action. Photo-elicitation can therefore occur within one-on-one interview settings, which may be useful for accessing sensitive personal information (Harper, 2002; Padgett et al., 2013). In this study, photo-

elicitation helped to collect data about the adolescents' lived experience and perception of their context. It also aided in the exploration of the adolescents' meaning-making around their suicide attempts, suitable to an intimate and private setting. Photo-elicitation has been combined with IPA in a number of studies to provide an idiographic understanding of patients' lived experiences (e.g., Burton et al., 2017; Lachal et al., 2012; Rayment et al., 2019; Silver & Farrants, 2016).

3.4.4.3 Phase 3: Follow-up Interview with the Adolescent

The second in-depth interview with the adolescents centred around a discussion of their photographs. The developed photographs were presented to the adolescent, who was asked to tell me about the significance and meaning of them. Control was largely ceded to the adolescent, who could determine what photographs they wanted to discuss or focus on, and the order in which this was done. The interview was more unstructured than the first one and was guided by the adolescents' descriptions of the photographs. The interview was rounded off by asking the adolescents about their experience of receiving mental health services after their suicide attempt, and their experience of engaging with the research (Appendix 7). Follow-up interviews lasted an average of 57 minutes.

One participant had difficulty returning to the CAMH unit for her second interview, as she had defaulted treatment and her caregiver was reluctant to bring her back to the hospital. It was agreed that I could collect her from her home and interview her in the community. Yet we struggled to find a place in her community that was private and quiet, and also safe. Her home was also not an option due to a lack of privacy. We ended up buying takeaways and conducting the interview in my car, although even here we were frequently interrupted by beggars knocking on the car window.

3.4.4.4 Phase 4: Interview with the Caregiver

One-on-one in-depth interviews were held with caregivers linked to the adolescent participants. The semi-structured interviews lasted for an average of 72 minutes (with a range of 50 to 121 minutes in duration). A total of 10 interviews were held with caregivers, and all took place in the allocated office in the CAMH unit. Interviews with caregivers occurred at any timepoint

following the first interview with the respective adolescent. I started by asking each caregiver to tell me about their relationship with the adolescent. Other questions concerned the caregivers' understandings of the adolescents' suicide attempts, their ideas for adolescent suicide prevention, their expressed support needs, and their experience of the health care system following the adolescents' suicide attempt (Appendix 8). Except for the first question, the order of questions was not fixed, but interwoven into the discussion that took place.

3.4.4.5 Phase 5: Interview with the Clinician

One-to-one in-depth semi-structured interviews were conducted with nine clinicians. One clinician was interviewed in connection with two adolescents, as she was able to provide the most insight into the adolescents' experiences. One interview was held in a private location outside the hospital setting, as requested by the clinician. All other interviews were held in the allocated office in the CAMH unit, as this was the most convenient arrangement for the majority of clinicians. Interviews with clinicians took place at any time after the first interview with the adolescent and lasted an average of 46 minutes. I started the interview by asking clinicians about their experience of working with suicidal adolescents. Other questions concerned their understanding of the adolescent's suicide attempt, their ideas for youth suicide prevention, and their support needs (Appendix 9).

3.4.4.6 Phase 6: Adolescent Focus Group

All adolescent participants were invited to attend the focus group, which took place after all individual interviews had been completed. The aim of the focus group was to provide feedback to the adolescents regarding the preliminary findings arising from my interpretation of their accounts, and to engage in a discussion around these. This served the purpose of member checking, to discuss convergences and divergences in experience, and ultimately to arrive at a richer understanding of the adolescents' experiences (Morgan, 2008; Sandelowski, 2008). Adolescents had been informed about the focus group at the outset of the study, but they were reminded about the purpose of the group prior to the time. For some participants almost a year had passed since they had completed their individual interviews, and therefore it was necessary to remind them about both the purpose and voluntary nature of the group. I tried to arrange a time and date that was convenient for the majority of participants. The choice of organised

group transport or reimbursement of travel expenses was offered to all adolescents, and all except one participant chose to be transported by a driver. In the end, seven out of 10 adolescents attended the group. One adolescent was unable to attend as he was working, another was ill on the day, and a third did not answer the doorbell when the driver arrived at her home (with the caregiver subsequently informing me that she had overslept).

A senior nursing sister from the CAMH unit co-facilitated the group with me. Due to her seniority and oversight role, she had not had much previous one-on-one interaction with the participants. The adolescents were assured of their confidentiality and reminded of the exceptions thereto. I decided to use a co-facilitator in case an emergency situation arose, requiring one of us to step out of the room. Although I had initially approached colleagues who did not work in the unit to co-facilitate, none were available.

Snacks and both hot and cold drinks were available for the participants prior to and after the group. At the start of the group, the adolescents were asked to draw up group rules for themselves. These included respect for each other, not using their cellphones for the duration of the group, providing everyone with an opportunity to contribute, and protecting the identity of the group members. I reminded the adolescents about the risk of inadvertent disclosure, requested that they keep the information discussed during the group confidential, and emphasised the voluntary nature of their contributions during the group. After the introductions, I presented the preliminary findings to the group. This was done with the aid of large sheets of paper on which I had written the themes, and which had been plastered on the walls of the room. I then proceeded to discuss these themes, while projecting a selection of their anonymised photographs which illustrated them. All participants were then provided with a printout listing the discussed themes and asked to place a sticker next to those themes they agreed with. An optional space was also provided for comments (Appendix 13). By asking participants to engage in this task, I wanted them to form and reflect on their own opinions, without pressure from the group. Only after this task was completed, was the discussion opened up to the group. The adolescents were asked to talk about any of the themes that were important to them, or that they disagreed with. This led to a lively discussion, which both confirmed some of my interpretations, but also provided additional insights and nuances to their experiences. At times participants revealed new information about themselves. Although the discussion part

of the focus group was largely participant-led, I did direct it at times, to ensure that the majority of themes were addressed.

The focus group signalled the termination of the adolescents' participation in the research. Towards the end of the group, I provided an opportunity for the adolescents to reflect on their experience of participation. Many expressed sadness at the ending of the process and conveyed the sense of validation that they had received from other group members and from participating in the research. Each participant received a personalised hand-written card from me, thanking them for their participation, together with a slab of Lindt chocolate. The overall focus group was approximately 3.5 hours in duration, including a brief toilet break. The discussion section of the focus group, which commenced after introductions, the setting of group rules, feedback regarding emerging themes, and the individual exercise, lasted 2 hours and 14 minutes.

3.4.5 Data Analysis

All interviews and the discussion section of the focus group were audio-recorded and subsequently transcribed. In total, 41 hours of conversation were recorded. Two professional transcribers assisted with the transcriptions: one with the Afrikaans interview and the other with the remaining interviews conducted in English. I chose to transcribe the focus group myself, as I was able to distinguish the voices of the group members and was therefore able to correctly attribute utterances. The Afrikaans interview was analysed in its Afrikaans form. Afrikaans is an expressive, colourful language, and I chose not to translate the interview into English, as I was concerned about losing meaning. To aid readability, Afrikaans quotes were translated into English for their inclusion in the findings, with the original Afrikaans quotes reflected in the footnotes. IPA focuses on an analysis of the participants' semantic utterances, and therefore prosodic elements are not reflected in the transcriptions (Smith et al., 2009). Where significant pauses or non-verbal utterances occur, these are reflected via notes in the transcript. I checked all transcriptions, to ensure that the verbal utterances had been correctly captured. These final versions were uploaded into Atlas.ti version 7 for analysis.

I followed Smith et al.'s (2009) guide for analysing the data. Smith and his colleagues acknowledge that IPA is flexible in its approach, and do not prescribe a rigid method of data

analysis. The process that I engaged in can be broadly described as "moving from the particular to the shared, and from the descriptive to the interpretative" (Smith et al., 2009, p.79). It is outlined in steps 1 to 5 below.

As I had obtained data from three groups of participants, the process outlined in steps 1 to 4 was followed for each group. I began with an analysis of the data pertaining to the adolescents, followed by the caregivers, and finally the clinicians. In the final step (step 5), I attempted to integrate the findings across the three groups, and how the perspective of each contributed to a contextualised, nuanced understanding of the adolescents' suicide attempts.

3.4.5.1 Step 1: Reading and Re-Reading

Initially I listened to the audio recording of each interview, while simultaneously reading the transcript. This allowed me to immerse myself in the participant's world and aided with the recollection of feelings that were present in the room at the time of the interview. I also consulted the notes that I had made for each participant, which captured my experience of each interview. For the adolescent participants, I also examined their photos, and the associated discussion reflected in the transcripts. I subsequently reread all of the transcripts, without the accompanying audio recording. While rereading the transcripts in Atlas.ti, I started adding comments and notes about my observations. At this point my work process started overlapping with that in step 2.

3.4.5.2 Step 2: Initial Coding and Noting

I coded each transcript in Atlas.ti using an inductive manner of data analysis (Eatough & Smith, 2008), and therefore did not work with predetermined code names or categories. Assigned codes were both descriptive and conceptual in nature. Descriptive codes were based on the explicit content of the participant's account, particularly those aspects of experience that were important to the person. Conceptual codes involved a level of abstraction and interpretation, attempting to reflect the participant's overall understanding of the matter they were discussing (Smith et al., 2009). I also continued to add notes, commenting on interpretations that sprung to mind, contradictions within the participants' accounts, and idiosyncrasies of language use that revealed meaningful aspects of the person's experience. Due to the inductive nature of

coding, I initially was “drowning in data”, with the initial coding exercise producing 1255 codes.

3.4.5.3 Step 3: Identifying Emergent Themes

I reduced the vast number of codes for each group of participants into themes. This was challenging, as I wanted to maintain the complexity of the data, while creating a manageable number of coherent themes. In order to do so, I combined codes that addressed similar aspects of experience. I also focused on those codes that dealt with the meaning-making aspects of participants’ experience and revisited my research questions to foreground codes that were relevant to these. This entailed eliminating the majority of codes. In combining codes, the distinction between codes and themes often became blurred, as themes started to evolve in the joining of codes, and the merging of the descriptive with the interpretative. Discussions with my supervisor, who had read through the initial few transcripts, assisted with developing coherent themes; as did referring to the comments and notes I had previously made. The creation of themes was an iterative process. The hermeneutic circle was evident, with the part being interpreted in relation to the whole, and the whole in relation to the part (Smith et al., 2009).

In traditional IPA research with small samples, themes and superordinate themes are initially created for each participant, before moving onto the next case. However, due to the relatively large sample size for an IPA study, I focused on identifying emergent themes for each group of participants. These group themes can however be linked back to the individuals, reflected in the quotes and photographs provided in the findings chapters. The idiographic is thereby not lost.

3.4.5.4 Step 4: Searching for Connections Among Emergent Themes

In this step, I linked themes so that clusters were created that linked to superordinate themes. The superordinate themes were based on abstract similarities, as well as polarisation (Smith et al., 2009). It was possible to group themes in various ways, depending on my interpretation and choice of focus. I reminded myself of the research questions, in order to aid this process.

Apart from utilising the grouping and sorting functions available in Atlas.ti, I also created a large sheet with post-its to refine the final themes and superordinate themes.

Smith et al. (2009) emphasise that for studies with larger samples, it is vital to measure recurrence across cases; although there is no fixed rule as to how frequently a theme should recur across cases in order to be included. To aid transparency, the final superordinate themes, themes, and subthemes for each group are reflected in tables 2 to 4 below. The numbers in brackets indicate the total number of participants whose accounts endorsed each theme.

Table 2

Themes Reflected in the Adolescents' Accounts

Superordinate theme	Theme	Subtheme
The relational context (10)	A dangerous world (10)	
	The home environment (10)	Disconnection from parents (10)
		The role of siblings (10)
		The comfort of pets (3)
		The need for validation and communication (10)
	Belonging vs isolation: The importance of peers (10)	Learning and sharing suicidal behaviours (5)
		The role of technology and social media (5)
Autonomy and treatment following the suicide attempt (10)		
Making meaning (10)	Incorporating psychiatric speak (6)	
	Ambivalence about living and dying (8)	
	Narrowed choices: Suicide attempts as an escape and solution to problems (10)	

Note: The maximum number for endorsement is 10, as there were 10 adolescent participants.

Table 3

Themes Reflected in the Caregivers' Accounts

Superordinate theme	Theme	Subtheme
Parenting in the context of adversity (10)	Parenting in the context of socio-economic struggles (10)	
	Parenting in the context of violence and sexual abuse (7)	Parenting and corporal punishment (4)
Living with the aftershock of the suicide attempt (10)	Living with anxiety, hypervigilance, and helplessness (10)	
	Living with guilt and self-blame (3)	
Making sense of the adolescents' suicide attempts (10)	Adolescent suicide attempts as a hidden problem (8)	
	A relational understanding of the suicide attempts (10)	
	Uncertainty and confusion in understanding the suicide attempts (10)	

Note: The maximum number for endorsement is 10, as there were 10 caregivers.

Table 4

Themes Reflected in the Clinicians' Accounts

Superordinate theme	Theme
Working in the public health system (9)	Working in a resource constrained system (7)
	Working in an audit culture (4)
	Working in a context of trauma (9)
The emotional impact of working with suicidal adolescents (9)	
Making sense of the adolescents' suicide attempts (9)	Attempted suicide is a relational act (9)
	The psychiatric cannot be separated from its context (9)
	The normalisation of suicidal behaviour: A socio-cultural understanding (4)

Note: The maximum number for endorsement is 9, as there were 9 clinicians.

3.4.5.5. Step 5: Identifying Patterns Across the Three Groups

Once I had decided on the themes and superordinate themes for each of the three groups of participants, I considered how these three different vantage points contributed to an understanding of the phenomenon of adolescent suicide attempts. The analysis therefore also took place across and between the groups, thereby embracing a multiperspectival approach (Larkin et al., 2019). Comparisons across participant groups highlighted areas of agreement, as well as contested meanings. The process was iterative, leading to a relabelling and reconfiguring of themes to enhance meaning-making and to allow for improved cohesiveness in the discussion.

In chapters 4, 5, and 6 I present the findings of the analysis for the adolescent, caregiver, and clinician groups respectively. These chapters allow the reader to stay close to the data and participants' experience, focusing on the phenomenological and idiographic of IPA. In Chapter 7 I synthesise the analysis of the three groups and bring the interpretative to the fore.

3.4.5.5 A Note about the Role of the Photographs in Data Analysis

The use of photo-elicitation implies that the photographs were a conduit to aid the discussion with each adolescent. That is, the images themselves were not analysed, but were foregrounded in the interpretation and description provided by the adolescents. The interview therefore remains the primary method of analysis. This approach fits well with the interpretative and phenomenological assumptions inherent in IPA (Bates et al., 2017; Burton et al., 2017). The use of photographs provides greater context to the participants' accounts, and acts as a memory cue, thereby yielding richer descriptions than verbal-only interviews (Bates et al., 2017). Photographs are provided alongside the verbal quotes in Chapter 4 to enhance the illustration of themes.

3.5 ENSURING QUALITY IN QUALITATIVE RESEARCH

Due to the fundamental differences in the world views underlying quantitative and qualitative research, it is not possible to simply borrow the criteria of validity and reliability from quantitative research when assessing quality in qualitative research (Smith et al., 2009; Yardley, 2000). Yet, there are no universally agreed criteria for assessing the quality of

qualitative research studies, although various formulations have been suggested (e.g., Elliott et al., 1999; Guba, 1981; Yardley, 2000). In addition, the wide range of ontological and epistemological positions adopted within qualitative research itself, has led to a debate of whether each method of qualitative research requires its own criteria for assessing quality (Spencer & Ritchie, 2012). I have decided to use Yardley's (2000) guiding principles, as they provide a broad base from which to demonstrate and assess the quality of qualitative research. These guiding principles are: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Each of these principles is discussed in relation to its application to IPA and this research.

3.5.1 Sensitivity to Context

Sensitivity to context can be demonstrated through awareness of the study's socio-economic, cultural, and historical setting; obtaining rich data, which pays attention to the particular; engaging deeply with the material obtained from participants; and by situating the findings within the existing literature (Smith et al., 2009; Yardley, 2000). By using purposive sampling, participants were drawn from communities facing similar challenges, thereby paying attention to context. I was aware that by conducting most interviews on the hospital premises, I was removed from the external context of the adolescents' daily lives. Inviting the adolescents to take photographs, allowed me a degree of access into their daily lived world. The photographs, alongside the in-depth interviews, allowed me to closely engage with the idiographic for each participant. Presenting verbatim extracts (as evident in the findings chapters) and situating the findings within the relevant literature (as done in the discussion chapter) is coherent with IPA and its emphasis on sensitivity to context.

3.5.2 Commitment and Rigour

Commitment requires prolonged engagement with the subject matter, immersion in the data, and competent use of the selected methods. Rigour in turn encompasses the thoroughness of data collection and analysis (Yardley, 2000). By providing an overview of the endorsement of themes by participants, as well as verbatim extracts representative of all participants, I have tried to contribute to the rigour of the study. I have tried to demonstrate competent use of IPA, by paying attention to both the phenomenological and interpretative components, grounded within the participants' rich descriptions.

3.5.2.1 Respondent Validation

Member checking, also referred to as respondent validation, was used to enhance the rigour of the research. It acknowledges that participants are experts in their own lives, and aims to ensure accurate representation of participants' lived experience (Sandelowski, 2008). I employed member checking while conducting the in-depth interviews, by asking for clarification of explanations, requesting participants to elaborate when necessary, and summarising and reflecting their accounts back to them to ensure that I had understood them as intended. The primary purpose of the focus group was to allow for member checking, as I presented my preliminary findings and interpretations of their accounts to the adolescents, and asked for their feedback about these (Sandelowski, 2008). The concept of member checking has however been criticised, as it has been argued that participants may disagree with the interpretation if it is not compatible with their self-image (Abrams, 1984), and that people do not necessarily have "privileged status as commentators on their actions" (Fielding & Fielding, 1986, p.24). In addition, the individual participants do not have an overview of the entirety of accounts that the researcher bases their analysis on (Varpio et al., 2017). Therefore, rather than attempting to aim for an objective truth (which is incompatible with the philosophies underlying IPA, as well as my own world view), member checking during the focus groups was used to explore the convergences and divergences in interpretation and understanding among members, and in relation to my interpretation of the preliminary findings. Comments made by participants during the focus group, as well as contested meaning, are therefore incorporated into the findings and discussion (chapters 4 and 7). Overall, the focus group discussion enhanced my understanding of the adolescents' lived experiences and provided further nuance to the findings.

3.5.2.2 Triangulation

Triangulation contributes to the rigour of the study. Triangulation, as described here, is not aimed at obtaining "the truth", which would be incompatible with the interpretivist and phenomenological epistemology of IPA. Rather, it aims to add rigour, complexity, and depth to the research (D. Silverman, 2011; Varpio et al., 2017). The triangulation of viewpoints (those of the adolescents, caregivers, and clinicians) in the multiperspectival design of this study can contribute to trustworthiness of the research as it allows us to understand the phenomenon of adolescent suicide attempts in a more complex manner. This is through triangulated consensus,

if it is present, and through transparency, when meaning is contested (Larkin et al., 2019). It may also allow for improved transferability across similar contexts, although causality can never be claimed (Larkin et al., 2019). The variety of perspectives are represented in the findings chapters, and the convergences and divergences are further explored in the discussion chapter.

3.5.3 Transparency and Coherence

The transparency of the research is concerned with how clearly the research process and its stages are described (Smith et al., 2009; Yardley, 2000). I have aimed for transparency by providing a comprehensive description of the research process, including participants, sampling, data collection, and data analysis. Coherence concerns whether the study presents a cogent argument, and a fit between research aims, philosophical perspective, methods, and analysis (Smith et al., 2009; Yardley, 2000). During the write up, I was aware of a third hermeneutic, namely the audience of this work, and therefore tried to present the material in an academic, but also engaging, manner. I also frequently redrafted chapters, in order to improve readability and coherence.

3.5.3.1 Reflexivity

Reflexivity is important in meeting the criterion of transparency. Reflexive researchers are those who are self-aware and examine how their values and backgrounds influence the research process and interaction with participants (Dowling, 2008; Payne & Payne, 2004). Reflexivity also involves consideration of how interactions occurring during the research are situated within a context that is bound by time and place (Shaw, 2010). In order to aid reflexivity, I kept both a personal and research journal throughout the study. I made notes after all interactions with participants and documented my thoughts and feelings regarding the process of research. I explored the impact that the subject matter had on me, documented decisions regarding ethical dilemmas, and pondered different ways of understanding. I also used supervision and personal therapy to reflect on some of these aspects. My positioning in relation to the research is briefly described later in this chapter; and further analysis is provided in Chapter 8.

3.5.4 Impact and Importance

This criterion is concerned with the utility of the research, and whether it is interesting to the reader (Smith et al., 2009; Yardley, 2000). I hope that this research presents new perspectives that are relevant for the local context, although this judgement is ultimately made by the reader. I do believe that the research has demonstrated utility by benefitting the participants. The adolescents appeared to experience the research as validating, as evidenced by their enthusiasm, commitment to the research process, and verbal feedback. Although it was not intended as a therapeutic intervention, many stated that it had benefitted them, and allowed them to reflect on their experience. Participation in the research also created additional opportunities for the adolescents, with two of them linking up with a local NGO that had partnered with the hospital and becoming involved in a creative programme for adolescents. At the time of writing, all the adolescents who had participated in the research were still alive. Although no causality can be implied, the research itself may have provided a protective function. Caregivers also expressed relief at being able to share their experience and distress. In some instances, participation in the research appeared to have led to improved communication within families and between adolescents and their caregivers. The clinicians in the CAMH unit expressed interest in the outcome of the research, hoping that it could aid them in their daily work. I have had the opportunity to provide feedback to the clinicians in the unit, and hope to schedule another follow-up session. The research has also created opportunities for advocacy. I presented to teachers and principals from the local school district at a suicide indaba[4], opening a discussion that placed adolescent suicide in context, moving away from a reductionistic cause-and-effect explanation. Two radio interviews concerning adolescent suicide took place. One of these was with an adolescent interviewer at Radio Red Cross, a radio station run by child patients at Red Cross Children's Hospital.

3.6 THE POSITIONING OF THE RESEARCHER

My interest in the topic of suicide developed due to my work with suicidal adolescents in the CAMH unit. Regarding my assumptions about suicide, I believe that it should be prevented, where possible. This belief is informed by having witnessed the pain of those who have been affected by another person's suicide, as well as the knowledge that life has the potential to surprise us in the most unexpected, yet beautiful ways. However, I also believe in the autonomy

[4] South African term meaning conference

of choice, and therefore support the right to euthanasia where it is well considered and can end extreme suffering. I do acknowledge that an additional layer of complexity is added when the choice regarding euthanasia concerns adolescents, and that each person's case should be determined on its own merits. My first choice would always be to create a space for hope and the possibility of life; while at the same time respecting the choice of a competent, insightful person in prolonged, extreme distress. These beliefs influenced my desire to contribute to the understanding of adolescent suicide attempts, and the prevention thereof.

I previously worked as a clinical psychologist in the CAMH unit where this research study was situated. This was beneficial, as ex-colleagues facilitated access to the site and supported the research. I also had the benefit of an insider's perspective regarding the institutional systems and the daily work of the clinicians on the unit. Yet, I was aware that this prior experience shaped my assumptions about the lived experiences of participants. For example, I was acutely aware of the socio-economic challenges and the high rates of violence faced by the communities attending the hospital, and the impact of strained family relationships on the presentation of children and adolescents attending the unit. I empathised with some of the frustrations experienced by the clinicians, and the feelings of helplessness when confronted with poverty and historical disadvantage faced by patients at the unit. This meant that I needed to be aware of the potential of overidentifying with the clinician participants, and how this could skew my interpretation of their accounts.

I was cognisant of the potential for role confusion between the roles of researcher and clinician, due to my prior training and work as a clinical psychologist. This is a common experience for clinician-researchers, who struggle with both internal role confusion (experiencing conflict between roles) and external role confusion (requiring clarification of roles to others) (Hay-Smith et al., 2016). Although I was not working in the CAMH unit at the time of the research, and had not previously interacted with any of the adolescent or caregiver participants in a clinical capacity, it was impossible to entirely bracket my training and ways of interacting. In the spirit of openness, I shared that I was a registered clinical psychologist, who had previously worked in the unit. I also emphasised that I was not employed by the hospital and was present in the capacity of researcher. Despite emphasising my role as researcher, and the limited number of meetings, the interaction at times felt like a therapeutic one. I was astounded at the

speed and intensity of the attachment that some of the adolescents formed with me. Although I had made it clear at the outset of the research process that we would only have two individual interviews, some participants forgot about this. Using clinical techniques such as reflection, summarising, and clarification, I may have mirrored the adolescents' experience of their interaction with other mental health professionals on the unit; thereby blurring the boundaries between research and therapy. The distinction between researcher and clinician was further blurred due to the agreement that I would break confidentiality if I became concerned about risk. This decision also required a judgement call based on my clinical expertise.

Another area in which I was cognisant of potential role confusion was in my interaction with ex-colleagues. Clinicians on the unit would ask for my opinion about certain participants, whom they were concurrently treating. I was mindful of not breaking confidentiality, while wanting to ensure that participants received the best treatment possible (in line with the principle of beneficence). There were instances in which colleagues wanted to corroborate their experiences or theories about a patient. In these instances, I would confirm (or oppose) a colleague's experience of a patient. I would also engage in instances of informally "formulating" the patient. In these instances, the basic background of the patient was known to the team and myself, and therefore I was not sharing information that was not already known to the clinicians. Sharing experiences of countertransference and informal hypotheses or formulations about patients provided a reflective space for both the clinicians and myself. These discussions hopefully aided in making meaning of the patient's experience and informing treatment. On occasions, some staff members would visit my office to debrief informally about a patient or to vent about the stresses of their work. My position straddling an outsider (as an external researcher, who was not employed by the hospital) and insider status (as ex-colleague), may have allowed for these informal spaces to spring into existence. It was important to keep in mind how straddling these different roles would impact on both data collection and analysis. I was therefore aware of the danger of overidentifying with ex-colleagues and the importance of maintaining my role as researcher. At the same time, drawing on clinical experience allowed me to prioritise the participants' well-being and to provide a (hopefully) containing space, while maintaining appropriate boundaries.

My identity as a White woman in her thirties from a middle-class background was relevant to the research setting, as all the adolescent and caregiver participants were black. I also do not live in the communities where the adolescents and caregivers reside and am therefore an outsider. Given the injustices of apartheid, the percentage of White medical and allied health professionals working in the public health sector is disproportionate to that in the general population. Therefore, it is not unusual for patients to consult with White clinicians. None of the adolescent participants (all of whom were born after the end of apartheid) commented on our racial differences, and it did not overtly appear to impact on our rapport. Yet, the prominence of racial discourse in South Africa, and the historical power imbalances, may have impacted their decision of what was left unsaid. Only one of the caregivers, all of whom were older than me and had lived through apartheid, mentioned race. She commented that she did not like the use of racial categories (which are still widely used on all official forms in South Africa) while completing the brief demographic questionnaire. Despite my efforts to the contrary, perceived power imbalances (due to being a White, educated, and middle-class person) may have influenced the participants' discourse and choice of what was spoken about.

3.7 ETHICS

In planning, conducting, and writing up this research, I was aware of the plethora of potential ethical concerns. Caution is noted when conducting research involving minors, who are deemed to be "vulnerable" (Department of Health, 2015). Therefore, minors who have attempted suicide, are diagnosed with mental health conditions, and live within a context of socio-economic disadvantage could possibly be considered quadruply vulnerable. Yet, the concept of designating a group of people as vulnerable, based on a characteristic such as age or socio-economic status, has been criticised; and often conflicts with participants' self-perception (van den Hoonaard, 2018). I was therefore cognisant of not being overly paternalistic and respecting the adolescents' autonomy, while simultaneously implementing the appropriate measures to minimise potential harm. Other aspects that are particular to this study were the use of photography and the choice of a multiperspectival research design. I discuss their ethical implications below.

3.7.1 Institutional Approval

Institutional permission to conduct the study was granted by the Health Research Ethics Committee at Stellenbosch University (Reference number S16/09/171; Appendix 15), the Western Cape Department of Health (Reference number WC_2017RP15_919; Appendix 16), and the management board of the psychiatric hospital at which this research was based. The research was guided by the ethical principles outlined by the Declaration of Helsinki (World Medical Association, 2013), the Department of Health's (2015) Guidelines for Ethical Research, and the South African Medical Research Council's (2018) Guidelines. As a registered clinical psychologist I am also bound by the ethical code of the Health Professions Council of South Africa and adhere to the ethical principles and guidelines outlined for psychologists and by the Health Professions Act of 1974 (Department of Health, 2006). Ethical principles outlined in these documents include those of autonomy, beneficence, non-maleficence, and justice. The guidelines aim to protect the rights and health of research participants, and emphasise that the generation of new knowledge can never take precedence over the rights and interest of the individual. Bearing these guidelines and principles in mind, I now discuss the measures that were taken to protect the rights and safety of participants.

3.7.2 Informed Consent and Assent

Informed consent was required to participate in the study. This involved informing all participants about the purpose of the study, their expected role, and the possible risks and benefits of partaking (Brinkmann & Kvale, 2017). I emphasised that participation was voluntary and that participants could choose to withdraw from the study at any time. Sufficient opportunity was provided for all participants to ask questions about any aspect of the study and to ensure understanding of what the research involved. I was cognisant that all the recruited adolescents were also patients in the CAMH unit, and therefore stressed that their decision to participate or not would not impact on their treatment in any manner. As each person in the adolescent-caregiver-clinician triad was aware of the others' existence and involvement, it was possible that co-participants could pressurise one another to participate. Therefore, each participant in the adolescent-caregiver-clinician triad was individually given the choice of whether to participate or not and did not require a justification to withdraw from the study. I thereby wanted to prevent any individual from feeling obligated to participate if, for example, their child chose to do so.

In South Africa, research involving a person under the age of 18 years requires both the permission of an adult responsible for the child, as well as the child's assent to participate (Department of Health, 2015). In this study, both the assent of the adolescent and the consent of a parent, legal guardian, or caregiver were required for an adolescent to participate in the research. In three cases, a legally appointed guardian or the primary caregiver whom the adolescent was living with provided consent to participate in the research, as the parents were uninvolved in the adolescents' lives or their whereabouts were unknown.

All participants (adolescents, caregivers, and clinicians) were required to provide both verbal and written consent/ assent. Copies of the information sheets and consent/ assent forms were given to all participants to read through in their own time (appendices 2 to 5). These were available in both English and Afrikaans, but only one person chose to use the Afrikaans version. I asked those participants whose home language was isiXhosa whether they would like for me to arrange a translation of the consent and assent forms into isiXhosa. However, all were proficient in English and none accepted the offer.

3.7.3 Confidentiality

In discussing confidentiality, I distinguish between external and internal confidentiality. External confidentiality, traditionally simply termed confidentiality, ensures that participants are not identifiable to the public audience when findings are published or disseminated (Brinkmann & Kvale, 2017; Ogden, 2008). I addressed this through traditional means such as the use of pseudonyms and not naming the psychiatric hospital at which this research was based. I protected the collected data by storing both digital and physical data in safe formats (password-protected and in a locked cabinet, respectively). Apart from my supervisor, two professional transcribers had access to the audio recordings, and I requested that these were deleted once the transcriptions had been completed. Using photography raises ethical concerns around inadvertent disclosure of participants' identity, and I discuss this later in this chapter. In comparison to external confidentiality, internal confidentiality is concerned with the possibility that participants in the same study may be able to attribute opinions and verbatim quotations to each other (Tolich, 2004; Ummel & Achille, 2016). This is pertinent to the use of a multiperspectival research design in this study.

3.7.3.1 Considerations around Threat to Internal Confidentiality in Multiperspectival Research Designs

Using multiperspectival designs creates the risk that participants may be able to link quotes to particular participants, who form part of their lived world. This is because participants are likely to recognise their own quotes and pseudonyms, and can therefore link these to other pseudonyms used in relation to them (Larkin et al., 2019; Tolich, 2004; Ummel & Achille, 2016). It is also possible that in an intimate setting such as the CAMH unit, clinicians may recognise the idiosyncratic language use of colleagues, thereby attributing quotes to each other. I have attempted to minimise the risk of this occurring in a number of ways. Firstly, I have chosen to present the data at the general group level. For example, rather than presenting the data for each triad (adolescent, caregiver, clinician), I have chosen to assemble the perspectives of each group. I therefore do not explicitly identify which adolescent was linked to which particular caregiver, or to which clinician. Secondly, I have attempted to present the data in such a manner that some pseudonyms are excluded in the statements made by participants. Despite this, the risk remains that participants may be able to attribute quotations to specific others through idiographic experiences or expressions, or through recognizing photographs that the participant has taken. Although I have taken measures to conceal participants' identities and to ensure internal confidentiality, this cannot be guaranteed. For example, although members of the focus group were requested to maintain confidentiality and protect each other's identities, I cannot control what participants decide to reveal outside of the group space. The participants were made aware of this potential risk to confidentiality during recruitment and the informed consent process.

Interviewing both adolescents and their caregivers inevitably leads to curiosity among participants about what the other has said. I pre-empted this possibility by informing the adolescents and their caregivers that any information they shared with me would remain confidential and would therefore not be conveyed to their child or caregiver. Although some caregivers and adolescents expressed curiosity about what the other had said in relation to them, they respected my reminders that this information was confidential. This assurance was vital to creating a space that was safe enough for participants to share intimate details of their lived experience. The implication for me as a researcher was that I had to remain aware of who had informed me of what, so as not to reveal what I already knew, and not to let this prior knowledge dictate or influence the direction of the participant's account. It also created an interesting

dynamic when one participant introduced aspects of a narrative that were not mentioned at all by the other.

Exceptions to confidentiality were discussed with all participants prior to the start of data collection. These related to safety concerns. For example, it was agreed that if an adolescent presented a threat to themselves, the treating clinician would be informed. This is discussed in detail in section 3.7.5. Ultimately, protecting participants' identity and confidentiality needs to be done in such a manner that the richness and nuance inherent in the data is not lost. Saunders et al. (2015) describe this as a continuum, "along which researchers balance two competing priorities: maximising protection of participants' identities and maintaining the value and integrity of the data" (p.617). By changing too many unique details or obscuring the context, there is a danger of the particular being lost. I hope that by taking the measures described, I have managed to obtain the correct balance.

3.7.4 Ethical Considerations Relating to the Use of Photography

Ethical concerns relating to the photography concern both the *process* and the *product* (the images produced) (Harley & Langdon, 2018). In terms of the process, I was concerned that participants may place themselves in dangerous situations in order to obtain desired photographs. I emphasised that their safety took precedence over the photography. We discussed, for example, that participants should not enter isolated areas alone. I also emphasised that I did not want to receive photographs of them harming themselves, and we explored how expressions of emotions could instead be achieved by abstract imagery. The adolescents adhered to these requests. Another consideration was how the act of taking photos may impact on the adolescents' relationships with the subjects of the photos and the subjects themselves (Harley & Langdon, 2018). It was agreed that if people occurred in their photographs incidentally, such as for example strangers in a mall who were depicted in the background, consent was not required. In South African law, no permission is required to take photographs of people in public spaces or who can be viewed from such spaces. This excludes places such as lavatory cubicles, changing rooms, or private residences where people can reasonably be expected to desire privacy. The non-commercial use of photographs of people for education, art, news, or information does not require their permission (Fouché, 2015; McGregor, 2014). Adolescents were however requested always to ask for permission before

taking photographs of people who formed a part of their social world, such as for example family members or friends. They were also required to explain that the photography was for research purposes and to avoid taking photographs that may embarrass or shame others.

The inadvertent disclosure of the participants' and others' identity is an ethical concern related to both the process and content of the photography. Being identified as or associated with an individual who has previously attempted suicide may result in stigma (Carpiniello & Pinna, 2017; Oexle et al., 2019). Although some researchers ask participants to avoid taking photographs of people (e.g., Allen, 2012), I wanted to minimise the restrictions placed on the subject matter, in order to empower participants to take photographs that were meaningful to them. Although it is impossible to guarantee complete anonymity, measures were taken to protect identity. We discussed how photos of people could be taken to preserve their anonymity, for example, by considering the photographic angle. The adolescents were also asked to take into account how confidentiality could be compromised by institutional logos or the depicted background. Many adolescents worked within these guidelines, for example by taking photographs which obscured people's faces. Some adolescents however took photographs of people in which they were clearly identifiable. In consultation with the adolescents, it was agreed to blank out the faces to protect identity. However, one adolescent stated that she was happy to have photographs depicting both her face and those of family members and friends published. This raises questions about autonomy, power, and the function that being identifiable may serve for this adolescent. I nevertheless decided to blank out the faces in her photographs. My reasoning was that a future version of herself may regret having an image of herself published, and that the wishes of those depicted in her photographs may differ from her own. Yet, I am cognisant that by making this decision, I am asserting my power as researcher in the relationship. Adolescents had the right to decide which photographs to select for publication, presentation, and conference purposes. They were asked to sign a release form (Appendix 14), which listed the chosen photographs. Physical copies of their photographs were offered to the adolescents, and all chose to keep these.

An ethical dilemma that arose with regards to the photography was that in one instance the caregiver did not approve of the idea of the disposable camera, insisting on the use of a phone camera instead. I explored this separately with the adolescent during a private consultation.

She insisted that the reason for not wanting to use the disposable camera was that her brother would want to play with the camera, and that she did not want to upset him by refusing his request. However, I suspect that her caregiver wanted to monitor the photographs she took, as she had to borrow his phone in order to take and send the photographs. The photographs I received only reflected positive aspects of her experience. When I queried whether there were any untaken photographs during her second interview, she admitted that she had not been able to take a photograph of "dagga" (cannabis). Therefore, this restriction may have limited her freedom and privacy in shooting the photographs of her choosing.

3.7.5 Safety of Participants

In order to ensure the safety of the adolescent participants, emergency arrangements were made with the CAMH unit. All adolescents were already registered patients with the CAMH unit at the time of joining the study. It was therefore agreed with the clinical management team of the unit that I could contact the psychiatric registrar on call if I believed that an adolescent was at imminent risk to themselves or someone else. A containment bed was available in the inpatient unit for this purpose. The adolescents and their caregivers were informed that if I was concerned about risk, I had a duty to inform the adolescent's treating doctor and/or the registrar on call, who would conduct an assessment and determine the appropriate course of action. I also explained that if I became aware of instances of child abuse, I had a duty to report this to both the clinical team and the authorities (the Department of Social Development). These exceptions to confidentiality were clearly explained to the adolescents and their caregivers during the recruitment process, and all accepted these prerequisites to participation.

Instances of potential risk to the safety of adolescents and other people arose during the research. In one instance an adolescent described behaviour that was putting her at risk of serious harm and/or death, namely crossing a large and busy highway without looking, and expressed indifference about being hit by a car. I informed the medical doctor, who conducted a mental state assessment and subsequently admitted her to the inpatient unit. Another adolescent, who was an inpatient at the time of her interview, expressed both suicidal ideation and homicidal intent towards a particular person who had abused her, and I informed the inpatient staff. On other occasions, adolescents mentioned behaviours such as NSSI or suicidal ideation without intent. In these instances, apart from allowing the adolescent to talk about

these feelings and behaviours, I also advised the adolescent to discuss them with their treating clinician. I also informed the treating clinician about the suicidal behaviours and thoughts, so that they could be discussed with the adolescent during their following session. In all instances where I broke confidentiality, I informed the adolescent that I was going to do so prior to the time.

Child abuse was frequently mentioned by the adolescents, both in relation to themselves and other individuals. In most instances, the abuse suffered by the adolescent participants had already been reported to the relevant authorities by the CAMH team. However, the ethical duty to protect other children, with whom I was not directly in contact, came to the fore. For example, an adolescent participant informed me about past abuse at the hands of a relative, and the family's reluctance to address this. Although she was no longer at risk of being abused by the perpetrator, she told me that he held a position in the community where he worked with children. I broached this with her caregiver, who after some discussion agreed to provide the relevant details so that I could report the ongoing risk to children to the relevant authorities. I ended up doing so by submitting the required documentation (a form 22) to the Department of Social Development, and subsequently following up with the allocated social worker. On another occasion, an adolescent told me about her school friend who was being abused by her father and requested my assistance. In this instance, we agreed that I would contact the school counsellor, who could meet with the girl, assess, and handle the matter; and this was done. This was deemed the most appropriate course of action, as intervening based on second-hand information and without access to the relevant details, such as names, addresses, and contact details, complicates the reporting of them.

Apart from the physical and emotional safety of adolescent participants, I also needed to consider how to address extreme emotional distress or suicidal ideation among the caregivers and clinicians who participated in the research. Although I provided containment and debriefing when indicated during the consultations, caregivers were informed that if they became excessively emotionally distressed during the interview, the multi-disciplinary team in the CAMH unit would be informed. The caregiver would have the option of being referred to a counselling service in the community or to the hospital's outpatient department. In an emergency, such as an acute suicidal crisis, the caregiver would be referred to the local district

hospital, which is located adjacent to the psychiatric hospital. In this instance a family member or friend would be asked to accompany the individual, failing which hospital transport, and finally the police, would be asked for assistance. None of the caregivers required emergency admission. One caregiver requested a referral to family counselling, and this was discussed with and arranged by her son's clinician. Another caregiver acknowledged the need for her own therapy and decided to approach a private practitioner herself. All adolescents and caregivers were also provided with a list of community-based mental health organisations and child services (Appendix 17), with some adolescents requesting additional printouts for their friends. In the case of clinicians becoming severely distressed, it was decided that they could either be referred to the employee wellness programme or to a private practitioner, depending on their preference. None required this.

3.7.6 Means of Communication and Boundaries

A dedicated research phone was used to communicate with participants. I clarified that I would only be available during working hours and that participants could contact me on the number to arrange appointments or if they had research-related questions. Based on the adolescents' and caregivers' preference, What's App was the main mode of communication. At the outset of the research, I had clarified my role as a researcher, and informed participants that I did not work for the hospital. I also reminded the participants that all therapeutic concerns should be discussed with their treating clinician. Most participants respected these boundaries. However, one adolescent participant repeatedly challenged them. She initially sent me a What's App message implying that she was suicidal and bidding me farewell. I responded in an empathic manner and reminded her to go to the nearest emergency room if she was feeling suicidal. I also informed her that I would be contacting her caregiver and treating clinician, which I proceeded to do. She responded in an angry manner, asking me not to tell her caregiver, and claiming I would "ruin" her life by doing so. She subsequently repeatedly apologised and queried why I cared about her. Her treating clinician discussed the behaviour with her, and I also reinforced the appropriate boundaries. Yet, she continued to test boundaries, both with me and clinicians in the unit, and attempted to engage me in various conversations over What's App. My training as a clinical psychologist, and the relationships with colleagues in the unit, allowed me and the team to manage her presentation and behaviour, and to respond to her in a consistent and unified manner.

3.7.7 Remuneration for Travel Expenses

Participants were not paid for participating in the research, as this could be regarded as undue inducement, particularly in an area of socio-economic deprivation (Resnik, 2015). Participants were however reimbursed for their transport costs, being paid R50 (equivalent to approximately US$2.93[5]) for each visit to the hospital. Reimbursement for expenses that are incurred due to participation in research is standard practice (Department of Health, 2015). Nevertheless, when I first applied for ethics approval at Stellenbosch University, the committee asked me to provide the adolescents with vouchers instead of cash, as they were concerned that the adolescents would use the cash to purchase banned substances. I successfully countered this request as I believed that it enacted several discriminatory assumptions about adolescents living in areas of socio-economic disadvantage. In addition to substance use being neither an inclusion nor exclusion criteria for recruitment into the study, research does not support the notion that cash payments increase the rate of substance use (Festinger et al., 2005; Thurstone et al., 2010).

Being reimbursed for transport elicited various reactions among participants. A few participants were embarrassed to accept money, and one caregiver wanted to pay me for attending. In one instance a caregiver asked to talk with me in private, explaining that although the adolescent was too embarrassed to accept the transport money, she desperately required it to cover their transport costs. I managed these scenarios by explaining to the adolescents and caregivers that it was standard procedure for all participants to receive R50 for transport, and that no-one was receiving special treatment. This appeared to alleviate the anxiety around accepting the money.

3.8 CONCLUSION

In this chapter I have outlined the theoretical framework underlying the chosen methodology and explicated the research design. I have also explored how my own positioning in relation to the research may have influenced the design and interpretation of the findings; and the steps I have taken to enhance the quality of the research. In describing the research design and ethical considerations, the contextual realities faced by the participants start to emerge. The next

[5] 1 US Dollar = 17.06 South African Rands. Converted on the 02/07/2020 at currency-convertor.uk

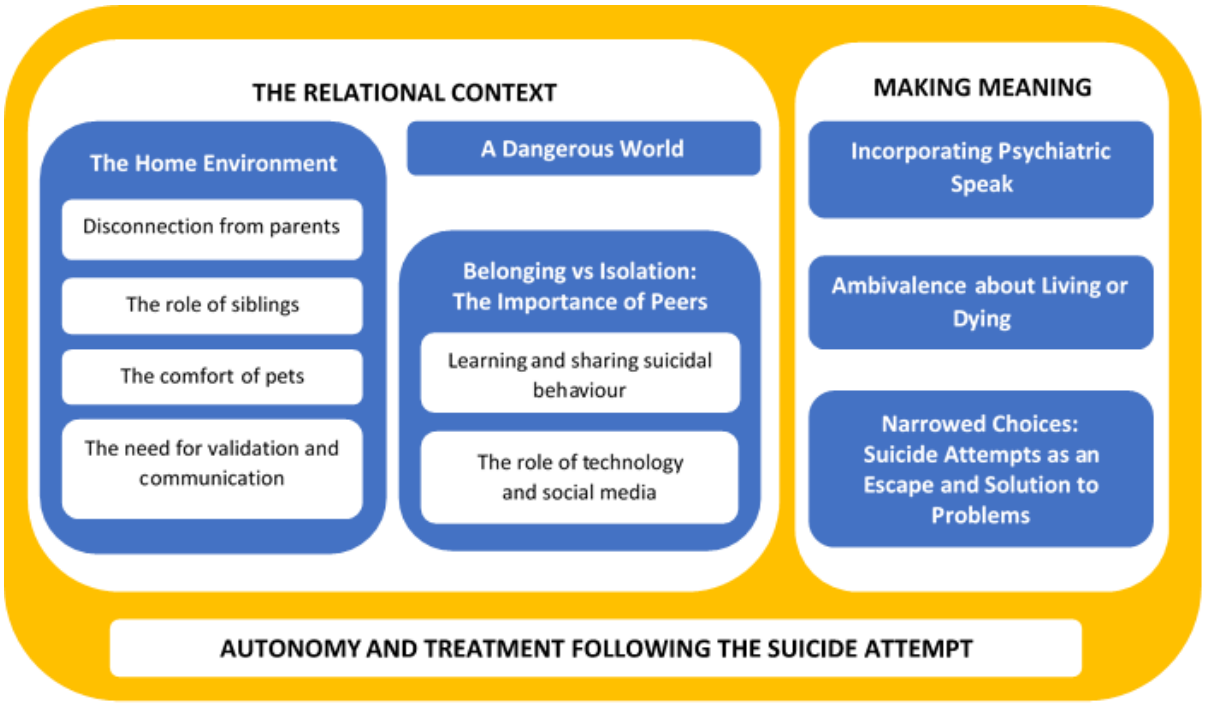
chapter explores the lived experience of the adolescent participants; and forms the first of the three findings chapters.

CHAPTER 4
FINDINGS: THE ADOLESCENTS

The richness of the adolescents' accounts presented opportunities to explore numerous facets of their lived experience. It was not possible to include all, and certain aspects of their experience have been silenced by omission. Most of the adolescents had received psychiatric diagnoses, predominantly those of anxiety, depressive, and trauma-related disorders. Yet, they foregrounded the relational in their accounts of their suicide attempts. The themes discussed in this chapter present core aspects that despite their individual nuances were central to the lived experience of the adolescent participants in relation to their suicide attempts. Figure 1 presents an overview of the themes and subthemes evident in the adolescents' narratives. This depiction is reductionistic, as the themes are interlinked and bidirectional, and the boundaries are more fluid than indicated in the image. I have nevertheless decided to include Figure 1 to enhance readability and sense-making for the reader.

Figure 1

Overview of Themes in the Adolescents' Accounts



4.1 THE RELATIONAL CONTEXT

Proximal relationships with parents, siblings, family members, and peers were central to the adolescents' descriptions of their lived experience and understanding of their suicide attempts. The adolescents recount how these relationships occur within a context that threatens bodily and psychological integrity. Danger is present both within and outside the family and detracts from relational security. The themes contained within the superordinate theme of "The Relational Context" include "A Dangerous World", "The Home Environment", and "Belonging versus Isolation: The Importance of Peers".

4.1.1 A Dangerous World

The adolescents spoke about living in a dangerous world, in which their physical and psychological safety was unassured. They did not feel safe in public spaces, vigilant of the potential dangers to person and property. Dean for example informed me that he was unable to take a photo of the ocean, as *"I would have had to walk to the beach with a camera and that's a bit dangerous."* Anonymous observed that *"our environment is just not compatible to our mental state."* In many instances, danger extended to the school and home environment, traditionally considered places of refuge. Both Debbie and Natasha took photographs of their schools' premises (photos 1 and 2), describing atmospheres of fear and danger. Natasha, who was raped on her school's grounds, told me how this trauma *"is what led to my suicidal thoughts and attempts"*. Debbie, Leah, and Anonymous described being bullied at school. Debbie linked being bullied to her suicidal behaviour. Describing her photograph *"Fear"* she told me, "*That's where I got bullied and everything really started."*

Almost all the adolescents in the study had been physically, emotionally, or sexually abused. The trauma of abuse was exacerbated when caregivers did not believe the adolescents' reports or minimised their experience. This left the adolescents feeling betrayed, worthless, and alone. For example, Natasha told me: *"They think that my rape is a lie."* The lack of validation and emotional support for the trauma endured was described as contributing to the adolescents' suicidal behaviour. In Nadine's words: *"I tried to hang myself with it, but because I couldn't handle the pain that I was feeling, of being not supported, not being, all these things, being raped."*

Photo 1

"Fear" (Debbie)

Photo 2

"Photo of Where My Rape Took Place" (Natasha)

Abuse was frequently perpetrated by relatives and people known to the adolescents. Some of the adolescents described how this contributed to their family's denial of the abuse and protection of the perpetrators. Debbie reported how she had informed her parents about being abused by her brother as a young child, and thought that they had addressed it, only to discover that this had never happened. She stated: "*My mother told me that she never actually spoke to my brother years ago. She thought I was lying when I was young, when I told her what my brother did."* In Nadine's case, she was punished when informing her mother about being raped by her stepfather. Describing her mother's reaction, she said: *"She came home and she said, why would you lie about my husband? I said it's the truth, then she beated me thrice."* Kimberlyn described how the lack of protection by caregivers contributed to her suicidal state: *"And then she caught him do it also. But yet she still did nothing, so that is when I started feeling hopeless, like nobody is going to do anything about this. She sees it happening and yet she does nothing about it."* Apart from the feeling of hopelessness described by Kimberlyn, the adolescents felt angry and betrayed by those who were meant to protect them. Catelynn summed up the minimisation and normalisation of abuse, and her family's reaction when she informed hospital staff about the abuse she had suffered:

> *"Like already when I was admitted in hospital his wife was on me, like the family, even though he did the stuff to them, you know, they were still on his side man. Even though they were like no they are on my side and stuff, they were like no you shouldn't have reported it, he is family and all this stuff, like that…"* (Catelynn)

4.1.2 The Home Environment

The theme of "The Home Environment" includes the subthemes of "Disconnection from Parents", "The Role of Siblings", "The Comfort of Pets", and "The Need for Validation and Communication". The home environment, and the relationships with those in it, were foregrounded in all the adolescents' accounts about their suicide attempts.

4.1.2.1 Disconnection from Parents

The adolescents spoke about the emotional impact of disconnection from parents, with many feeling rejected, unloved, and uncared for. Some parents were physically absent, with two of the adolescents' fathers being deceased. Debbie, who did not live with her parents when younger, emphasised that, *"I had a hard time at school and I just really needed my parents with me."* Catelynn told me, *"Um, I have a mommy and a daddy, but I don't stay with them. I feel like an orphan."* Talking about her mother she added, *"She cries on the phone that she doesn't see me and stuff, but then when I am there, then she's with her boyfriend the whole time, or she is sleeping or something."* Dean described the dissolution of the family after his parents' divorce, and the resultant absence of his father, as factors which contributed to one of his suicide attempts. He said, *"And when they first started getting divorced, I was like, life is stupid."* His photograph, *"This House of Memories"*, depicts the interior of the wendy house his family lived in when they were a unit. A toy from his childhood is displayed on the table, linking him to an earlier, idealised time.

Photo 3

"This House of Memories" (Dean)

Some of the adolescents expressed awareness of how contextual challenges, including parents' financial difficulties and struggles with addiction and mental health, impacted on the relationships with their parents. Debbie related how she had lived with her grandmother, so that her parents could work. Yet both Debbie and Dean emphasised that financial sacrifice could not replace a strong emotional connection with their parents. Debbie stated that *"they pay for your better life… they expect that to make you happy"*, while Dean said that receiving material gifts at times *"feels like bribery"*. He emphasised that *"we need love."* Natasha sympathised with her mother's struggle as a single parent, saying, *"Yes, they go through what they go through, but a parent's love and care at this moment would mean more than anything."*

Although some parents were physically absent, in many cases parents lived nearby or in the home but were still perceived as emotionally absent by the adolescents. For example, Natasha reported, *"It's just that me and my mother had no relationship, she doesn't know how to, in other words, love."* Adolescents reported feelings of rejection, illustrated by both LDB's photograph *"Not Feeling Welcome"* and Kimberlyn's photograph *"Rejected"*. Explaining her photograph, Kimberlyn said, *"It represents how I felt like I was being pushed, like shunned by my family and pushed away from them, like they turned their backs on me."* The emotional disconnection from parents, and perceived lack of familial belonging, was identified by many of the adolescents as a factor contributing to their suicide attempt. Nadine stated, *"My first wish is, I wanted to die. Or have a family."* Talking about the relationship with her father, Leah said, *"It was kind of a big factor in my suicide, because I felt unloved."*

Photo 4

"Rejected" (Kimberlyn)

Photo 5

"Not Feeling Welcome" (LDB)

All of the adolescents emphasised that improved relationships with parents were essential for support, and more generally, in prevention of adolescent suicidal behaviour. TC, who has an acrimonious relationship with her mother, fondly describes a rare outing with her mother as *"the best day of my life, like, the best of all time".* She also told me that her suicide attempt would have been prevented *"if we had solved our problems with my mother".* The need for improved parental relationships was also accentuated by LDB, who said, *"I think that's the only thing that can help me, if my father just treats me differently."* Natasha stressed that *"parents should be more involved emotionally and physically"*. Leah described her desire for an improved relationship with her father:

> *"The one thing that I was supposed to have and like I needed, it wasn't there and it doesn't feel like it's ever going to be there. Like I am not going to get a proper father figure from him, so ja."*

In expressing these support needs the adolescents articulated a wish for a closer connection with their parents, characterised by care and love. While improved relationships with parents were described as essential in preventing adolescent suicide, a sense of responsibility towards the family was described as a reason to continue living. Kimberlyn was concerned that her current caregiver may *"think it's her fault"* if she killed herself. Dean described how the suffering of the parents of a school peer who had suicided was an *"eye opener"* for him and gave him *"a better reason to live"*. Leah described how concern for her mother averted a suicide attempt:

> *"I thought about my mom, and about how upset she would be and then I thought about how all of this is going to cost her. And then I decided that I shouldn't do it. And then I cleaned myself up and I threw the note away."*

Kimberlyn described the importance of extended family, and how family played both a contributing and protective role in relation to her suicide attempts. She explained how the experience of rejection by both her parents and her extended family had contributed to her suicide attempts. Although her parents remained absent following her attempts, she did manage to elicit the required care and support from extended family members. Her jellybean photos illustrate her experience before (Photo 6) and after (Photo 7) her suicide attempts. She explained:

> *"Family was the reason why I wanted to kill myself, because of the way I felt, and how I felt they were treating me. And family is also why I am still here, because now they are like, I am surrounded by ones that are actually there for me and actually care for me and are looking after me and that."*

Photo 6

"Outcast, Black Sheep" (Kimberlyn)

Photo 7

"Acceptance" (Kimberlyn)

4.1.2.2 The Role of Siblings

Adolescents narrated how their younger siblings provided a sense of relational security and a reason to continue living. A number of adolescents took photographs of their younger siblings, with TC for example describing her younger brother as her *"smile keeper"*, while Catelynn titled a photograph of her sister as, "*Find your motivation, find what makes you strive, mine is my sister."* Some of the adolescents expressed concern about the impact their suicide would have on their remaining siblings, and that this prevented them from killing themselves. For example, Leah said:

> *"I don't want her, I didn't want her to kind of be traumatised by me. I felt like if I did something I would have been selfish, I would have hurt her in a way that nothing, it would be hard for her to come back from."*

The quotations in Table 5 highlight both the protective function of younger siblings, as well as the degree of parentification taken on by some of the adolescents in caring for their younger siblings. Adolescents explained that their parents were frequently unable to provide the needed

care, and they therefore took on this responsibility. Speaking about her younger brother, Kimberlyn told me, *"I had to play the role of the mother, because my mother wasn't able to."* She added that, *"He grew up thinking I was his mother."* Natasha related that, *"as far as I can remember, I look after my baby sisters."* She also regarded her younger sisters as a reason to live, as illustrated by Photograph 9 and its accompanying title.

Left:

Photo 8

"My Smile Keeper" (TC)

Right:

Photo 9

"Photo of My Two Baby Sisters Who Are My Main Priority" (Natasha)

Table 5

Quotations Illustrating the Perception that Younger Siblings Are a Reason to Live

"She is another reason why I keep living." (Catelynn)
"And then there's also my little brother. There has to be someone there for him to look up to." (Dean)
"And my plan is to look after my brothers. To take them in and like look after them and prevent their lives from turning out as mine. So then I was like, if I had to kill myself, I would not be able to do that, and that would have been really selfish of me, because then I would be leaving them alone… So I was sitting there and I started crying because I realised how selfish it was of me. To actually do it again. To want to do it again." (Kimberlyn)
"But she's the only one that makes me be who I am, still alive… I don't want to hurt her." (Nadine)

Although relationships with younger siblings were depicted as a reason for living, this did not necessarily apply to the relationships with older siblings. Debbie and Anonymous related how abuse at the hands of their older brothers had detracted from a sense of relational security. Anonymous stated:

> "*We have no relationship, and I wouldn't think of him as a reason to live. And he isn't my older brother and protective and amazing. He is an abuser."*

For LDB the suicide of his older brother, a father figure and *"role model"*, was the catalyst for his own suicidal behaviour. LDB said:

> *"Um, I think it started when my older brother passed away. He committed suicide. He hung himself. That was four years ago."*

4.1.2.3 The Comfort of Pets

Pets featured in the photographs of five of the adolescents. Dean, Debbie, and Catelynn specifically described their pets as providing emotional comfort and companionship. The title of Dean's photo, *"The Menacing Dog with a Soft Heart"* describes the contradiction of a fierce watch dog, that bestows on his owner the desired love and care. Catelynn related that *"a good thing to calm you down and make you feel loved is a kitten or a puppy."* Debbie spoke about her love for her pets, titling a photograph of her dog, *"My Baby"*. Dean described how his dog had prevented a previous suicide attempt by alerting his mother through insistent barking:

> *"There was a time when I was actually going to die, and the dog was barking, and my room is like by the entrance of the yard. So my mommy came to check and then she saw I was busy. That's how she found me the first time."*

Dean related how spending time with animals *"cheers"* him up and the role of his pet dog in providing companionship during trying times:

> *"Every time I felt like I wanted to cut myself or anything, he would like bang against the window, because he knew something was wrong. And then I would sit with him and then he would lay on my lap and we would just look at the sky together, the whole night."*

Photo 10

"My Baby" (Debbie)

Photo 11

"The Menacing Dog with a Soft Heart" (Dean)

4.1.2.4 The Need for Validation and Communication

All the adolescents described feeling invalidated by their families, in particular their parents. They reported feeling misunderstood, unappreciated, and unheard. Feeling invalidated also occurred in relation to not being believed, or having their trauma minimised, when adolescents reported instances of abuse or sexual assault (see section 4.1.1). Debbie described feeling misunderstood, saying, *"It's like you love your parents, but they don't understand, you feel alone."* Leah spoke about being made to feel like a *"trophy"*, rather than being validated for her person. Speaking about her father, she said:

> *"He likes to like show us off, like we're trophies… I don't feel like a human being when he does that. I just feel like, look at me, I'm a pretty trophy, it's a terrible feeling."*

Both TC and Natasha felt that despite their efforts they disappointed their mothers. Natasha stated, *"Never does she see the things that I am actually doing. It's like she doesn't appreciate what I do."* TC linked her experience of feeling unvalued by her mother to her suicide attempt:

> *"I felt like there's nothing good that I could do and my mother is not proud of me, and all I bring her is pain. And stuff like that, so I then decided that I must just end my life."*

Some of the adolescents spoke about the therapeutic value of their relationships with clinicians in the CAMH unit. These supportive therapeutic relationships provided the validation desired by the adolescents, which was perceived to be lacking in their relationships with their parents.

Adolescents valued the non-judgemental attitude of staff, and the ability to *"really talk my heart out"* (Debbie). Natasha mentioned that *"I can be myself, share my thoughts and not be judged."*

Being validated was identified as important for suicide prevention. TC spoke about the importance of feeling understood in mitigating adolescent suicide attempts, saying:

> *"I think it's if, like we found a person that really understood us, and how we like really feel and stuff like that… Yes, and someone that could deal with our emotions and, yes."*

Kimberlyn emphasised how feeling cared for and valued would prevent adolescent suicide:

> *"That is one way how they can prevent it, if the teenager knows somebody cares, somebody knows about it and they are trying to stop me. They don't want me to do it, because like it's gonna make the risk less. The teenager is gonna think, people are there for me, people care."*

For Dean, being regarded as a valued member of society was critical for suicide prevention:

> *"But if I had to say, just give them the right amount of support, make them feel like they are still needed in the world. They still have to be here. They, give them tasks to do that only they can do. Like make them feel special. That would basically help. Because that worked for me, so it might work for others."*

Feeling invalidated was frequently discussed in relation to communication difficulties within the family. All the adolescents described communication difficulties, including a lack of communication between the teenager and their caregiver, critical or hostile communication, and difficulties expressing concerns (see Table 6). At times there was a complete absence of communication. For example, LDB related how his father, who had been absent for many years, moved back in with the family without his being informed or consulted.

Table 6

Quotations Illustrating Communication Difficulties with Caregivers

"I don't really have a lot of talks with him ever. I see him and I am like hi, and sometimes he doesn't even respond. A lot of the time he doesn't respond." (Anonymous)
"Sometimes when I talk to her, she says, hah, leave me alone, I'm busy. So that's why I don't talk to my mom, I just keep it inside." (Nadine)
"He would brush off my opinions… Like I would try and say something about how I feel about a certain thing that's happening at school, and then he would just say something and relate it to himself." (Leah)
"… her words personally, she doesn't hit me or anything, her words personally breaks my soul." (Natasha)
"I feel like they always just point out my flaws and stuff. You should up your grades, you should lose weight, you should do your hair…" (Catelynn)

The option of non-orally communicating distress was frequently sought out by the adolescents (see Table 7). Leah, for example, wrote poetry expressing her feelings, which she would pin to her bedroom wall. Anonymous's statement that, "*Unless I was laying there in a pool of my own blood, I don't think anyone would have done anything"* suggests that suicidal behaviour may be an attempt at non-verbal communication. Yet when I queried this during the focus group, almost all the adolescents disagreed with this interpretation. Many describe hiding their suicidal behaviour. For example, Dean told me that *"my attempts were always secret"*, while Leah describes *"tidying up"* after her attempt. She did however add that "*I kind of regret cleaning myself up."*

Table 7

Quotations Describing Non-Oral and Non-Verbal Communication

"The second time I wrote a letter, but it didn't work. So I woke up and the letter was still there, so I just took it and I hid it in my cupboard and after that, I ran away, so I thought they would get the letter, but my mom didn't say anything about it, so I am guessing it's still there in the cupboard." (LDB)
"…because I couldn't tell it to him, I typed it out on his phone, not, on his keypad, and I told him I was raped…." (Natasha)
"And the weird thing about it is that a lot of the times when I did get suicidal and I did want to hurt myself, I would sleep in the lounge, and not in my own room. And everyone would know like, she's not doing great. And everyone would ask me, when are you moving back to your room? And I would know that they would want me to go back to my room, because that would mean that I was okay again. And that was very consoling." (Anonymous)

Improved communication with their parents, which tied in with the need for validation and the desire to be *"understood"* was desired by the adolescents. Adults were requested to *"just sit and listen"* (Kimberlyn) and to *"get the teenager to open up to you; relate to how they're feeling"* (Dean). For some of the adolescents, their suicide attempt did improve awareness of their suffering and increased communication with their caregivers. For example, LDB expressed relief that following his suicide attempt someone in the family knows *"how I have been feeling and what caused it"*, while Kimberlyn states that *"after my attempts then it did actually give a breakthrough in communication. I didn't intend for it to, but then it just happened."* A few of the adolescents also described how their own efforts to express their feelings with family members had improved communication. Anonymous stated:

> *"I've learnt that through communication, and talking to the people in the house, and letting them know how I feel, and what they can do better, has really helped me."*

4.1.3 Belonging vs Isolation: The Importance of Peers

All of the adolescents related a desire to belong and be accepted by their peers. Catelynn told me that, *"Even when I am with my friends, I don't feel like I belong"*, adding that, *"I just want to feel accepted"*. Feelings of isolation and being *"different"* were illustrated by Leah's photo, *"Alone"*, which she described as follows:

> "*So there was the one flower, surrounded by like grass… one of me and everybody else is completely different. So I am like alone in the world; everybody else is just there."*

Photo 12

"Alone" (Leah)

Photo 13

"Lonely" (Nadine)

Some of the adolescents discussed their perceived lack of belonging as linked to their suicidal behaviour. Nadine turned to suicidal behaviour when feelings of loneliness overwhelmed her, as illustrated by her photo *"Lonely"*. Catelynn and Debbie attributed their suicide attempts to feelings of exclusion and isolation from their peers:

> *"I am tired of feeling left out, rejected, not accepted, and if I am dead, I won't feel that anymore."* (Catelynn)

> *"People say some people commit suicide because they feel like they have no one, I also feel like I have no one."* (Debbie)

The adolescents narrated how friendships and classmates were *"keeping me going, keeping me normal"* (Natasha). Catelynn's photo *"A Good Friendship is Key to Happiness"* illustrates the value placed on friendship. Friends and supportive teachers provided a sense of safety in a school environment that could be threatening due to bullying, substance use, and even physical

threat. This juxtaposition is illustrated by the title of Natasha's photo *"Photo of Friend while Learners use Substances"*. For some, the school environment offered a refuge, a place of belonging. This is instantiated by LDB's comment that *"at school it's fine, everywhere but home."*

Photo 14

"A Good Friendship is Key to Happiness" (Catelynn)

Photo 15

"Photo of Friend While Learners Use Substances" (Natasha)

4.1.3.1 Learning and Sharing Suicidal Behaviour

Belonging, even if it meant taking on an unorthodox identity, was vital to these adolescents. For example, Natasha emphasised the graffiti at her school, which included *"tagging"* of gang symbols by scholars who had joined gangs in the community. Many of the adolescents found connection, and therefore a sense of belonging, with peers who had experienced similar struggles, including suicidal behaviour. Debbie informed me that *"I have so many friends who have tried to kill themselves, who have hurt themselves."* Natasha told me how she had assisted a friend who was *"also at a time suicidal"* and that *"that is how we grew our bond and our bond is basically strong"*. Dean told me that *"us cutters refer to it as bursting"*, highlighting how suicidal behaviour may contribute to a sense of identity and belonging. LDB emphasised how being able to relate to another person with the same struggles would lessen the likelihood of suicide:

> *"If they can like relate to someone like… I have the same story, we're in the same boat, if there was something like that. Then I think it would like prevent, yes."* (LDB)

While bonding over their struggles alleviated feelings of isolation, some of the adolescents described how they were introduced to suicidal behaviour by peers. Catelynn discussed learning about cutting in the adolescent inpatient unit:

> *"The reason why I actually started to cut is because Kimberlyn told me about it and she said it calms you down… But she told me I shouldn't try it, because it's not going to benefit me at the end of the day, so I was like, I'm not going to try it. But I ended up trying it, so..."* (Catelynn)

Nadine was curious about cutting and *"begged"* another patient to cut her, with the result that *"she cutted me, and I cutted her too"*. She also described being provided with an idea of how to kill herself by another person in the hospital:

> *"And I remember, I was here, in hospital, someone told me that there is a way… Then she said, you know, people want to kill themselves, it's easy, you can buy rat poison, and then mix it together… Then I said to myself, it's a good idea. And I tried once, but I ruined it, because I put it on my food, then it didn't work. Then I was so angry in the morning. Why am I still awake? I'm supposed to be sleeping dead, I'm supposed to be dead by now, ne."*

Although the adolescents primarily described learning about suicidal behaviours from peers, the suicide of loved ones opened the door to the possibility of suicide for both LDB and Natasha. Talking about her father's suicide, Natasha recounted:

> *"And I am not sure if I have told you, but I also used it as an excuse. Because he committed suicide. I thought like, why can't I? So, yes."*

4.1.3.2 The Role of Technology and Social Media

Technology, in the form of cellphones, the internet, and social media, allowed the adolescents to be part of an online community and to stay in touch with their peer networks. As TC noted, *"it's the only way that I can communicate with people."* The adolescents spoke about how social media reduced their sense of isolation. Nadine spoke about joining a Facebook group of people who were facing similar challenges to her, while Natasha mentioned that online conversation made her *"feel closer"* to friends and family. Anonymous spoke about how social media helped her to cope with challenges:

> *"And through social media a lot of the time I would tell my friends that I was not feeling good. And that I needed help and that I couldn't cope with what I was feeling, and they would pick me up and they'd say, listen, let's go do something, you need to get your mind off this. For most of the time, social media really helped me cope with what I was going through."*

The adolescents described accessing suicidal videos or sites. Some of the adolescents told me how they actively sought out ideas on *"the easy way to commit suicide"* (Nadine), while Debbie related seeking out a suicidal video to *"motivate"* her to go through with an attempt. She noted, *"That video just kind of motivated me. To do it… I just needed a little bit of a push to do it."* Yet Debbie also emphasised that online forums depicting suicidal behaviours decreased her sense of isolation. She said, "*There were times when I felt alone, then I would go on the internet and I would see that there are more people out there, who do things that I do, and ja, it would make me feel like I am not alone."* Her photograph *"Taking and Giving"* shows her googling *"depressing things"* and is meant to convey that *"the internet was a bad thing and a good thing."* Natasha similarly emphasised the dual role of the internet and social media:

> *"Yes, it would give me ideas, but the songs that plays in the videos, the pain that the people are experiencing, seeing them crying and things like that, that actually made me feel at peace, as if… I am not the only one."* (Natasha)

Photo 16

"Taking and Giving" (Debbie)

4.2 AUTONOMY AND TREATMENT FOLLOWING THE SUICIDE ATTEMPT

The theme of autonomy was clearly and consistently apparent in all the adolescents' narratives. This was discussed not only in the context of factors that contributed to their suicide attempt, but also in relation to their treatment following their suicide attempts. Some adolescents felt that their autonomy over accessing or refusing healthcare was thwarted. Nadine told me that her mother was unaware that she was attending counselling sessions in the community, but when she found out *"said I must quit going to counselling, so I stopped even going to school counselling"*. TC, who greatly valued her outpatient sessions at the CAMH unit, described how restricting access to counselling was used as a form of punishment by her father:

> *"So he was shouting at me all the time telling me… that I am never ever going to the hospital again, because I don't listen…. So, it was a way of him punishing me for being in trouble at school."*

Other adolescents felt that their autonomy was being infringed on by the clinicians and the health care system, and they tried to reassert power by resisting the treatment. For example, LDB said that *"the doctors didn't give me much free will"* and that *"it's like they insisting on helping you, but you don't actually want it."* Nadine attempted to reclaim the autonomy over her embodied self, while also questioning a psychiatric understanding of her behaviour, by not taking her prescribed medication. She said, *"To tell you the truth, I have the medication at home, but I don't eat it. I just don't feel like eating medication, because I don't know what's the use of it, you know."* Kimberlyn suggested that an empathic conversation with a caring individual may have persuaded her to seek treatment, rather than having it *"forced upon me"*:

> *"I didn't choose to go for help. I was told that I need to go. But if I spoke to someone about it and if they like made me agree to go for help. Maybe that would have stopped everything."*

The sense of having their autonomy violated was particularly heightened for those adolescents who had experienced inpatient hospitalisation. Catelynn emphasised how the lack of freedom contributed to her feelings of depression: *"I can't listen to my music, what I like. I can't be on my phone and all that stuff. I can't smoke. Nothing… So that made me like more depressed like."* The sense of being *"imprisoned"*, as well as the lack of privacy and autonomy was a concern for many of the adolescents. Nadine described the inpatient setting as being *"stuck in a cage"*. In contrast, the adolescents appeared to appreciate the voluntary nature of the outpatient services. Nevertheless, some of the adolescents did appreciate the containment

offered by the inpatient setting, for example stating that *"being hospitalised was very, very helpful for me"* (Anonymous). Kimberlyn and Leah's conversation during the focus group highlights these different perspectives:

> Kimberlyn: *"You come for the day to talk, and then you go home, knowing that … you are not here, so it was like better."*
>
> Leah: *"Some days that actually scared me, because I was very afraid that I would hurt myself. Some days I would be, I actually don't want to go home. (crying)"*

Hospitalisation exacerbated the loss of autonomy over the embodied self for many of the adolescents. Three of the adolescents described being placed in an adult ward prior to their transfer to the CAMH unit. LDB spoke about this experience, detailing his powerlessness, and his attempts to regain autonomy by trying to avoid showering:

> *"When you go shower, they wake you up 5 o'clock, shower, shower, shower, get your mattress. All you know is, go to the shower, get naked and you just see the line full of naked men. You just stand there and then, the worst thing is they don't go one person by one person, it's like 5 people standing in one shower… And then if you don't do whoever says outside says, to wash your hair, they must do exactly everything they say. Wash your hair, rinse your hair, or whatever, if you don't, they like take the stuff you dry with and like hit you.… Then the second time, it started to get worse, because then I felt like I didn't want to shower anymore. I thought maybe I could like skip, but it didn't work, because they catch everyone. There's a guy waiting for you at the door and then he counts everyone. Everyone."*

At the time of the study, the adolescent unit did not yet have a safe containment area, and therefore adolescents deemed to pose an acute risk to themselves were placed in adult wards. Apart from the concerns that the placement of adolescents in adult services raises, Kimberlyn also clearly described the power differential and the sense of being punished for refusing to take the medication offered to her. Her autonomy over her embodied self is lost:

> *"And then they wanted to give me a tablet, and I refused to take the tablet, so then they said, if you are not going to take it, they are going to transfer me. So then they transferred me, and that was also what messed me up. The way they handled me there, that messed me up, and that is also why I say being hospitalised made it worse. …… I got there, it was at night. I got there, the first thing they did was strip me of all my*

clothing. And they injected me and they put me into a room where there was just a mattress."

The ultimate expression of autonomy over the self is the decision of whether to end one's life. Adolescents asserted their power through conveying their choice over living or dying, as illustrated by Nadine and LDB:

"But nothing can change my mind from now on. I have made up my mind, I want to die. I am going to die. Whether they like it or not. They can't keep me here forever. I am going to do what's right for me." (Nadine)

"And like who are the doctors to say it's abnormal, but it's my choice. It's my life and I don't want to live anymore, but for them suicide, it's like it's abnormal, you need help…." (LDB)

Debbie, however, decided that staying alive was a way of asserting her power by defying those who had bullied her in the past:

"I just came to the conclusion that you took everything, but you didn't take my life… Even though you took everything, I am still standing on my feet and I am still breathing, literally breathing. And that is something that you can't take away from me. That sort of gave me a little bit of strength, you know."

4.3 MAKING MEANING

In trying to make sense of their suicide attempts, the adolescents expressed a variety of understandings. All of them appeared to reach a state where they felt overwhelmed and their choices were narrowed. Attempting suicide was regarded as an escape from their painful experience. Yet, the majority were ambivalent about their suicide attempts, both before, during, and after the event. Although the adolescents incorporated psychiatric terminology when talking about their attempts, their understanding remained grounded in a relational context, that left them feeling insecure, unsafe, and unheard. The subthemes contained within the theme of "Making Meaning" include "Incorporating Psychiatric Speak", "Ambivalence about Living or Dying", and "Narrowed Choices: Suicide Attempts as an Escape and Solution to Problems".

4.3.1 Incorporating Psychiatric Speak

Some of the adolescents incorporated a psychiatric explanation into their understanding of their suicidal behaviour, although no-one solely attributed their suicide attempt to a mental disorder. The adolescents mainly depicted symptoms of depression and anxiety, which were frequently tied in with feelings of worthlessness. Debbie informed me that *"social anxiety is something that ruined my life."* Leah elucidated the role of cognition, telling me that "*my mind is my greatest enemy."* She explained, "*it was just the thoughts in my mind, that was the biggest, biggest contribution, 'cause I was just negative."* LDB identified with his depressive symptoms, choosing the pseudonym "Little Depressed Boy" (LDB) to encapsulate this. His photograph *"Depressive Symptoms"* depicts his unmade bed to illustrate both his excessive sleeping when depressed, and the lack of energy to make his bed. Similarly, the title of the photo *"Blue"* also captures feelings of depression. Anonymous explained that it was taken at school, *"because there are actually a lot of things at school that contribute to my suicide attempts"*. As illustrated by Anonymous's statement, the adolescents linked their psychiatric symptoms to what was happening in their relationships and environment.

Photo 17

"Depressive Symptoms" (LDB)

Photo 18

"Blue" (Anonymous)

All the adolescents had been exposed to psychiatric discourse during their treatment at the hospital, and psychiatric terms had been incorporated into their accounts of their suicide attempts. Yet as described in section 4.1 above, the relational context took precedence in their understanding of their attempts, and proposed solutions centered around improved relationships and an increased sense of belonging.

4.3.2 Ambivalence about Living or Dying

The adolescents expressed ambivalence about their desire to live or die. This uncertainty was expressed during their conversations with me, with wishes of living and dying at times being voiced during the same interview. Anonymous told me, "'*Cause, a lot of the time I'm trying to stay alive but simultaneously that's not my wish."* Catelynn expressed indifference towards life, saying, *"But every day I'm just like, if I should die, if I don't die, it doesn't matter."* Debbie named the confusion experienced during a prior attempt, stating, "*I was confused. I mean if I did die I die, I was ok with it. And today I still want to die. But I am not thinking, do I want to do it?"* Although she was not currently contemplating suicide, it remained an *"option"* that was *"always there"*.

Many of the adolescents told me about their ambivalence at the time of the attempt. Kimberlyn described how she fluctuated between wanting to live and die while attempting to strangle herself, saying, *"And first I tried to get it off and then I just let go because I wanted to die at that moment."* Catelynn changed her mind at the last minute, interrupting an attempt. She told me, *"I couldn't breathe any more, but I wake up on the last minute, I felt like I was going to pass out, then I took the bag off."* LDB explained how he confused his desire to feel pain with a wish for death:

> *"I was like about to like cut my pulse, but I couldn't and then I started cutting more and more and going over it, over and over. And then I realised it wasn't about like killing myself, it was just about feeling pain."*

4.3.3 Narrowed Choices: Suicide Attempts as an Escape and Solution to Problems

The adolescents reached a point where they perceived their lived experiences as unbearable, and their choices appeared to be narrowed. All the adolescents regarded suicide as a solution to their problems, and/or an escape from painful emotions and realities. The quotations in Table 8 illustrate this perception. The desire to escape was frequently linked to strained family relationships. For example, TC said:

"And I had told my dad, I think a week before I did that, that I was not happy at the house, at home, yes… And I wanted to like go to a boarding school or something, I wanted to get away from them because I was not happy. And then he asked me why did I do it, and then I told him, that I had told you that I was not happy, so I was trying to relieve myself from the pain."

Table 8

Quotations Illustrating the Theme "Narrowed Choices: Suicide Attempts as an Escape and Solution to Problems"

"I just wanted everything to stop." (Anonymous)
"I just woke up in the middle of the night and had this really overwhelming emotional negative feelings inside of me and thought, 'this is going on way too long, I can't deal with it any more', and did what I thought I had to do." (Debbie)
"Basically the divorce triggered everything. I just got sick of it. All the negativity in the house and stuff. I just wanted to go." (Dean)
"I was just thinking of, how much better it would be, like I won't have to worry about family problems anymore. I won't have to worry about all the pain anymore, I wouldn't feel anything anymore." (Kimberlyn)
"I just thought I can't take it anymore." (Nadine)
"The whole committing suicide is a sin and you will go straight to hell, but I actually felt like hell would be a much better place to be than this world." (Natasha)
"I was doing everyone around me a favour, just to not have me around anymore." (LDB)
"I thought I was a charity case… and I didn't want to be a burden to her anymore… so that is when I thought, you know what it would just be best if I just end it all." (Catelynn)

Suicide was also regarded as a solution to burdensomeness. The concept of burdensomeness took on salience in a context of historic and socio-economic disadvantage. Leah, Catelynn, and Kimberlyn all expressed how their deaths would alleviate financial pressure on their families. Leah told me:

> *"My suicide was going to help people. There would be one less person to worry about, one less person to pay for, and that money that was spent on me could be spent on the others in the house."*

The adolescents' environment is frequently one of danger, where bodily integrity and autonomy is threatened. Many of the adolescents had been abused, and Nadine's suicide attempt was a way to *"kill"* off the perpetrator, who had abused her. She said:

> *"I took a breadknife, a knife and I put it into my heart, and at the time I was still the same, emotional, angry, and then I looked myself in the mirror and I was crying, crying, and it's like I see him through the mirror and I wanted to do it."*

For some of the adolescents their suicide attempt did provide a sense of solution, as it resulted in a desired outcome. This included increased care by parents or caregivers. Kimberly noted how after her attempt and admission to the hospital, *"Their eyes opened. So now they can tell, okay, if she's like this, then something's wrong, so then they will try and cheer you up. That's nice."* In hindsight, LDB noted that his suicide attempt had offered some form of solution, telling me that *"it's not like I regret it"*, and *"that got me here"* (referring to the CAMH unit). For TC, her suicide attempt enabled her to access help. She said, *"I think I shouldn't have done it… But I am also glad that I did it, because it also helped me… Because now I can come here and speak to a psychologist and tell them how I feel and stuff like that."* Reflecting on their experience, a few of the adolescents recognised that suicide is no longer a viable solution for them:

> *"I don't feel that way anymore, because killing myself wouldn't have made things easier. Like I wouldn't have solved the problem. I would have just created more."* (Kimberlyn)

> *"I have realised that death isn't an escape of anything. Because it will take the pain away, but you'll just be causing more pain for others. I have learnt my lesson, that's why I don't attempt suicide anymore. I have just decided not to live for myself but to*

live for others, try to help others where I can, to make a contribution that way rather than killing myself." (Dean)

4.4 CONCLUSION

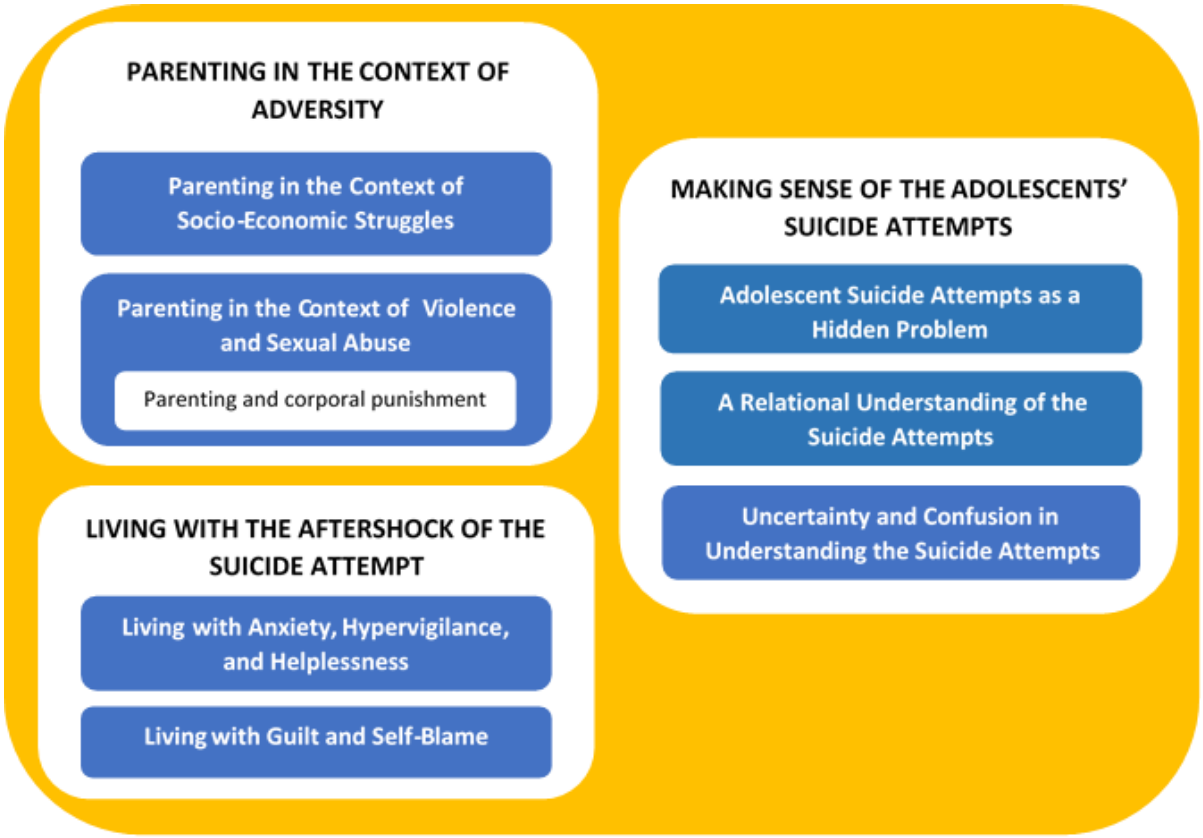
The adolescents provided non-reductionistic accounts of how their suicide attempts were situated within complex relational contexts. Relationships with parents, family members, and peers were described as both the source of their suicide attempts, as well as the solution to preventing attempts. These relationships were situated within and shaped by exposure to abuse, trauma, and financial hardship. Although the adolescents desired protection and validation from their families, the family itself was often a source of danger. The abuse, and the feeling of betrayal associated with having their abuse minimised or denied, was described as contributing to emotional disconnection from their families and to their suicide attempts. The adolescents also spoke about feeling invisible, and desperately wanting to be seen and validated. Younger siblings and pets were described as providing a sense of relational security and were regarded as protective against repeat attempts. The adolescents reported that peers provided a sense of belonging, but also acknowledged sharing and bonding over suicidal behaviours. The adolescents' accounts suggest that they struggled to assert their autonomy in their lives and over their bodies, an experience which was frequently replicated in a hospital setting. Although some of the adolescents appreciated the containment offered by the inpatient unit, others felt restricted and rebelled against their loss of autonomy, for example by refusing medication. Some of the adolescents had incorporated psychiatric explanations and terminology in making sense of their suicide attempts, but ultimately their understanding was foregrounded in the relational. Multiple experiences culminated at a point where the adolescents perceived their choices as limited, regarding suicide as a solution to their problems and an escape from pain. Yet, ambivalence about living and dying was common to most of the adolescents, both before, during, and after their attempts.

CHAPTER 5
FINDINGS: THE CAREGIVERS

This chapter explores the caregivers' accounts of the adolescents' suicide attempts. I have taken the term "caregiver" to denote any adult who takes on the primary responsibility of caring for the adolescent. The caregivers interviewed included parents, as well as members of the extended family. The term "parenting" describes the act of raising the adolescent and is not limited to biological parents. Three superordinate themes emerged from the caregivers' accounts. These are "Parenting in the Context of Adversity", "Living with the Aftershock of the Suicide Attempt", and "Making Sense of the Adolescents' Suicide Attempts". Figure 2 provides an overview of the superordinate themes and their subthemes.

Figure 2

Overview of Themes in the Caregivers' Accounts



5.1 PARENTING IN THE CONTEXT OF ADVERSITY

The caregivers' narratives reflect how contextual challenges impact on their ability to parent the adolescents. Subthemes contained within the superordinate theme of "Parenting in the Context of Adversity" include "Parenting in the Context of Socio-Economic Struggles" and "Parenting in the Context of Violence and Sexual Abuse".

5.1.1 Parenting in the Context of Socio-Economic Struggles

The caregivers described how financial strain and their efforts to earn money compromised their ability to spend sufficient time with the adolescents. Caregivers said they worked long hours, and some described holding multiple jobs, which they said impeded their ability to take care of their children. Maria described both her lack of time and exhaustion from working two jobs. She said: *"Sometimes it is a bit much because I am doing two jobs at the moment."* Lengthy commutes to places of work impacted on the ability to supervise children. Hazel said, *"Because my problem is, I am starting, I am leaving the house at 5 o'clock. I don't know what he's doing after that time."* Reggie told me how he had relocated to the Western Cape with his daughter, due to better schooling and work opportunities. He described how this had split the family unit, and detrimentally affected the relationship between his daughter and her mother:

> *"I had house on that side, ne, the other house. And then her mother was still there, and then we stayed together here…. And I think it's where the gap started between them."*

Some elderly relatives took on the parenting role, due to parents' unemployment and challenges with addiction or mental illness. The government pension received by elderly people is often the sole source of income for the family. Sally and Olivia are both pensioners, who support themselves and various family members on a monthly government pension of R1780 (equivalent to approximately US Dollar 104.37[6]). Olivia told me, *"Now I have to share my pension with them. But we only, I tell them, I can only buy yous food with it".* Food rationing was one of the ways of coping with the lack of resources. Sally said, *"We don't go 'all-out', like many, just take and just eat and just do, we are not like that. I have a routine in the house,*

[6] 1 US Dollar = 17.06 South African Rands. Converted on the 02/07/2020 at currency-convertor.uk

because I am a pensioner."[7] Despite the evident financial strain, Sally expressed a willingness to care for X[8], and an awareness of how X may experience feelings of burdensomeness:

> *"I assured her that it is not a problem for me, the reason I took her in is because I know that her grandmother isn't here, I know her mother is on drugs, I know there's nowhere that she can get help, and it's no effort for me to take her in."*[9]

Olivia emphasised that despite her willingness, it was stressful trying to provide for the children in her care. She reported that the childcare grant intended for X and her sister was being misused by their mother: *"And her mother also, going out with an old guy that's on drugs. Stealing their money, their SASSA*[10] *money. Unless I've got the card, there was hardly any money, she made so many loans."* Olivia had attempted to transfer the childcare grant into her own name but had encountered barriers in an overburdened social service system. This left her feeling unsupported and frustrated in her role as caregiver:

> *"I went to the social worker, because the SASSA people said to me that they can't help me. It must go through a social worker. I went to her and she said to me I must have an affidavit and it's going to lay there for months because they are so full. So then I just left it, I got so…"* (Olivia)

The responsibility of caring for the adolescents was predominantly carried by women. Seven of the adolescents were being raised by a single mother or by a female relative, such as a

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[7] Translated from the Afrikaans: *"Ons gaan nie so 'all-out' nie, soos baie, vat nou net, en eet nou net, en maak nou net, ons nie so nie. Ek het 'n roetine in die huis, en, uh, omdat ek mos nou pensioenaris is"*

[8] I have redacted the adolescents' pseudonyms in this chapter to protect internal confidentiality. All the adolescents' pseudonyms have been replaced with "X".

[9] Translated from the Afrikaans: *"Ek het haar verseker dit is nie 'n probleem vir my nie, die rede hoekom ek haar gevat het is omdat ek weet haar ouma is nie hier nie, ek weet haar ma is op drugs, ek weet daar's nêrens wat sy hulp kry nie en dis nie moeite vir my om vir haar by my te vat nie."*

[10] South African Social Security Agency

grandmother or aunt. Only three of the adolescents were living with both parents, with LDB's father having recently re-entered his homelife after being absent for most of his childhood. Some of the women emphasised how challenging it was to be the primary caregiver. Amari, whose husband lives in a different country, spoke about her exhaustion and the strain of parenting alone. She said:

> *"You know I had a big blow out with my husband because I organised to have a sterilisation…. I don't want any more children. I just can't deal with it no more. You know, I said no, enough is enough, I have three children. I can't, I can't, I don't want to."*

Apart from the economic burden of being a sole parent, the women described being single mothers as emotionally taxing. The women felt overwhelmed and exhausted, expressing the need for support with parenting. Talking about her children's father, Storm said: *"The support that I need, I feel I'm not going to get…. I need their dad to be there for them. He doesn't understand what he's doing to them."* Similarly, Amari talks about needing the father of her children to play his role: *"I cannot take it anymore, I am the only one that has to deal with this problem. Your turn, it's your turn."* LD spoke of the exhaustion of being a single mother and sole breadwinner. She described how the strains of parenting and the burden of being a single mother resulted in her own idealisation of death:

> *"One day the guy from my transport laughed at me, so he says, you look very tired, so I said, yes, I'm very tired, and you know how I envy the dead people. He says, why the dead people? You know what stands there on their name tag or whatever, you may rest in peace, because I'm now going to go and sleep and I must wake up tomorrow and I must get up and go to work again. So he laughed, he says, I never thought people could think of things the way you think of it. So I said yes, we go and sleep, we don't rest. So I do envy the dead people. My husband is now where, having his eternal sleep, whereas I need to still continue doing what needs to be done."*

5.1.2 Parenting in the Context of Violence and Sexual Abuse

The caregivers spoke about the realities of living in communities that have high levels of violence, and the impact this has on their ability to parent and provide safety to their adolescent

children. They felt both anxious and powerless to protect the adolescents. Olivia told me: *"I hate it when she go out… I'm so scared and I worry, ja."* LD spoke about her daughter being sexually assaulted on school premises, a place where *"you're supposed to be protected"*. These fears at times led caregivers to curtail the adolescents' freedom:

> *"Yes, I don't give them much freedom, I'll be honest with you, like you see she is coming for the counselling, I travel with her. They don't know what it is to climb in the taxi*[11] *and go somewhere on their own and come back, I am sorry, it's maybe possessiveness, it's protectiveness, but I just feel you are my girls, anything can happen to you."* (LD)

The caregivers also spoke of the danger of violence within their homes, and the impact of this on their adolescents. Sally, who understood sexual abuse as a factor in X's suicide attempts, pondered whether her own sons were capable of this behaviour:

> *"I have two sons, a son who stays in the house, and I now started thinking many things. But my daughter reassured me, no, she has spoken with X and X said, no, the problem is not here with us, the problem already existed."*[12]

Some of the caregivers linked interpersonal violence to the adolescents' suicidal behaviour. Talking about X's mother, Reggie informed me that *"mom beat her and threatened to kill her and choked her, tried to choke her, and then that really made things even worse…. from what they were before."* He told me that he had underestimated the impact this violence could have on X, adding, *"That situation that is there in the house, I never thought it would lead her to try to take her life."* Olivia related the impact of X's abuse by a relative: *"He was touching her, and he was talking about sex to her. He's supposed to teach her Maths, I trusted him…. That*

[11] "Taxi" refers to the 16-seater minibus vans that are a common mode of shared public transport in South Africa.

[12] Translated from the Afrikaans: *"Ek het twee seuns, en ek het 'n seun in die huis wat bly, en ek het toe nog baie dinge begin dink nou. Maar my dogter het my gerus gestel en gesê, nee, sy't gepraat saam met X, en X sê, nee, dis nie daar by ons die probleem nie, die probleem kom nou al aan al."*

also affected her." LD in turn spoke about how her husband's suicide was an act that was intended to protect their children from the abuse X's oldest sister had been subjected to:

> *"If you read that letter he feels that he was very wrong what he did, it was not his intentions to hurt her the way he did by physically abusing her, and he feels it's best that he is no longer around, because he doesn't want to do that to the other children."*

Despite awareness of the high rates of child abuse and interpersonal violence in South African society, some caregivers questioned the reliability of the adolescents' accounts. LD questioned X's account of sexual assault, because she only revealed it many months after it had occurred:

> *"What's puzzling me also right now, currently, is if something like that happened, surely teachers would have picked it up? You do have close friends who could have picked it up. And you sat the whole day, at school…. So there is a lot of things that I am pondering about…. Why carry it and then you don't speak about it the same time when I come home. You leave it for months later… Do you understand?"*

Grandmother also questioned the validity of X's account of being raped by her stepfather:

> *"And what I am scared of, and I am sure everybody is scared about that, what she has done to her stepfather, because she just write a story, she just tell a story that he raped, you know the people now are just scared."*

Sally shared how X had experienced the family's denial of her sexual abuse at the hands of a relative: *"But to also be resented and told that you are telling lies isn't nice, and you know that it happened."*[13] In other instances, caregivers were reluctant to involve the police or social service systems, because the perpetrator was a family member. For example, Olivia recounted the family's awareness of the past abuse committed by the relative who had abused X. Although the family had raised their concerns with him, no external agencies had been involved prior to the referral to the CAMH unit. Despite acknowledging the impact of the abuse on X, Oliva was defended against the possibility that this man had continued abusing children:

[13] Translated from the Afrikaans: *"Want om verwyt te word ook en sê jy praat leuens is dan nou nie lekker nie, en jy weet dit het gebeur."*

> *"He's been doing this from forty years ago. We don't know what other people, children he did it to…. And now he's got a granddaughter that's 10 years old in the house. She's so depressed, so withdrawn, I don't know why."*

5.1.2.1 Parenting and Corporal Punishment

Another form of violence in the home was the use of corporal punishment. Caregivers described the wide-spread acceptance of corporal punishment, placing it within an intergenerational and cultural context. Amari, for example, told me, *"I don't want to be racially biased now but Coloured people, they like to say, you must discipline the children, you must hit them…*" Some parents regarded corporal punishment as an acceptable form of discipline. Reggie told me how he had beaten both his daughter and her friend (at the urging of the friend's mother) for experimenting with cannabis. He said, *"I took a belt, my belt, I beat X. This lady said you must beat both of them. This one also, you must beat her."*

Other caregivers expressed their unease with corporal punishment, aware of how it may negatively impact on the relationship with their children. Olivia said, *"And I pray to God not to let me touch her…. And so far I haven't hit her for six months now…. Ja, because I don't want to hit her, that don't work."* Amari expressed regret at having hit her child. Describing a conversation with her sister, she told me, "*And my sister was like, you know, I have to shake your hand because it was a good thing, and I am like no, it wasn't. I didn't like the fact that I hit my child."* Amari emphasised the intergenerational transmission of ways of being and parenting, and the effort to challenge those:

> *"I try, it's very hard to reconcile myself with the woman that I want to be, or that I am trying to be, for my children, against the woman that I was raised to be. There is a difference, there's a big difference between that."*

5.2 LIVING WITH THE AFTERSHOCK OF THE SUICIDE ATTEMPT

Caregivers described how they were living in a constant state of anxiety since their adolescents' suicide attempts. Many feared the possibility of another attempt, reporting increased levels of vigilance. Others questioned their parenting ability. These experiences are described in the

subthemes of "Living with Anxiety, Hypervigilance, and Helplessness" and "Living with Guilt and Self-Blame".

5.2.1 Living with Anxiety, Hypervigilance, and Helplessness

Anxiety was palpable in the narratives of the caregivers, who feared their adolescents' death due to suicidal behaviour. The fear of a repeat attempt was described by numerous caregivers, with Reggie for example telling me, *"But I don't know if she can't do it again."* Amari expressed this fear:

> *"I have never, never said to anybody, how afraid I really am. I am afraid that I'll come home one day and find my children dead…. And that is the biggest fear that I have."*

This anxiety led to hypervigilance, with caregivers talking about the need to monitor their teenagers' behaviours and moods. Grandmother told me that, *"I can't leave her alone."* Olivia told me that she would arrange supervision for X if she went out:

> "*My sister is there, my sister will keep an eye on them for me. I always worry if I go out, will she be alright, but ok, so far so good, she never tried it again."*

Amari's account reflects this heightened sense of hypervigilance, saying:

> *"Nobody locks any doors and if I hear a key turn, I get anxious. I am like, why are you two locking the door? Then I go and I (knocks), get out of the toilet, what are you doing in the toilet, come out, come out. And it's like no, and it's like no what, nobody locks doors in this house, you know, I refuse for them to lock doors."*

Some of the caregivers appeared traumatised, reporting how their anxiety and hypervigilance impacted on their day-to-day functioning. Storm spoke about how difficult it was for her to focus at work *"when my mind is working all the time"*. She told me that although *"I can't be with him 24/7"*, she constantly monitored her phone in case her son needed her, saying that "*if he sends me a message, mommy I need you now, I am there."* The suicide attempts also seem to have altered the caregivers' ways of relating to the adolescents in some respects. While Storm was highly attuned to her son's possible distress, other caregivers feared doing or saying something that may trigger the adolescents' suicidal behaviour. Hazel spoke about *"having to*

walk on eggshells" around her son, while Olivia expressed the fear of saying *"something wrong"*:

> *"But I am so scared to say something wrong, and that's going to lead her to cut her again. No, until she get stronger, I am being very firm and loving."*

Mr Wilson alluded to an erosion in the ability to trust his daughter after the attempt, as well as clarifying his feelings of helplessness:

> *"She could have been gone, in the blink of a second, so it was ja it was a very traumatic situation because all kinds of thoughts go through your mind. Ja. All kinds of questions. You basically feel helpless because it's like, you know, you feel helpless, you feel that you can't trust her because you don't know if she is going to do it again."*

The caregivers described how the adolescents' suicide attempts left them feeling helpless and powerless. They expressed not knowing how to assist the adolescents and wanted experts to tell them *"what to do"*. LD conveyed her sense of helplessness, saying, *"I told her, I don't know how to help you. I am being honest, I don't know."* Maria sought help in this regard saying, *"I actually went to see someone to say, I don't know how to cope because I don't know what to do."* Similarly, Amari desired guidance and advice on how to handle her daughter's suicide attempt and its aftermath:

> *"So please tell me, I wish someone can tell me what to do, I wish someone can write a book and say, this is what you do, when this situation happens. But there is unfortunately no book like that, there is no guidelines."*

Apart from guidance on how to handle the adolescent, some caregivers also articulated a desire for emotional support for themselves and their families. Amari acknowledged the need for her own counselling, saying, *"I probably should see someone, but I just don't have the time or the energy to do that, you know. I should talk to someone."* Mr Wilson emphasised how the impact of the adolescent's suicide attempt on the family necessitates a health care system that also provides assistance for the family members:

> *"Let's say a particular child commits suicide and he was under treatment at the hospital, would the doctor that was dealing with the child say to the parents or the rest of the family, 'I think you guys need to go for treatment as well. You need to sit down,*

> *you need to talk'.... I think that would be a good process. Ja. Um, it's just, um, it's just the effect it has on the family. Whether the person commits suicide or whether the person attempts to commit suicide, it's just the effects it has on the family."*

5.2.2 Living with Guilt and Self-Blame

Many of the parents blamed themselves for their children's suicide attempts and questioned their own ability to parent. Hazel described her feelings of guilt, telling me, *"It's just hard for me, like the guilt. It's always there. I just wonder all the time, where did I go wrong? (cries)"* Mr Wilson wondered what the correct way of parenting is:

> *"Ja, and um, you know, you start questioning yourself as a parent. Are you too negative as a parent, or should you be more positive as a parent? And if you are more positive as a parent is the child going to take advantage of that situation?"*

Amari, who told me that *"it's my fault"*, wondered if she was being punished:

> *"Where did I go wrong? Is this punishment? For things that I've done before? Am I being punished? I know I shouldn't look at it that way, but that's how you feel, it's human nature to feel like you are being punished for something. You didn't do something right, you are not being a good mother."*

5.3 MAKING SENSE OF THE ADOLESCENTS' SUICIDE ATTEMPTS

In attempting to make sense of the adolescents' suicide attempts, caregivers endorsed multiple, and at times contradictory, accounts. These ways of understanding are described in the themes "Adolescent Suicide Attempts as a Hidden Problem", "A Relational Understanding of the Suicide Attempts", and "Uncertainty and Confusion in Understanding the Suicide Attempts".

5.3.1 Adolescent Suicide Attempts as a Hidden Problem

Caregivers described suicidal behaviour as a hidden problem, emphasising the unexpectedness of the adolescents' suicide attempts. They expressed shock that despite living under the same roof, they were unaware of the adolescents' suicidal behaviour. Sally told me, *"She hid it well…*

that's why it was such a shock for me."[14] Maria was shocked to find out about the suicide attempt from the school. She said, *"Sonja, you know, when I got that phone call from the school, I was like, what is going on here? Why don't I know, we live in the same house, what is happening here?"* Storm was concerned that her son continued to hide suicidal behaviours from her, saying, *"I don't know if there has been any more attempts that I maybe do not know of."*

A few of the caregivers attributed the adolescents' secrecy to their developmental stage. Mr Wilson highlighted a general sense of secrecy concerning adolescents' lives, saying, *"The children sometimes hide things from their parents. And the parents say I didn't know that about my child."* LD felt angry and hurt that her daughter hid certain things from her, including her suicide attempt. She said, *"I am the mother of this house, but I am a stranger, because I don't even know what is going on."* Amari, who described X's suicide attempt as *"just out of the blue"*, attributes this secrecy to the adolescent stage of development:

> *"I am in the house with them all the time, but I don't know, but that's teenagers for you. You know, they are so clever. They just know how to hide things from you as a parent."*

Some caregivers suggested that if adolescents communicated their concerns, this may prevent suicidal behaviour. Yet, some of them struggled to reflect on their own role in the communication difficulties. Hazel expressed the futility of attempting to elicit communication, telling me, *"But how many times do I ask, X what's wrong? But he don't want to talk."* Storm related how a lack of communication could contribute to a suicide attempt:

> *"But maybe if they're just more open about it and talk about it, because they tend to hide these things and keep it in and not telling anyone about it. And when it eventually gets too much, then that's normally the time when it is too late."*

5.3.2 A Relational Understanding of the Suicide Attempts

Many of the caregivers partially attributed the adolescents' suicide attempts to relational difficulties with parents, family members, or peers. Talking about X's attempt, Olivia stated,

[14] Translated from the Afrikaans: *"Sy't dit mooi weggesteek... Daarom was dit so 'n skok vir my."*

"Well, she became unhappy because of her mother and her father." Hazel considered the importance of the familial context, attributing X's suicide attempt to the desire to escape from a difficult home environment. She told me, "*Because he want to get away out of his situation in the house. I don't know, he could have tell me he is not happy with his dad living there, instead of doing this."*

Some of the caregivers understood the relational difficulties between parents and their adolescents to be situated within a context of endemic substance use. Some parents were unable to provide the necessary care due to their addiction. For example, Sally told me, *"Her mom is addicted, yes, her mom is addicted"*.[15] Hazel spoke about the impact on X, saying, "*I asked his dad not to drink, please…. That's the main factor, because he is drinking."* She elaborated on the communicative function served by the father's intoxication:

> *"I told him to leave the children alone, like he don't talk to them when he's sober. Now when he's drunk he must tell you how I love you and all that stuff, now he want to talk to him."*

Caregivers expressed how the adolescents felt uncared for by their parents, linking this to their suicide attempts. Sally explained that *"she probably feels that she has no one, no one cares for her"*.[16] Similarly, Grandmother stated, *"She just say that her mother doesn't care about her."* Maria believed that improved relationships with parents would prevent adolescent suicide attempts:

> *"And I feel that, you know if you have kids that's your responsibility, you have got to love and you've got to care for them. You have got to be there for them. And from my perspective they are not."*

Some of the parents pondered how their own relationships with their adolescents may have contributed to the adolescents' suicidal behaviour. LD told me, *"because I seem also to be the problem in a way"*. She added, *"the thing is, like I say, the relationship, the communication*

[15] Translated from the Afrikaans: *"Haar ma is verslaaf, ja, haar ma is verslaaf."*

[16] Translated from the Afrikaans: *"Sy voel seker maar nou sy het niemand nie, niemand nie gee om vir haar nie"*

between me and her is not so good." Some parents blamed themselves for their adolescents' suicide attempt, as described in section 5.2.2.

Caregivers also considered relationships with peers as influencing their adolescents' suicidal behaviour. This included the role of bullying. Storm said, *"in most cases like when kids feel suicidal it's because of bullying and stuff"*. A few of the caregivers thought that relationships with peers, who engaged in suicidal behaviour and talk, may have influenced their adolescents to consider this as an option. LD opined, *"Maybe she don't know the right steps, and the idea of maybe suicide is continuously hearing from her friend, I'd rather kill myself."*

Attention-seeking was considered as one possible explanation for the adolescents' suicide attempts. Grandmother felt that, *"She just want everybody to, you know, to look at her. At the time she is trying to do that. Just haai! Yoh! You know?"* Yet other caregivers expressed ambivalence around attributing suicidal behaviour to attention seeking. For example, Mr Wilson told me, *"The word is attention, that plays a big part in my philosophy."* Yet he also questions this understanding: *"Is she looking for attention? Or is it, I'm seriously struggling here."* Maria expressed similar uncertainty:

> *"Sometimes I feel, is it looking for attention? Is it something serious? That's why I'm in like a catch 22, I don't know."*

5.3.3 Uncertainty and Confusion in Understanding the Suicide Attempts

Caregivers held multiple and at times contradictory understandings of their adolescents' suicide attempts. Some of the explanations echoed those supplied by the adolescents. These included regarding suicide as an escape or solution to problems, as well as an attempt to alleviate burdensomeness. Examples of these forms of understanding can be found in Table 9.

Table 9

Caregivers' Understanding of Suicide Attempts Shared with Adolescents

Escape	Solution to problems	Alleviating burdensomeness
"She just felt that it was too much. Everything was too much for her." (Amari)	"*Most probably she felt that there was no answer to her or no solution to the problems that she had, um, because at that stage she was, she just didn't want to go to school anymore, because of the bullying"* (Mr Wilson)	*"She would rather kill herself because she doesn't want to be a burden to other people."*[17] (Sally)

Suicide attempts were understood to occur within challenging contexts. In LD's words, *"Some might be living in unimaginable situation that leads them to do things like that."* Despite this acknowledgement, she felt that, *"Today's kids, the way I look at it is, they give up too easily…. They don't see possibility."*

Most caregivers' narratives did not reflect a biomedical or psychiatric understanding of the adolescents' suicide attempts. Olivia however endorsed a medical explanation offered to her, telling me that, *"Ja, they can't help it that, the doctor was telling me, the chemicals in the brain, there is too much or something like that, that's why they need a tablet to calm them."* Grandmother was ambivalent around accepting depression as a cause for X's suicide attempt, saying, *"But I wish I can get what's wrong with X. If it's that depression, I don't know what is the cause of the depression."*

[17] Translated from the Afrikaans: *"Sy wil haar maar liewer vir haar doodmaak want sy wil nie 'n las wees vir ander mense nie."*

Apart from a multitude of ways of understanding, caregivers expressed uncertainty and incomprehensibility in their explanations of the adolescents' suicide attempts. Maria told me that the reason for X's attempt was unknown, something *"that's between her and herself"*. Amari expressed the sense of incomprehensibility: *"I don't understand it. I don't. Even though she has now been in here for a couple of weeks. I still don't understand it. I still don't get it."* Reggie highlighted that the complexity and uniqueness of every adolescent's lived experience meant that there was no uniform approach when contemplating suicide prevention:

> *"I think that one differs, on the causes, on the causes… They have different reasons to do that thing. Yes. So I think that, that will differ on the reasons. That will depend on the reasons."*

5.4 CONCLUSION

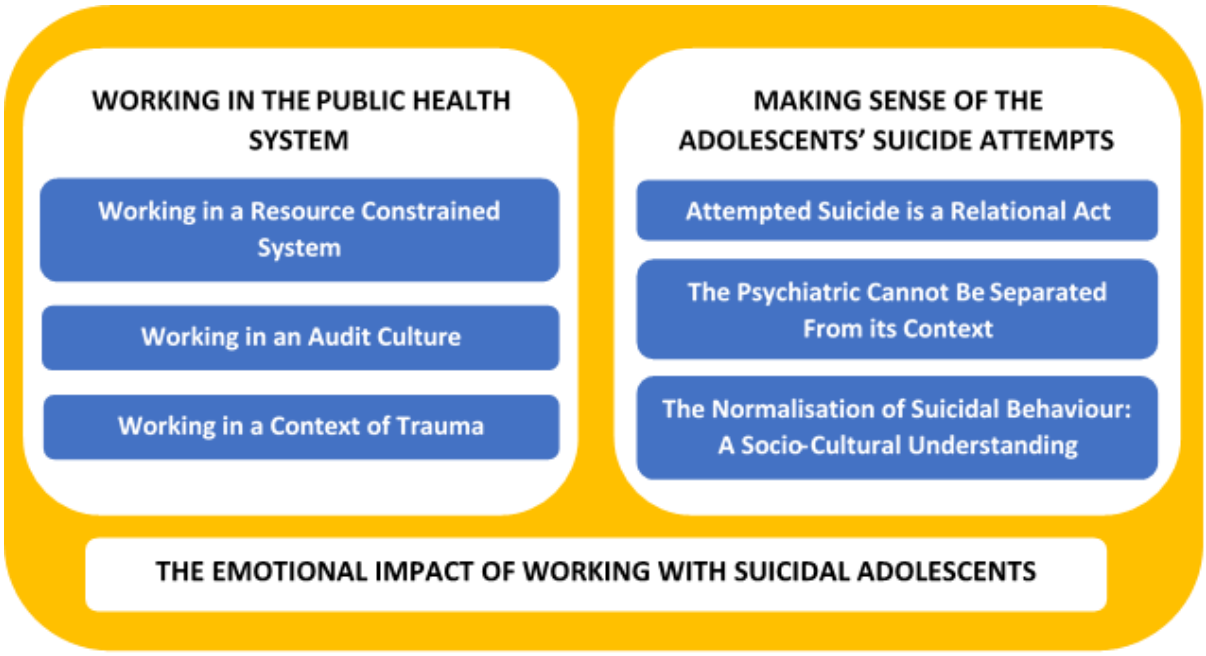
Caregivers described how living in a context of adversity increased the challenge of effectively parenting the adolescents. Caregivers were protective of their adolescents, linking interpersonal violence to the adolescents' suicide attempts. Yet they at times minimised the violence that intruded into the familial space. Caregivers were fearful of further suicide attempts by the adolescents, living in a state of hypervigilance and anxiety. They expressed uncertainty about their understanding of the adolescents' suicide attempts, describing the behaviour as hidden and unexpected. Explanations for the attempts were multiple, complex and, at times, contradictory.

CHAPTER 6
FINDINGS: THE CLINICIANS

This chapter describes the clinicians' accounts and understanding of the adolescents' suicide attempts. For brevity, the term "clinician" is used interchangeably with that of health care professional. Three superordinate themes emerged from the clinicians' narratives. These are "Working in the Public Health System", "The Emotional Impact of Working with Suicidal Adolescents", and "Making Sense of the Adolescents' Suicide Attempts". Figure 3 presents an overview of the superordinate themes and their subthemes, which I will discuss in this chapter.

Figure 3

Overview of Themes in the Clinicians' Accounts



6.1 WORKING IN THE PUBLIC HEALTH SYSTEM

Clinicians described how systemic resource constraints and an institutional audit culture impacted on their work with suicidal adolescents. They voiced their frustrations with the system and described how it impeded their ability to reduce the risk of suicide in their adolescent patients. Themes contained within the superordinate theme of "Working in the Public Health System" include "Working in a Resource Constrained System", "Working in an Audit Culture", and "Working in a Context of Trauma".

6.1.1 Working in a Resource Constrained System

Clinicians spoke about how resource constraints in society and the public health and social service systems impacted on the adolescents in their care. Resource constraints were understood to influence the adolescents' wellbeing, as well as the ability of staff to provide the necessary services:

> *"I think in South Africa we have very unique challenges. There isn't enough money, there isn't enough training, because there isn't enough money. There isn't enough support, because there isn't enough money. These children are in this position, because there isn't enough money and work and that seems to be like the recurring theme, like resources."* (James)

Some of the clinicians spoke about inadequate numbers of health care professionals in the public health system. They mentioned long waiting lists at the CAMH unit. Adolescents and children who are at risk of suicide are prioritised, although they *"don't get seen fast enough"* (Thandi). This impacts on other patients, who are already on the waiting list:

> *"It's really hard because you land up prioritising high risk suicide cases and then self-harm and then you have other adolescents who didn't present with that as their index presentation, but who might develop that because they're not getting seen to soon enough."* (Thandi)

The lack of experienced nursing staff was mentioned by some of the clinicians. Peter told me: *"We are only relying on the old nurses, you see, their experience"*. Blommie says that the unit tries to address this by doing *"a lot of in-service training"* and emphasised a need for adequate training on how to manage suicidal adolescents in the public health system. The *"failure of the*

system" (Anna) was also described in relation to social services. James spoke about how an overburdened foster care system resulted in adolescents being *"bounced"* (constantly moved between placements). He remarked how this had contributed to the suicidality of one of the adolescents in his care, explaining, *"She also had like nine foster placements and each one worse than the other one, and being abused and molested in some of them…"* Clinicians said that these systemic failures made it difficult for them to ensure a safe and consistent environment for the suicidal adolescents following their discharge from inpatient care.

6.1.2 Working in an Audit Culture

Clinicians described working in an audit culture that focuses on statistics, and how this impacted on the services offered to suicidal adolescents and their families. They spoke about a disconnect between managerial structures and clinicians, and a diminution of the complexity of their work. Thandi for example noted: *"In public health, there is a big emphasis on statistics, and how many patients you are seeing and there isn't an appreciation in child psychiatry of what seeing one patient entails."* The emphasis by hospital management on statistics, in combination with the high patient load, meant that clinicians felt pressurised to offer short term interventions. Anna told me: *"I thought, you know, this child is only going to have the opportunity to be seen for like a maximum of eight sessions, so I need to figure out what I can do to actually help her."* David expressed frustration with this restriction: *"I could just rant on about the need for therapy that goes on for longer than just like four months…."* Clinicians emphasised that effective and ethical interventions with suicidal adolescents frequently required longer term work:

> *"We've got a lot of short-term evidence-based treatments, but a lot of these children don't need that, they need a longer term, intensive work. A lot of family work and family intervention and social work will do, and it just isn't always ethical to do a ten or twelve session treatment with a child who has gone through what a lot of these have gone through."* (Thandi)

6.1.3 Working in a Context of Trauma

The clinicians emphasised the trauma that they were relentlessly exposed to through their work, including adolescent suicidality. James spoke about *"trauma, and stuff that can cause like*

PTSD levels of stress". For staff who had been working in the system for some time, there was a risk of desensitisation. As Thandi mentioned, staff *"become cut off*". The adaptation to and normalisation of the high levels of trauma is described by James:

> *"You sit in a ward round and then a new intern that has no experience walks in and sits in the back and half way through the ward round discussion you can see on their faces, and it takes you a few seconds to go, oh ja, they are not used to hearing this every single day…*"

Staff coped with the systemic trauma through informal debriefing with colleagues, although this also had unintended effects. Thandi said, *"We land up using our ward rounds and meeting times to debrief and unload, which is really important, but of course it means that case presentations get delayed, that everyone gets more overloaded"*. Some clinicians expressed the desire for a formal space in which they could debrief. As Nina told me, *"it's a very heavy toll on one and there is little support from a work point of view, for people to sit with that anguish."* Blommie requested *"a debriefing session, where we could just raise some concerns, would be nice, but more at a formal level, not just us in the ward."* Claire expressed how resource and institutional constraints hindered access to a support group for staff:

> *"I think a support group would be good. I know that the unit has tried to access one, but I think the system again, I think systems and managers sometimes forget what it's like for us who have to work at the coal face."*

Some clinicians recommended external therapy or supervision. Although clinicians have access to a limited amount of sessions through the employee wellness programme (known as ICAS), Peter mentioned concerns around confidentiality, saying that *"gossip starts from the management to the boardroom"* and that *"if you actually go and see the ICAS, it's gonna be all over the hospital".* He also spoke about possible stigma for seeking help and the intersections between race and gender, telling me that *"especially for male nurses, African male nurses, if you come and consult it's like you are weak".* Yet the option of accessing private therapy or supervision was regarded as financially prohibitive by many of the clinicians. James commented that: *"The best thing would be if I could afford, for example, to see someone myself."*

6.2 THE EMOTIONAL IMPACT OF WORKING WITH SUICIDAL ADOLESCENTS

Clinicians spoke about the unpredictability of the suicidal adolescents they worked with. Claire stressed the difficulty in predicting *"what's going to happen in the next hour or what could possibly set them off tomorrow."* The role of impulsivity and rapid fluctuations in suicidal behaviour were emphasised by Nina, who said: *"They might sort of be ok when they leave and then the smallest trigger might happen and then they might be impulsive again and do it again."* The impact of this unpredictability on the health care workers was described as *"intolerable at times"* (Tess). Clinicians mentioned feeling *"helpless"* (Claire, David) and *"emotionally drained"* (Peter). Heightened levels of anxiety were reported by all the clinicians. Blommie spoke about *"hypervigilance, but on a different level"*, while James mentioned the *"pressure"* of the work. Clinicians feared that adolescents may kill themselves between sessions. David alluded to this anxiety, saying: *"I was there hoping the next week they're going to come back without…"*, and Tess said: *"It feels risky all the time. And I am always thinking about it, I am always feeling anxious. Um, and kind of anticipatory anxiety about the unpredictability of it all, you know*."

The clinicians describe feeling a tremendous sense of responsibility for the welfare and continued life of the adolescents in their care. Anna spoke about this *"feeling of responsibility"* and the *"very serious consequences"* if she did not perform her role well. Apart from fearing the adolescents' death, clinicians said they worried about how others (colleagues and the public) would perceive them and their profession if an adolescent suicided. Nina said, *"But I almost get the feeling other people feel, ja, we as the health profession should feel ashamed because we have failed the child."* A few clinicians questioned the expectation placed on clinicians to prevent an adolescent in their care from suiciding. Tess, for example, stated, *"No one has the power to prevent suicide. You know, as much as we tell ourselves that we do, I don't believe we do."* Blommie also wondered whether suicide prevention was a realistic expectation: *"I don't think there would have been anything that could have prevented or stuff like that, 'cause she's got the supportive family."*

Clinicians coped with the sense of responsibility for preventing the adolescents' death by trying to demonstrate their competence to their colleagues and managers. For example, Tess told me that: *"I always have a need to explain what I did and what I didn't do."* Clinicians said they

made use of *"risk assessments"* and documentation in order to *"cover"* themselves and demonstrate clinical competence. Yet some of the clinicians questioned the clinical utility of risk assessment scales and checklists. For example, Claire said that risk assessments were at best a *"snapshot of that particular hour of that particular day, but you can't use it to say anything about the next hour."*

Some of the clinicians reflected on the impact that their hypervigilance and anxiety about accurately assessing suicide risk had on their work with the adolescents. David described his experience: *"I needed to ask about ideation, intent, planning, a method, all that sort of thing. And I felt like a parent."* He added that the suicidality at times was *"a symptom of what we actually need to talk about".* The counter-therapeutic impact of foregrounding risk in the work was also mentioned by Claire:

> *"I think the hypervigilance isn't always helpful. I think sometimes it can be counter-therapeutic, because one then tends or the team then tends to focus on suicide risk instead of thinking about the other therapeutic factors that could be focused on or worked on…"*

Another means of coping with the anxiety elicited by the work was relying on colleagues for a second opinion. This allowed the clinician to: *"Spread it, share it… then you feel more safe"* (Nina). A few of the clinicians highlighted the increased stress of working with adolescents as outpatients, while in an inpatient setting there is the *"comfort of knowing that at least they are safe"* (Claire). This resulted in the contradictory position where those adolescents deemed to be at higher risk of suicide were perceived as easier to manage:

> *"The highest risk ones are a bit easier to manage, because I can involve other team members… they get admitted and they won't be able to go home without, without really being cleared of that. It's more the kind of lower more chronic risk that fluctuates, that's harder to manage because I know that or I fear that in some of those cases, the risk can become high quite quickly..."* (Thandi)

6.3 MAKING SENSE OF THE ADOLESCENTS' SUICIDE ATTEMPTS

The superordinate theme of "Making Sense of the Adolescents' Suicide Attempts" includes the themes of "Attempted Suicide is a Relational Act", "The Psychiatric Cannot Be Separated From its Context", and "The Normalisation of Suicidal Behaviour: A Socio-Cultural Understanding". Some of the clinicians' ways of understanding the adolescents' suicide attempts overlapped with those of the adolescents and caregivers. This included interpreting suicide attempts as an escape, a perceived solution to problems, or an alleviation of burdensomeness. Examples are provided in Table 10. Clinicians believed that the adolescents' desired outcome was not necessarily death, and that the adolescents struggled consciously to separate their desire for escape or resolution from a wish for death. Thandi said: "*I think the other thing is, particularly this age group, is distinguishing between just wanting to disappear, just wanting to not be around, wanting to exit, and then actually wanting to kill oneself."* Similarly, David explained: *"I think it was more an attempt to escape those feelings and get away from those feelings, than it was her actually wanting to die."*

Table 10

Clinicians' Understanding of Suicide Attempts Shared with Adolescents and Caregivers

Escape	Solution to problems	Alleviating burdensomeness
"Feeling like there was no other way out" (Anna)	*"She's tried everything now up to that point and there wasn't another solution."* (James)	*"Maybe I am, with all my badness, causing so much trouble for my mom and dad, that I would be better off, they'd be better off without me. I think there was a possibility that there was some of that going on."* (David)

6.3.1 Attempted Suicide is a Relational Act

Clinicians said they understood the adolescents' suicide attempts as relational acts. Tess described suicidal adolescents as reaching *"a point of complete disconnect from themselves, and from other people."* Thandi emphasised the centrality of relationships, saying:

> *"I don't think teenagers are thinking I've got no prospects in life, I am not going to get a job, I am not going to get rich, and then commit suicide. I don't think it's about that, I think it's about the relationships they're having and what's happening in those relationships.*"

Clinicians understood the adolescents' relationships with their parents and families to be central in their suicide attempts. For example, Claire stated: *"One of the contributing factors does seem to be family. And either feeling isolated or ostracised within the family or feeling misunderstood or not understood by the family. That, that plays a role."* Clinicians described how the socio-economic and historical context increased the challenge of effectively parenting the adolescents. David commented on "*the impact of being a working-class parent and the pressures that that puts on parents"*, while Thandi said:

> *"I think in places where there's a lot of trauma in the society, a lot of inequality, a lot of violence, a lot of those things, socio-economic abuse, and like the history that we've got, then there is more chance for that to develop. Parents are faced with more difficulties."*

Suicidal behaviours were also regarded as a way to assert power within the parent-child relationship, in James's words: *"a way of trying to take power back"*. Tess similarly described an adolescent's suicide attempt: *"It felt very powerful for her in particular. Because she knew the reaction that it got from people, she knew the seriousness of it."* Nina described *"a manipulative sort of element to it"*, saying: *"So we take it serious, but one always have the feeling, you know, is the child not just trying to get his own way."* David related how an adolescent's suicide attempt was used to punish a parent: *"He kind of acknowledged that by killing himself, he could ultimately get back at his father, and punish his father."*

Clinicians spoke about the role of secure relationships in preventing suicide. David commented that an attempt may have been prevented *"if she had a relationship that felt safe and holding"*. Other clinicians spoke about the need for *"good communication between the parents and their children"* (Nina), and *"more understanding"* (Thandi). Some clinicians recommended working with the caregivers themselves, either in the form of therapy for the parent or to assist with parenting skills, as an important aspect of preventing future suicidal behaviour. For example, Anna commented: *"I think mom's also very overburdened and overwhelmed. She feels almost like at the end of her psychological tether in a way, and she needs her own support very badly."* Yet, clinicians noted that this was not always easy to do, as illustrated by Thandi's observation that some parents are *"not open to shifting themselves"*. She questioned the poor attendance at parenting skills workshops: *"Is that because we run a really crappy workshop… or is it because parents don't see a problem with their parenting, they don't want to be confronted with it, or they don't see themselves as the problem, the child is the problem."*

6.3.2 The Psychiatric Cannot Be Separated From its Context

Clinicians endorsed a psychiatric understanding of adolescent suicide attempts, although they also emphasised the interplay with contextual factors. Thandi for example stated: *"There is so much that teenagers in under-resourced areas in this country face, that it's not surprising that they present with all sorts of psychiatric things from addiction to suicidality to risky behaviours."* Anna linked her patient's suicide attempt *"to the sexual assault… and the associated PTSD"*. James described how psychiatric symptoms would often diminish on admission: *"She is not the first child that's come and then gotten here and then just like a lot of the symptoms just start lessening and, you know, because it's the environment."* Claire pondered the temporal relationship between contextual factors and psychiatric disorders:

> *"In my experience there has been an underlying psychiatric disorder. So yes, but I am not always sure which one came first. Did the self-harming behaviour precede the psychiatric symptoms, was it part of the psychiatric symptoms, did the psychiatric symptoms come before and that led to the suicidal behaviour, so I am always not quite sure which one came first. And how they have contributed to each other."*

At the same time, she cautioned against over-medicalising the adolescents' presentation, expressing a desire not to pathologise the adolescents:

> *"The focus is so easily put just on the cluster B traits and that we need to watch for an emerging PD[18]. And I don't think it's always appropriate, I think sometimes there is a connection, but I don't think it should be the first assumption."* (Claire)

Clinicians' understanding of the adolescents' psychiatric presentation being intertwined with the contextual, influenced their ideas about suicide prevention. They expressed awareness of the limited role of the health care system, and stressed that there were no simple, short-term solutions:

> *"It's all long term and I think beyond perhaps working with the system and with the family and I think all one can do once they present is working with the child. And teaching them those inner resilient resources that they can utilise. But it is about changing the environment of the child. And what they're exposed to."* (Claire)

Some clinicians mentioned community involvement as a possible way to decrease the prevalence of adolescent suicide attempts. Peter described community outreach as *"the best"*, adding that *"we must identify people that are gonna work with us hand in hand"*. James expressed similar sentiments:

> *"I feel that the most neglected part is community building. It's having a centre or a place where you can do both prevention and aftercare work. By giving these kids either skills or giving them a place to relax, you can remove them from that environment."*

Blommie emphasised how community involvement and support superseded psychoeducation about suicide when considering preventative work. She said, *"The kids know everything really. They've got access to social media and stuff, I just think the support of the community itself, that, that."*

6.3.3 The Normalisation of Suicidal Behaviour: A Socio-Cultural Understanding

Clinicians considered the socio-cultural context as possibly contributing to suicide attempts among adolescents. James described the *"rise of the anti-hero"* in popular culture, and how this may contribute to the *"normalisation"* of suicidal behaviour. He explained: *"So they take*

[18] Personality disorder

that typical angsty teen stuff and now it's being put in a light where suicide is now suddenly a solution… the almost normalisation, that is what people do." He added, *"With that normalisation… comes this thing that it's an option."* Nina described how at times adolescents who have suicided become *"almost like the hero"* and are glorified by the peers left behind.

Clinicians discussed the possible influence of popular culture on the adolescents' suicide attempts. "13 Reasons Why", a TV series that centres around the suicide of a female adolescent, was popular at the time of this research. Speaking about 13 Reasons Why, Claire mentioned how the adolescents' suicidal behaviour *"becomes like a replica of behaviour that they have seen that they imitate"*. Thandi wondered about whether suicidal behaviour could become fashionable:

> *"Committing suicide becoming less of a foreign thing and being more prevalent and almost being a bit catchy. I think with some teenagers, like self-harm and eating disorders, and it becomes almost trendy, and I wonder if that happens with suicide."*

6.4 CONCLUSION

The clinicians described the adolescents' suicide attempts as inseparable from their context, offering multi-dimensional understandings. They foregrounded suicide attempts as relational in nature. Yet the pressures of the clinicians' work context, combined with a resource constrained public health system, made it difficult to provide the relational security desired by the adolescents. Clinicians reported feeling anxious and helpless when working with suicidal adolescents. This resulted in prioritising risk assessments, at times distracting from a therapeutic focus. Improved relationships, particularly with parents, were regarded as critical to preventing adolescent suicide attempts.

CHAPTER 7
DISCUSSION

In this chapter, I synthesise and reflect on the perspectives of the adolescents, their caregivers, and clinicians. I critically discuss these findings in relation to the literature and bring my own interpretation of the findings to the fore. The kind of qualitative research methods used in this study does not allow me to draw conclusions about the causes of adolescent suicide attempts, a point that I will return to in the final chapter. Nonetheless I will, where appropriate, make links to theory and practice by hypothesising about what the findings might mean for advancing the field of adolescent suicide prevention and the development of theory in this domain.

7.1 RELATIONAL ASPECTS OF UNDERSTANDING ADOLESCENT SUICIDE ATTEMPTS

The adolescents, their caregivers, and clinicians consistently said that they understood the suicide attempts as a function of the adolescents' relationships, particularly difficult relationships with parents. This finding is consistent with existing research that emphasises the role of relational difficulties in adolescents' suicide attempts (Grimmond et al., 2019; Lachal et al., 2015; Latakienė & Skruibis, 2015). The adolescents in this study described feeling misunderstood, unloved, and rejected by their parents, mirroring feelings described by other suicidal adolescents in similar studies (Holliday & Vandermause, 2015; Nicolopoulos et al., 2018; Orri et al., 2014). Similarly, the clinicians also described the adolescents as misunderstood, isolated, and emotionally disconnected from their parents, and identified this as a precipitating factor in the suicide attempts. Some of the caregivers in turn described the adolescents as uncared for by their parent(s), saying that this influenced the adolescents' decisions to attempt suicide. However, those caregivers who were the adolescents' biological parents noted that this observation did not describe their own relationship with the adolescent but rather that of an uninvolved co-parent. Both adolescents and their caregivers also identified bullying by peers as contributing to the adolescents' suicide attempts, supporting the findings of both qualitative and quantitative research (Castellví et al., 2017; Katsaras et al., 2018; Lachal et al., 2015). All three groups of participants understood improved relationships with parents as essential for the adolescents' recovery, and suicide prevention in general, as also reflected

in the literature (Lachal et al., 2015; Orri et al., 2014). In the subsections below I will discuss the various aspects of the relational dimensions of the adolescents' suicide attempts, including those related to caregivers, siblings, and peers.

7.1.1 Family as a Source of Safety and Danger

The participants highlighted how the family was both a source of physical and psychological threat, but also a source of safety and protection. They spoke of family relationships as a contributing factor to adolescents' suicidal behaviour, for example when adolescents felt betrayed by caregivers. However, they also said that family relationships could potentially be a protective factor and that relationships within the family, for example attachments to siblings or pets, could ameliorate the risk of suicidality. The adolescents explicitly said they desired protection and understanding from family members who often minimised or denied their experiences of abuse.

7.1.1.1 Betrayal by Those Meant to Protect

The adolescents described being physically and sexually abused, mostly within their families, and how this abuse had been minimised or denied by their caregivers. They described feeling betrayed, angry, unimportant, and helpless when the perpetrators were protected by the family's unwillingness or inability to face the abuse. The adolescents explicitly linked their suicide attempts to their experience of abuse and the lack of protection by their families. Indeed, some of the caregivers corroborated the adolescents' perceptions of their families' reactions (or lack thereof) to their abuse. Some caregivers said that they doubted the adolescents' accounts of sexual abuse, while others clearly minimised or denied the impact of sexual and physical abuse on the adolescents. Corporal punishment was another form of violence in the home. Some caregivers did not regard this as problematic, but others were aware of its detrimental impact on their relationship with the adolescent and described trying to break this intergenerational pattern of behaviour. There was an inherent contradiction in the caregivers' narratives; they expressed concern for the adolescents' safety, with some caregivers describing being overprotective and vigilant to possible dangers in the community, but simultaneously minimised the violence that occurred within the immediate and extended family.

Similarly to the findings of this study, adolescents from a variety of geographies, including South Africa (Aspaslan, 2003), have ascribed their suicide attempts to violence within the family, and physical and sexual abuse (Grimmond et al., 2019; Nicolopoulos et al., 2018; Rice & Tan, 2017). These observations also align with quantitative research in which interpersonal violence and adverse childhood experiences, including physical and sexual abuse, increased the risk of adolescent suicide attempts (Castellví et al., 2017; Cha et al., 2018; Cluver et al., 2015). The high rates of adolescent abuse in South Africa (Meinck et al., 2016) are therefore pertinent to discussions of adolescent suicide prevention. While many theories of suicidal behaviour identify the role of emotions such as hopelessness in the aetiology of suicide (e.g., Beck et al., 1989; van Orden et al., 2010; Wenzel & Beck, 2008), few theories acknowledge how experiences of betrayal (particularly betrayal by people who are responsible for taking care of the adolescent) may be a central component precipitating suicidal behaviour. While my findings do not allow me to make inference about causality, the findings do point to the need to explore how experiences of betrayal may increase adolescents' risk of suicidality. One qualitative study that has explored this theme reported that young female Latinas living in New York named their parents' failure to protect them from abuse as influencing their suicide attempts (Zayas et al., 2010). Zayas et al. (2010) theorised that the adolescent suicide attempts were an expression of anger towards parents for failing to protect them. This hypothesis appears to be supported by studies among adults, for example perceptions of institutional betrayal by veterans exposed to military sexual trauma have been associated with increased odds of attempting suicide (Monteith et al., 2016).

Truth Danger Theory (J. Anderson et al., 2012) postulates that "fractured reality" is a driver of adolescent suicide. "Fractured reality" refers to "a marked disparity between the young person's experience of relationships in the family and the family's own account of their situation" (J. Anderson et al., 2012, p.130). Anderson and colleagues (2012) hypothesise that this fractured reality arises because the family, consciously or unconsciously, is denying or trying to hide aspects of the family's functioning or history. Acknowledging these aspects of the family's reality would threaten the adolescent or other family members (the "truth danger"). Where the truth is not openly known, it is referred to as the "hidden truth", while where it is known but uncontained, it is named the "raw truth". The adolescent fears not being believed; fears that talking about it may create trouble for themselves or the family, or that the family or clinicians may think of them as mad if they raise their views. Within this conceptualisation of

adolescent suicide attempts, we can understand how the reality of the adolescents in this study could have been fractured by their experience of abuse and the incompatible experience of their family's denial or minimisation of the abuse. When caregivers deny the adolescents' abuse (the "hidden truth") or minimise and do not address it (the "raw truth"), the adolescents feel as if they are at a "dead end". Their suicidal behaviour then becomes a way for the adolescent to change their reality and to attempt to repair the fracture by forcing the caregivers to acknowledge and confront the abuse. This formulation of the adolescents' suicide attempts has clear implications for supporting the recovery of suicidal adolescents and suggests that it is important for clinicians to validate the adolescents' experiences, to address allegations of abuse, and to work with the family system as a whole. It may also be necessary to offer the adolescents containment in an inpatient unit or another safe space, if so desired, while allegations of abuse are addressed.

In trying to understand the lack of protection afforded to the adolescents and their caregivers' minimisation of abuse, we need to consider the experience and personal histories of the caregivers. All the caregivers grew up in the era of apartheid, with institutionalised violence and abuse, and most continue to live in resource constrained environments with endemic rates of crime, poverty, and unemployment. Furthermore, the caregivers often describe the absence of the adolescents' biological parents, which was frequently attributed to substance use and/or mental illness. Collectively these factors may have made it very difficult for caregivers to take care of the adolescents and respond to the abuse. Studies in South Africa have linked the absence of parents from households to children's increased risk for violence (Dawes et al., 2016). The caregivers in this study also described living under great financial strain, with many of them relying on other family members for survival. It is possible that under these circumstances caregivers may not have felt it possible to confront the adolescents' abuse without disrupting the equilibrium of the family system and threatening relationships on which they were dependant for survival. This perceived threat to survival, if allegations of abuse were to be uncovered and addressed, may make it more difficult to successfully engage some caregivers and families in treatment. It also points towards the necessity of considering the broader socio-economic context when designing policies targeting suicide prevention, and that the responsibility for preventing suicide cannot solely be that of the mental health treatment system.

The pervasiveness of violence in the adolescents' lives described by the participants in this study is remarkable and reflects broader social dynamics in South Africa. High rates of violence and trauma in South Africa have been well documented (Institute for Economics & Peace, 2020), and have been attributed to apartheid, gangsterism, poverty, and lawlessness (e.g., Makanga et al., 2017; Pinnock, 2017). Violence is often resorted to within South African society when communities feel unheard, as an expression of anger, or as a form of protest (Alexander, 2010; Paret, 2015). Violence also continues to be used as a method of resolving conflict, and appears to be normalised to some extent within South African society (Makanga et al., 2017; Pandey, 2012). In this sense, the violence evident in the microsystem of the adolescents' lives mirrors that present in broader society. Although research has linked violence exposure to increased risk of suicide attempts among adolescents (Castellví et al., 2017; Saewyc & Chen, 2013), the pathway between the two is less clear. The adolescents' descriptions suggest that it is violence's impact on relational security and connectedness that is a key factor, although causality cannot be assumed. Another way of conceptualising this link is that self-directed violence, in the form of suicide attempts, is an outgrowth of violence within society. Here, violence could be thought of as becoming normalised, making it an option (both directed towards others and the self). The exposure to violence could also be regarded as contributing to desensitisation to pain, which may lead to an enhanced capability for attempting suicide, as suggested by the Interpersonal Theory of Suicide (Joiner, 2005; van Orden et al., 2010). Overall, the participants' descriptions of how violence was intertwined with the adolescents' suicide attempts suggests that violence prevention may be one of many aspects to consider when contemplating adolescent suicide prevention.

7.1.1.2 Younger Siblings and Pets: A Source of Relational Security

A novel finding of this study is the adolescents' descriptions of how attachments to younger siblings and pets acted as a protective factor against suicide. The adolescents described how their concern for the wellbeing of younger siblings curbed their suicidality and made them reconsider trying to end their lives. Pets in turn were described as offering comfort, unconditional love, and protection. It is notable that neither caregivers nor clinicians spoke about the protective role of siblings or pets. It seems that taking care of both younger siblings and pets allowed the adolescents to feel needed and provided a sense of worth and validation. This feeling of being needed was for example illustrated by the title, *"My Baby"*, that Debbie

chose for a photograph of her dog. Taking care of their younger siblings also seems to have provided a sense of importance, allowing the adolescents to access their own power and capacity for caretaking. The validation and emotional warmth provided by these relationships were aspects that were often lacking, but desired, in their relationships with their caregivers, especially their parents. Although the relationships with younger siblings seemed to provide a sense of relational security, relationships with older siblings were more ambiguous and at times contributed to a sense of psychological and physical threat, with two of the adolescents reporting having been abused by their older brothers.

Attachment theories suggest that the attuned and consistent attention of a primary caregiver early in life is needed (and desired) for the establishment of secure attachment (Bowlby, 1988; Wallin, 2007). The quality of this attachment is thought to shape internal working models of relationships, which influence future interactions and relationships (Bowlby, 1988; Wallin, 2007). Although the psychology literature mainly focuses on the importance of secure attachment during infancy and early childhood (e.g., Ainsworth, 1979; Tracy & Ainsworth, 1981), the quality of the caregiver-child relationship during adolescence continues to play an important role in the experience of relational security (Booth-Laforce et al., 2014; Koehn & Kerns, 2018). Research has found that adolescents who attempted suicide perceived their attachment to their parents as less secure than those adolescents who had not attempted suicide (Fergusson et al., 2000; Sheftall et al., 2013). In this study, it seems as if the unavailability of biological parents, and the lack of protection afforded by caregivers, made it difficult for the adolescents to form and maintain a secure attachment to a primary adult caregiver. Instead, they appeared to turn to their siblings in an attempt to gain a sense of relational security. Yet, although younger siblings may provide affection, they are unable to (and should not have to) protect the adolescents from physical, sexual, and psychological abuse. The adolescents' expressed need and desire for relational security also has implications for the treatment system. Clinicians are required to provide a safe, consistent, and emotionally attuned space. Yet, as described by the clinicians, this often becomes difficult in a resource constrained health system which makes it difficult to establish and maintain longer-term relationships. These observations also indicate the importance of trying to involve the family in treatment, in an attempt to strengthen the adolescent-caregiver relationship, and to enable clinicians to enquire into the wellbeing of siblings.

The adolescents' accounts of caring for their younger siblings point to their parentification, occurring within a context of absent parents and single mothers working long hours to earn sufficient income. Forced removals of black people during apartheid (Mabin, 1992) results in the caregivers and their families still living on the outskirts of Cape Town, often requiring lengthy commutes on public transport to their places of work. Although research often emphasises the negative aspects of parentification (e.g., Hooper et al., 2011; van Loon et al., 2017), in this study the adolescents' accounts suggest that it also offered them a degree of protection against repeat attempts. The relationships that suicidal adolescents have with their siblings is an underexplored area in suicidology, with research tending to focus on those bereaved by a sibling's suicide (e.g., Brent et al., 1996; Dyregrov & Dyregrov, 2005). Apart from one nurse who considered siblings as a protective factor (Matel-Anderson & Bekhet, 2016), the protective role of siblings and pets does not appear to have been reported on. In contrast to prior South African research (Shilubane et al., 2012), perceived favouritism towards siblings was not offered as a reason for attempting suicide by the adolescents in this study.

7.1.1.3 The Caregivers' Material and Emotional (In)Security

In trying to understand the adolescents' experiences of emotional disconnection from their caregivers, which they regarded as contributing to their suicide attempts, it may be useful to reflect on the experiences of the caregivers. Certainly, many of the caregivers described feeling overwhelmed. As discussed above, the caregivers described their financial stress, the burden of single parenting, and the absence or minimal involvement of parent(s) due to problematic substance use. Clinicians also related how parenting in a context of socio-economic stress and trauma depleted the caregivers' emotional resources necessary for providing the emotional support desired by the adolescents. A few caregivers acknowledged their own need for psychological support, and this was endorsed by the clinicians, who regarded the wellbeing of caregivers as essential for adolescent suicide prevention. The lack of parental wellbeing has been identified as a factor influencing adolescent suicide attempts (Asarnow et al., 2017; King et al., 2010). For example, South African adolescents mentioned parents' problematic alcohol use as a factor in their suicide attempts (Aspaslan, 2003); while other research demonstrated that adolescents were less likely to engage in a repeat attempt if parents received their own psychiatric treatment (Jakobsen et al., 2011). These experiences in turn are framed by the broader historical context of apartheid, with caregivers continuing to be impacted by the

lingering effects of historical trauma, structural and systemic inequality. Overall, it seems that it is difficult for the caregivers to provide the relational and emotional security desired by the adolescents when they themselves are lacking a sense of material and emotional safety.

7.1.2 Wanting to be Seen, but Feeling Invisible

The adolescents described feeling unheard and unseen, particularly by their caregivers. When they did attempt to communicate with their caregivers, they reported often being misunderstood, criticised, or dismissed. Instead they appeared to choose indirect or non-verbal ways of communicating their general distress. The caregivers in turn described the adolescents as being uncommunicative, hiding their problems, and concealing their suicidality. Very few caregivers spoke about their own role in these communication difficulties. Although the caregivers regarded the suicide attempts as hidden (a perception supported by the adolescents), some also questioned whether the behaviour was a form of attention seeking. The adolescents in turn strongly denied that attention seeking was a motivation for their suicide attempts, although some detailed how their suicide attempts did unintentionally lead to either an improvement in communication or to being taken seriously by their families. Both the adolescents and clinicians spoke about how communication difficulties contributed to distancing in the adolescent-parent relationship, and how better communication and being validated may have prevented the adolescents' suicide attempts in the first place, and was important for youth suicide prevention in general. It seems that the adolescents largely felt invisible to their caregivers and families, but that families also had the power through improved communication, listening, and validation to allow the adolescents to feel seen and heard.

These findings mirror those in the literature, where suicidal adolescents commonly report communication difficulties with their parents (Beekrum et al., 2011; Lachal et al., 2015), and where increased care and validation by parents is regarded as important for recovery by both adolescents and clinicians (Lachal et al., 2015). Although suicide attempts have often been reported to be a communication of distress (Grandclerc et al., 2019; Grimmond et al., 2019; Holliday & Vandermause, 2015; Lachal et al., 2015), the adolescents in this study disagreed with this interpretation. It is possible that the communication of distress was an unconscious motivation at the time of the attempt. For example, a study with American adolescents reports that they only became aware of this motivation during the process of reflecting on their

experience (Holliday & Vandermause, 2015). The description of communication difficulties by all three groups seems to point towards the importance of familial intervention during treatment, so that aspects of intrafamilial communication (or lack thereof) can be explored alongside other relational concerns. The participants' descriptions also highlight that it may be beneficial for clinicians to be highly attuned to the adolescents' non-verbal communications, and to assist the adolescents with verbalising these.

Not speaking about their own potential part in the communication difficulties may reflect the caregivers' overall struggle in reconciling their own role in the adolescents' suicide attempts. Although some (but not all) said that they experienced a sense of guilt and shame, they were uncertain as to what they could have done differently. One interpretation of this is that the caregivers are trying to avoid the emotional pain inherent in confronting the possibility that their parenting could be improved, and the fear of being stigmatised as a "bad" caregiver. This view was supported by a few of the clinicians, who questioned how open caregivers were to reflecting on or scrutinising their own parenting practices. Previous research has identified how parents of suicidal adolescents attempted to portray themselves as responsible parents (Buus et al., 2014), situated alongside feelings of shame (Buus et al., 2014; Dempsey et al., 2019; McLaughlin et al., 2014). These interpretations indicate how challenging it may be to engage caregivers in treatment, and for clinicians to ask caregivers to think about their own role in the adolescents' presentations. It also points towards the importance of avoiding blaming or shaming the caregivers, in order to successfully engage them in treatment.

7.1.3 Peers: Belonging at a Price?

This research highlights the complexity of the adolescents' peer relationships regarding their suicide attempts. Bonding with other suicidal peers decreased the adolescents' sense of isolation, but they also reported learning about suicidal behaviours from each other, including in the inpatient CAMH unit. At times, the suicidal behaviour appeared to be the very thing that the adolescents bonded over, although they also described helping each other to overcome suicidal crises. Similarly, caregivers expressed concern that suicidal peers may have influenced the adolescents' own suicidal behaviour, while recognising the importance of their inclusion in the peer group. Given the salience of belonging to a peer group in adolescence (Levine, 2000),

identifying around the shared experience of suicidal behaviour seems to have offered the adolescents in this study a degree of comfort.

The adolescents' search for belonging extended to the use of social media and technology. They reported that online groups and communication reduced their sense of isolation, and at times facilitated help-seeking from friends. Yet, the adolescents were upfront regarding the dual role of social media and the internet. They spoke about searching for suicidal content for ideas on how to suicide, and to provide motivation to follow through with an attempt. Yet some also used others' depictions of self-harm as a vicarious outlet for their own suicidal urges, saying it made them feel *"at peace"*. The easy accessibility of suicidal content seems to accord with the clinicians' belief that the normalisation, and even glorification, of suicidal behaviour in contemporary culture may have contributed to the adolescents considering suicide as a viable option. Overall, the sense of belonging that the adolescents gained from their friendships and online activity was regarded as protective by them, while simultaneously conferring risk by exposing them to suicidal behaviour and content.

These accounts align with both research describing the importance of peer connectedness as protective against adolescent suicide attempts (Czyz et al., 2012; Gunn et al., 2018); and research demonstrating that exposure to the suicidal behaviour of others, especially close friends and family members, increases the risk of attempted suicide among adolescents (Abrutyn & Mueller, 2014; Roberts et al., 2010). Similarly, the use of online forums and social media is reported to offer support and social connection (Biernesser et al., 2020; Daine et al., 2013; Marchant et al., 2017), but has also been found to normalise suicidal behaviours and facilitate the sharing of self-harming techniques among youth (Daine et al., 2013; Jacob et al., 2017; Marchant et al., 2017). Website users have described accessing online suicidal images as reducing feelings of loneliness and mitigating self-harm (Baker & Lewis, 2013), reflecting the accounts of some of the adolescents in this study. The clinicians' perception that the normalisation of suicidal behaviour in contemporary culture may partly influence suicidal adolescents has also been reported by British clinicians, who described the role of media and television alongside exposure to other people's suicidal behaviour (M. Anderson et al., 2005). A meta-analysis, however, did not support the role of fictional media in suicide contagion (Ferguson, 2019). The adolescents' descriptions of using online platforms to reduce feelings of

isolation, alongside the ubiquity of social media, seem to highlight the opportunity for online suicide prevention initiatives that enhance feelings of connectedness among suicidal adolescents. Online platforms could conceivably allow for provision of peer support, which in addition to enhancing feelings of belonging, may also reinforce feelings of agency and competence. Nevertheless, the participants' accounts also suggest that there is a risk of reinforcing suicidal behaviours. Although research into online prevention and intervention for suicidal youth is emerging (Perry et al., 2016), it is an area ripe for future research.

7.2 AUTONOMY (AND CONNECTEDNESS): SUICIDE ATTEMPTS AND THE HEALTH SYSTEM

The adolescents' accounts of their own suicidal behaviour pointed to their experience of powerlessness and loss of control in their lives. They described a context of abuse and contradictorily, overprotectiveness, which challenged their bodies and lives. It seems that for some of the adolescents, attempting suicide was an expression of autonomy and a means of reasserting control. Similarly, the clinicians also partly understood the adolescents' suicide attempts as an assertion of power and control, particularly in relation to their parents. The experience of thwarted autonomy and agency was reinforced for some of the adolescents during their hospitalisation. They complained about constant surveillance and curtailment of their freedom during their inpatient stay. Some of the adolescents challenged this and attempted to regain a sense of autonomy over their bodies by refusing to take medication, or by self-harming. Although some (but not all) of the adolescents struggled with inpatient hospitalisation, most appreciated outpatient services which they regarded as less restrictive. While adolescents emphasised their desire for autonomy, they also reported how their relationships with the clinicians partially met their needs for validation and non-judgemental acceptance. It seems as if secure relationships with clinicians were perceived as aiding their recovery after their suicide attempts. Yet, the clinicians emphasised how working within a resource constrained health system and audit culture made it more difficult to establish meaningful longer-term therapeutic relationships, due to the demand for services and management's focus on the number of patients seen.

The themes of autonomy and connectedness have also been noted in other research with suicidal adolescents. For example, adolescents have noted the importance of retaining an

element of control and choice over their treatment, and how this allowed them to remain engaged with their treatment in the CAMH unit (Hassett & Isbister, 2017). Other researchers have also interpreted adolescents' descriptions of their suicide attempts as a bid to regain control over their lives (Lachal et al., 2015; Nicolopoulos et al., 2018; Orri et al., 2014). The adolescents' desire for autonomy is pertinent to their developmental stage. Yet, while the adolescents expressed the need to assert their agency and autonomy, they simultaneously desired emotional connectedness with their parents and families, and clinicians. This speaks to Kagitcibasi's (2005, 2013) conceptualisaton of autonomy-relatedness as essential for healthy development. Here, autonomy refers to a sense of self that is separate from others and can act with volitional agency free from coercion; while relatedness refers to emotional connectedness. For Kagitcibasi (2005, 2013) autonomy and relatedness can (and should) co-exist. This emphasis on connectedness for healthy development tends to be neglected by Western psychology's focus on separation-individuation as a necessary developmental task during adolescence (Lawler, 1990; Quintana & Kerr, 1993). Yet, research with adolescents and young adults supports the notion that secure attachment to parents fosters a sense of agency (Meeus et al., 2011; Nawaz, 2011). Gaining autonomy may therefore have been complicated for these adolescents, due to their generally fraught relationships with their parents, and the lack of a secure attachment base to separate from. The relationship between autonomy and connectedness could be interpreted as a circular one. A lack of connectedness complicates the expression of autonomy and agency, but allowing a degree of autonomy (such as in the treatment setting) allows for greater connectedness, which in turn may provide the adolescents with the confidence to embrace more agency in their lives.

7.3 A SHARED UNDERSTANDING OF THE SUICIDE ATTEMPTS

The participants' accounts of the adolescents' suicide attempts were non-reductionistic, embracing multiple explanations. The caregivers also repeatedly voiced their confusion, stating their lack of understanding and uncertainty about the causes of the adolescents' suicide attempts. Yet, as discussed below, there were some similarities in the way the adolescents, their caregivers, and clinicians understood the adolescents' suicide attempts.

7.3.1 An Escape from Pain

In addition to a general relational understanding, all participants described the suicide attempts as either an escape from painful emotions or situations, or as a perceived solution to the adolescents' problems, including the alleviation of burdensomeness. Yet, the adolescents in this study at times seemed confused and ambivalent about death, both at the time of the attempt and afterwards. They described the escape from suffering as their primary goal. It appears as if they perceived their options as narrowed, with suicide remaining the only conceivable solution to escape their pain. These findings mirror other research which has found that adolescents mentioned a desire to escape from pain as the motivation for the attempt, rather than necessarily a desire to die (Holliday & Vandermause, 2015; Nicolopoulos et al., 2018; Orri et al., 2014). What is particular to this context is that some of the adolescents mentioned that their suicide would relieve the *economic* burden to their families. Suicide as a solution to alleviate the family's financial hardship has also been reported by Iranian adolescents (Keyvanara & Haghshenas, 2011).

Some aspects of the participants' descriptions of the adolescents' suicide attempts fit the Interpersonal Theory of Suicide (Joiner, 2005; van Orden et al., 2010), although no causal attributions can be made. Certainly, the adolescents appear to have experienced thwarted belongingness (both in relation to their families and peers) and perceived burdensomeness (particularly economic burdensomeness), which are regarded as necessary for a desire for suicide to manifest. Most of the adolescents had engaged in NSSI prior to their attempt(s) and had suffered sexual or physical abuse. This may have led to desensitisation and increased tolerance of physical pain, leading to the acquired capability for suicide regarded as necessary by the theory. Yet this explanation captures only *partial* aspects of the phenomenon of adolescent suicide attempts. It does not explore the intersubjective positioning of the adolescents' suicide attempts, or how these relational aspects are influenced by their specific context. Nuances in experience, such as the adolescents' sense of betrayal in relation to having their abuse minimised or denied by their caregivers, are lost. The messiness and complexity inherent in adolescents' suicide attempts, their contextual situatedness, as well as the variation in individual experience cannot be accurately captured by any single theory.

7.3.2 Incorporating and Challenging a Psychiatric Understanding of Suicide

Both the adolescents and the clinicians, and a few of the caregivers, incorporated psychiatric explanations into their understanding of the adolescents' suicide attempts. Popular biomedical tropes were used at times to explain the suicidality, for example one caregiver pointed to chemical imbalances in the brain as an explanation for the adolescent's suicide attempt. Yet psychiatric explanations were not the dominant form of understanding. Both the adolescents and the clinicians understood the psychiatric symptoms to be interwoven with what was happening in the adolescents' relationships and environment. Some of the clinicians cautioned against medicalising the adolescents' experience by reducing it to a psychiatric diagnosis. Yet, the clinicians' positioning within a psychiatric hospital setting meant that they had largely adopted the expectation that they should *prevent* adolescent suicide. Feeling responsible for stopping suicidal behaviour has also been reported by clinicians in other contexts (Rouski et al., 2017). The clinicians described how they felt compelled to demonstrate their competence to colleagues, and to protect themselves against liability, by conducting frequent risk assessments. The clinicians acknowledged that the focus on suicidal behaviour at times detracted from addressing underlying concerns and could impact on the relational rapport with the adolescents. The clinicians' accounts, as well as the adolescents' descriptions of their experiences in the CAMH unit, reflect Marsh's (2010) observations of how a medicalised understanding of suicide leads to the constitution of the "suicidal patient" and the "responsible, accountable and culpable clinician" (p.225). Therefore, despite the clinicians' critique of a purely psychiatric understanding of the adolescents' suicide attempts, their responses were shaped by a dominant biomedical understanding of suicide. Moving away from a purely psychiatric understanding of adolescent suicide attempts, as suggested by the participants in this study, implies extending the responsibility for suicide prevention beyond that of the medical and psychiatric domain. Creating spaces for these types of discourses may allow institutions to reflect on the expectations placed on clinicians and may simultaneously assist with reducing clinicians' anxiety.

7.4 THE IMPACT OF CARING FOR SUICIDAL ADOLESCENTS

Both the caregivers and clinicians described feelings of anxiety, hypervigilance, helplessness, and powerlessness elicited by the adolescents' suicidality. These experiences align with the findings of prior research (Buus et al., 2014; Daly, 2005; Lachal et al., 2015; McLaughlin et

al., 2014). Both groups feared the unpredictability and possibility of further suicide attempts. The caregivers dealt with this through increased monitoring of the adolescents' behaviour, and by trying to avoid saying or doing anything that they perceived could trigger another attempt. The suicide attempt appears to have altered the relationship with the adolescent in some form, for example a reduction in trust. Increased monitoring (Buus et al., 2014; Ferrey et al., 2016), *"walking on eggshells"* (Daly, 2005), and a loss of trust in their child (Byrne et al., 2008) have also all previously been reported by parents of suicidal adolescents. The caregivers requested advice on how to handle the adolescents, mirroring parents' desire for guidance in other research (Curtis et al., 2018; Dempsey et al., 2019). A few suggested counselling for the family to cope with the impact of the suicide attempt. Some of the adolescents described how their suicide attempts led to an improvement in the relationships with their families and caregivers. Yet, while some caregivers reported being more attuned to their adolescents' needs, and described their efforts to improve their parenting, their hypervigilance and fear of triggering another attempt also contradictorily made it more challenging to effectively parent the adolescents.

The clinicians in turn said they coped with feelings of anxiety by asking colleagues for a second opinion, or informally debriefing with one another, a strategy also reported by clinicians in other contexts (Rouski et al., 2017). Being able to admit an adolescent for hospitalisation also reduced anxiety, as the clinicians had the comfort of knowing that the adolescent would be observed. Some of the clinicians reflected on how their anxiety could detract from the therapeutic relationship, as risk assessments were prioritised. It therefore seems as if the clinicians' responses to their anxiety produced both potentially helpful and unhelpful responses. Asking colleagues for assistance allowed for second opinions, yet it also often resulted in the adolescents being subjected to a repetition of risk assessments. Apart from the anxiety elicited by working with suicidal adolescents, clinicians were exposed to high levels of trauma in their daily work. Many felt that an optional support group, facilitated by an external person, could be helpful. Clinicians also desired individual therapy or supervision with a professional from outside their work environment, although some considered this financially prohibitive.

7.5 CONCLUSION

In this chapter I synthesised the accounts of the adolescents, caregivers, and clinicians, thereby providing a multiperspectival overview of the phenomenon of adolescent suicide attempts. The accounts of the three groups suggest that the origin and perceived solutions to adolescent suicide attempts are often to be found in the same source. The relational was foregrounded in the understanding of the adolescents' suicide attempts, with emotional connection (but also autonomy) and belonging regarded as essential for suicide prevention. The accounts highlighted how the suicide attempts, and the responses to them, were situated and shaped by a particular historical and socio-cultural context.

CHAPTER 8
REFLECTIONS ON THE RESEARCH PROCESS

In this chapter, I reflect on the research process. Firstly, I discuss how the adolescents' experience of participating in the research appeared to mirror some of the themes discussed in the findings. I then describe the apparent unanticipated therapeutic aspects of the research, before reflecting on the research design and its limitations and strengths. Finally, I reflect on my own experience of conducting this research and engaging over a protracted period with the topic of adolescent suicidal behaviour.

8.1 THEMES MIRRORED IN THE ADOLESCENTS' EXPERIENCE OF THE RESEARCH PROCESS

The adolescents' descriptions of their experience of the research process appeared to mirror some of the themes discussed in the findings, particularly those of belonging and validation. The adolescents were curious about the other participants, asking me *"how many people there are just like me"* (Dean). Meeting the other adolescent participants during the focus group was experienced as validating, and the adolescents reported that this reduced feelings of isolation. For example, Natasha commented that, "*I'm glad to know that I'm not the only one"*, while Kimberlyn stated that *"I feel supported knowing that I met people who've been through similar things. So now I don't feel alone."* Being part of the research seemed to create a sense of belonging to a special group, something which the adolescents appeared to desire.

I did worry whether there was a danger of the identity of "suicide attempter" becoming foregrounded, and inadvertently reinforcing suicidal behaviour among the group of adolescent participants; although I did not observe this. Research has demonstrated the effect of "contagion", namely that exposure to friends who have attempted suicide can act as a trigger for suicidal behaviour, including attempts, among adolescents (Abrutyn & Mueller, 2014; Randall et al., 2015). The desire to identify with a peer group during adolescence (Levine, 2000) may therefore increase susceptibility to adopting suicidal behaviour. I cannot know for certain how participation in the research may or may not have contributed to the contagion of suicidal behaviour among the adolescent participants, although I did not observe it. This is

however an ethical consideration that should be contemplated when conducting research with suicidal adolescents, particularly when participants meet each other, such as in focus groups.

Some of the adolescents seemed to derive a feeling of importance by being part of the research. Dean contacted me on What's App and told me that he had conducted his own research at his school, following the suicide of a fellow pupil. He had organised a group session with his peers to find out how the suicide had impacted them. When we discussed it during our next meeting, he explained:

> *"I just decided I would represent X[19] Hospital. I wanted to make children aware about suicide. To also stop bullying, that's what I was doing. And my teacher was really proud of me for doing that… he was proud that I could muster the courage, because I am usually shy, but he was proud of me for mustering the courage to help other people."*

Through this act, Dean exercised agency, made himself visible, received validation from his teacher, and gained a sense of importance by affiliating himself with the hospital and the research. Although adolescents often report a fear of stigma for receiving psychiatric treatment (Elkington et al., 2012; Mitten et al., 2016), for Dean his self-claimed identity of "researcher", and the agency associated with it, seemed to provide status and worth. While we cannot attribute Dean's agency to participation in the research, it is notable that his actions contradict the concept of the passive, depressed suicidal patient, instead fitting that of an empowered activist. Although I lauded Dean's initiative and courage, his unsolicited act did raise ethical concerns for me. We used part of our next meeting to discuss his research and the ethical considerations involved in it, and to explore how Dean had been affected by the suicide of a peer. Small acts during the research process also appeared to make other adolescents feel valued and important. Kimberlyn commented with joy and surprise that I had remember how she liked her tea, while Dean remarked that I had made the effort to ensure that his favourite snacks were available for our meetings.

8.2 RESEARCH AS (UNINTENDED) THERAPY

Participation in the research appeared to have had unintended therapeutic effects. Some of the adolescents seemed to use the photography to connect with and engage their families. For

[19] The name of the hospital has been redacted for the sake of confidentiality.

example, one adolescent asked her father to transport her to places of interest, and others described how their photographic tasks elicited in-depth family discussions around their experiences. The photography therefore seemed to be used by the adolescents in a strategic, functional manner. The evolution into a family task has also been noted in other research involving adolescent-produced photography (Sibeoni et al., 2017). A few adolescents also chose to share their photographs with their clinicians to illustrate aspects of their experience. One adolescent, who struggled with social anxiety, described using the photographic task as a form of desensitisation training by forcing herself to enter social settings she would usually avoid. The adolescents seemed to enjoy the autonomy and agency offered by the photographic task. For example, while reflecting on her experience of the photography, TC happily commented, *"It's like I am kind of having my own way."* The photography may also have allowed the adolescents to access a playful part of themselves, with two of the adolescents describing it as *"fun"*. Arts-based methods, such as photography, have been described as a useful research tool to both engage adolescents and to allow them to express creative agency (Coemans & Hannes, 2017). Yet, the photography also seemed to raise power dynamics and issues of control in the adolescent-caregiver relationship; an aspect also noted by other researchers (Sibeoni et al., 2017). This was particularly the case for one adolescent, whose father insisted that she use his phone camera for the photography, thereby enabling him to monitor the photographs taken, while also conceivably alleviating his anxiety about what might be revealed through the photographic content.

The use of photography and photo-elicitation appeared to enhance the adolescents' reflective capacity, which has also been noted in other research (Burton et al., 2017; Thupayagale-Tshweneagae & Mokomane, 2013). It seemed to allow them to access a different way of knowing (Glaw et al., 2017). Catelynn remarked on the reflective space created by the photographic task:

> *"It was actually kind of difficult, it took me a while because, like normally, I would say, this makes me wanna, this makes me feel horrible, this makes me feel happy, but I would never like think long about it man. So I had to actually sit down and like think about what actually makes me happy, because normally when things make me happy or they make me sad, it just crosses at the back of my mind and I don't think about it again… And so I really had to think about it."*

Similarly, some of the caregivers and clinicians also reported that their participation in the research provided them with a reflective space to process their experience. For example, Tess stated, *"it was really therapeutic in a way to be able to express, I think the frustrations and the difficulties with doing this work"*; while Mr Wilson reflected on his own behaviour and his daughter's experience of engaging in therapy:

> *"It's been good speaking about it. Um, it's been, while I'm chatting I have actually realised some things as well, you know. Not to be too hasty in my criticism of my children… So it's good to see those things while I have this discussion with yourself, and realise that some of the answers is right in front of you. While I am talking to you. So it's been good to let go of some issues and to talk about it. Ja, now I know how she feels when she sits with the doctor."*

The apparent therapeutic value participants derived from taking part in the study has also been described by other researchers working in the suicidology field (Biddle et al., 2013; Littlewood et al., 2019). For example, a meta-analysis found reductions in subsequent suicidal ideation and attempts among participants involved in suicide research (Blades et al., 2018). The reduction in suicidal ideation was particularly pronounced for adolescent participants, while one-on-one interviews were associated with significant reductions in levels of distress.

My role as researcher meant that I was not responsible for the clinical treatment of the adolescents. Knowing that the clinical team was available in an emergency reduced my anxiety of engaging with and listening carefully to suicidal adolescents. I was aware of the fact that I did not have to focus on conducting risk assessments or make decisions on whether a person needed to be admitted. Not trying to provide a clinical service contradictorily made the interaction therapeutic, as I was able to truly listen to the adolescents' stories. Kimberlyn told me:

> *"So like, talking about it here is different to when I have to talk about it to doctors and whatever, because there it felt like I was being interrogated. Here it is different. You are just listening, kind of. It feels like you are just listening. So that is a good thing."*

These observations also highlight how clinicians' anxiety about trying to prevent suicidal behaviour can detract from the therapeutic relationship and being fully attuned to the adolescents. It is worth noting that the thing the adolescents are asking for – to be listened to,

and to have their experiences validated – can be lost when we focus solely on their suicidal behaviour.

8.3. REFLECTIONS ON THE RESEARCH DESIGN

In this section I reflect on aspects of the research design, namely the use of photography and photo-elicitation, and the choice of combining a multiperspectival design with IPA. I have previously discussed the ethical considerations inherent in the use of photography in section 3.7.4 and will therefore not revisit them here.

8.3.1 The Use of Photography and Photo-Elicitation

Incorporating photography into the research design proved useful in several ways. The photography enabled the adolescents to invite part of their external reality into the research (and hospital) environment in a creative and non-verbal manner. This provided me with an enhanced understanding of the adolescents' context. The use of photography also reinforced themes described by the adolescents during their first interview, for example those of isolation and emotional disconnection from caregivers. However, it also seemed to allow them to elaborate on aspects of their experience and to introduce novel concepts. Whereas the adolescents had predominantly focused on their experiences of distress during the first interview, the use of photography seemed to allow them to reflect on aspects of their experience that they described as protective from further suicide attempts, such as the role of younger siblings and pets. Overall, the use of photography appeared to enhance the adolescents' sense of agency, allowed them to reflect on their experience, and seemed to be used in therapeutic ways, as discussed in section 8.2 above. The choice of photography appeared to be an accessible, non-threatening medium, possibly aided by the prevalence of taking "selfies" in contemporary culture.

One of the disadvantages of using a disposable camera was that some photographs did not develop well. Some participants also attempted to take photographs of writing, such as diary entries, which ended up blurred and indecipherable. As data collection progressed, I therefore found myself reminding participants of the parameters of the camera, and the use of the flash for low-light conditions. Although most participants expressed excitement at the prospect of

using a camera, one adolescent stated her preference for using a phone to take photos. These factors led me to reflect on whether the choice of using digital cameras or participants' own phones, instead of disposable cameras, would have been a preferable option. Providing the adolescents with a choice of photographic equipment may have further enhanced their engagement with the research process and supported agency. Using a phone camera may also have been less obtrusive, although many of the adolescents appeared to enjoy the novelty of the disposable camera and the engagement it elicited from others. Yet, the use of digital photography could create pressure to take the "perfect" photograph and would allow adolescents to retrospectively revise and delete photographs. In addition, there were various practical reasons for choosing a disposable camera in this study, including the lack of phone ownership, cost considerations, and the privacy of photographic content, which I have previously discussed in section 3.4.4.2. In the future, I would encourage participants using disposable cameras to take multiple photographs of the same scene, for example with and without the use of the flash, to improve the chance of a well-developed photograph. For researchers who choose to use digital photography, it may be pertinent to consider setting a limit on the number of photographs submitted, to enhance reflectivity and to avoid being overwhelmed by large amounts of data.

In this study, the choice of photo-elicitation means that I did not analyse the photographs themselves, instead using them as a conduit to aid the discussion. Textual information, namely the transcribed interviews and the titles chosen for the photographs, were analysed. This approach allowed me to stay close to the participants' descriptions and interpretations of their photographs, as required by IPA (Bates et al., 2017; Burton et al., 2017). Asking the adolescents to choose titles for their photographs proved valuable, as it explicated the intended meaning, and added richness and nuance to the data. Yet, it is possible that by not analysing the photographs themselves, I may have missed additional meanings and interpretations that may have remained unconscious or that the adolescents were not able to talk about. It is interesting to note that most researchers use art, including photography, to support the research process, rather than analysing the art itself. This has been ascribed to restrictions imposed by academic conventions and funding agencies, as well as researchers' uncertainty of how to analyse art as data (Coemans & Hannes, 2017).

8.3.2 The Use of IPA with a Multiperspectival Research Design

IPA is traditionally conducted with a small, homogenous group of people (Smith et al., 2009). However, some researchers have started to use IPA with larger samples (e.g., Rostill-Brookes et al., 2011), especially with the emerging use of multiperspectival research design in IPA (Larkin et al., 2019). I chose a multiperspectival design as it allowed me to examine the phenomenon of adolescent suicide attempts from the perspectives of the adolescents, their caregivers, and the clinicians responsible for their treatment. This created the potential for a more detailed, three-dimensional, and nuanced understanding of a complex phenomenon. Yet, this made data analysis more challenging, as it brought forth the tension between maintaining the idiographic, while simultaneously incorporating three focal perspectives. This meant that I needed to integrate the findings not only within a sample of participants, but between the three groups of participants. This was a challenging and time-consuming task, as I needed to become intricately familiar with each participant's account, before analysing each of the three groups, and finally interpreting the intersecting perspectives. The relatively large number of participants also meant that I had a huge amount of data to work with, which complicated the choice of what to foreground, and what to omit in my interpretation of the data. Here I was guided by the aim of the research, as well as the novelty and pertinence of the findings. Although the use of a multiperspectival design complicated the analysis of the findings, it allowed me to explore congruences and contrasts in meaning-making, thereby contributing to a more nuanced and contextualised understanding of the phenomenon of adolescent suicide attempts.

The use of a multiperspectival design also meant that data were collected at different points in time. It is possible that participants spoke to each other about their experience, and that this influenced or altered subsequent accounts. I met with the adolescents over an extended period. This protracted engagement, as well as the personal nature of the discussions, may have allowed for a richer collection of data. It also implies that the description of the adolescent's experience and understanding is not a static one, but one created and co-created over time. In addition, the protracted interaction with the adolescents meant that some appeared to form a degree of attachment to me, something I previously discussed in section 3.6. Although I was cognisant of this potential, and was explicit in outlining the number of meetings, and my role as researcher, I do not know how the termination of the research may have impacted on the adolescents.

8.4 IMPACT OF DOING RESEARCH IN THE FIELD OF SUICIDOLOGY

Working with suicidal adolescents and their caregivers deeply impacted me. Although I had the reassurance of knowing that the clinical team was caring for the adolescents, I continued to wonder and worry about them. My professional relationship with some of the adolescents stretched out over 14 months from the time of recruitment to the final focus group, despite a limited number of interactions. I used What's App installed on a dedicated research phone to schedule meetings with participants, and some of the adolescents sent me the occasional message during this period. These were largely greetings, for example to wish me a merry Christmas. Occasionally, their profile photos and statuses alluded to suicidal thoughts, although the adolescents did not mention these in their messages to me. I was aware that their profiles might have been non-verbal attempts to communicate their distress, and possibly also to test my (and other peoples') reactions. In these instances, I voiced my concern for their wellbeing, and reminded them of the clinical support that was available to them. I did not break confidentiality, except in one instance when an adolescent expressed intent to kill herself (this is further discussed in section 3.7.6). These incidents highlight how challenging, and unnatural, it can be to maintain rigid boundaries. Although I had explicitly stated that the phone number was reserved for research-related queries, I also think that it would have been unkind, hurtful, and unhelpful to fail to acknowledge the occasional greeting. Knowing that I was available during working hours for research-related queries, may have enhanced the participants' engagement with the research process. However, it also illustrates how easily boundaries during extended research processes can become blurred, and how this could potentially endanger the psychological safety of both participants and researcher. My concern for the adolescents' wellbeing allowed me to reflect on the caregivers' experiences, and to empathise with their anxiety to some extent. It also allowed me to identify with the experience of powerlessness described by the clinicians, in being unable fully to meet the adolescents' needs. It was important to reflect on the emotions I experienced in the room with the participants, as well as during analysis and write-up. A "reflexivity of feelings" (Boden et al., 2016, p.1078) can provide insight into the participants' experiences, the intersubjective experience of the research encounter, and provide insight into how the researchers' feelings may have influenced the interpretation of the data (Boden et al., 2016). My research journal and notes, as well as my own personal journal, proved useful for this reflective process.

During the period of this research, I was sensitised to suicide and suicidal behaviours in my environment. A close friend of my husband's attempted suicide while I was conducting this research. This left me feeling sad, concerned, but also angry and irritated. It reminded me of the mixed emotions experienced by the caregivers, and their overall sense of confusion and disbelief. An ex-client also sent me an email telling me that she had attempted suicide and continued to feel suicidal. Prominent suicides during this time included those of the musicians Chris Cornell and Chester Bennington. Two of the adolescents in the group changed their What's App profile photos to that of Chester Bennington. Anonymous's status reflected that *"the end does matter"*, a play on the lyrics ("in the end it doesn't even matter") of a well-known song by Linkin Park of which Bennington was the lead vocalist. Two weeks after completing the focus group with the adolescents, Prof Bongani Mayosi, the Dean of the Faculty of Health Sciences at the University of Cape Town and a world-renowned cardiologist and researcher, suicided. Although I did not personally know him, I had previously worked in the same faculty, and was deeply troubled by his suicide. While some initial media reports ascribed his death to depression, recent reports have highlighted the contribution of a hostile institutional culture during a period of politically charged student-led protests (Schwartz & Ntsekhe, 2018; University of Cape Town, 2020b). For me it highlighted how his suicide could not be disentangled from its historical and political context. Being exposed to suicide both in the research and external environment, as well as to the trauma endured by the participants, left me feeling a range of emotions. These ranged from sadness, frustration (with their situations and the failures of the system), despondency, admiration for the participants' resilience, anger, as well as hope. I recall feeling tearful and emotionally depleted on the day following the completion of the focus group, releasing some of the pent-up anxiety of having held the adolescents in mind for an extended period. During the time of data analysis, I had a vivid dream, which I understood to be directly related to my research project. At the time, I documented the dream in my research journal, writing:

> "I found myself on a grassy hill near a cliff's edge with two girls. Suddenly I was a child, and my companions and I were 10-year-old girls. We were lying on the grassy slope, and I realised that I had slid precariously close to the edge of the cliff. The grass was long and slippery, and I asked my companions, who were behind me, to please pull me away from the edge, as I was nervous of trying to stand up and slipping. They did so, pulling me out of harm's way. I felt relief, but still had adrenalin pumping through me. We carried on walking, and almost immediately, one of my companions ran

> towards the edge and leapt off the cliff. I was shocked, and wondered if perhaps there was water below, and she would be safe, but at the same time realising that the ground below was sandy and rocky. I turned to talk to my remaining companion. As I did so, she ran towards the edge of the cliff, leaping into the void below. I was shell shocked, helpless, and numb. I did not know what to do, but a heaviness descended on me. There was no thought of joining them, but I was left feeling deeply wounded."

I was fortunate that I had access to both a clinically trained supervisor, as well as private therapy, to digest the impact of the work and discuss ethical nuances inherent in the research. It highlighted the importance of considering the wellbeing of individuals involved in suicide prevention research. Rereading my initial research proposal I was struck that although the ethical considerations relating to the wellbeing of the participants were outlined, I had not detailed those relating to myself, or to others involved, such as the transcribers. Nor had I been asked about this aspect during my defence of the proposal, or by the university or health departments' ethics committees. It is possible that it was considered unnecessary, due to my clinical training and supervision by a psychologist. The mental health impact of the work on researchers working in suicide prevention has been noted for both those with and without clinical training (Chen et al., 2019; McKenzie et al., 2017). Supervision, support and, where indicated, training has been recommended as essential for researchers working in suicide prevention and with other topics with the potential of vicarious traumatisation (Chen et al., 2019; Dickson-Swift et al., 2008). I believe that health research ethics committees should consider the wellbeing of researchers working with suicide and other sensitive topics when evaluating research proposals.

8.5 CONCLUSION

The adolescents' desire for belonging and validation, which they had previously described in relation to their daily lives and suicide attempts, was also apparent in their reflections of participating in the research. Furthermore, the adolescents often used the research process in a strategic manner, that seemed both therapeutic and enhanced their relational connectedness. Overall, the use of a multiperspectival research design increased the complexity of data analysis, although it allowed for a more nuanced understanding of adolescent suicide attempts.

The necessity for regular supervision when working with the topic of suicide over a prolonged period was evident, and the implications thereof will be further addressed in the final chapter.

CHAPTER 9
CONCLUSION

In this study, I aimed to provide a contextualised understanding of the phenomenon of suicide attempts by South African adolescents living in a low resource environment. Keeping this overall aim in mind, I start this chapter by revisiting the research questions and providing a summary of the findings. The implications of the findings for service delivery, suicide prevention, and future research are outlined, followed by a discussion of the limitations of the research. I end by considering the contributions of this research to the field of suicidology.

9.1 REVISITING THE RESEARCH QUESTIONS

How do participants understand the adolescents' suicide attempts?

The participants' accounts reflected the complexity of the phenomenon of adolescent suicide attempts. All participants identified multiple factors that influenced the adolescents' suicidal behaviour, with no simple one-to-one linear attributions being made. The adolescents, their caregivers, and clinicians all foregrounded the relational dimension of their understanding of adolescent suicide attempts. Relationships were identified as both the source of the adolescents' difficulties, as well as necessary for support after the attempt, and the prevention of adolescent suicide in general. Ruptures in proximal relationships with parents, families, and peers were understood as central to the adolescents' suicide attempts. Yet, the groups' understanding of how the relational related to the adolescents' suicide attempts differed in some respects. The adolescents described a sense of betrayal by their caregivers and families when their experiences of abuse were minimised, disbelieved, or ignored, and related how this contributed to the emotional disconnection from their caregivers or families. The caregivers, however, by doubting or minimising the adolescents' experience of abuse, negated the impact of their reaction on the relationships with the adolescents. These disparities in the adolescents' and caregivers' experiences seem to have led to a fractured reality for the adolescents, where the suicide attempts could be conceptualised as an attempt to alter their reality, or to force the caregivers to confront the abuse. The adolescents, caregivers, and clinicians also spoke about the importance of belonging for the adolescents. Rejection and bullying by peers, as well as

associating with peers engaging in suicidal behaviour, were regarded as possibly influencing the adolescents' attempts. Yet, while the adolescents acknowledged learning about and sharing suicidal behaviours with peers (both face-to-face and online), they also emphasised the support and acceptance they gained from these interactions, as well as the sense of connectedness these relationships enabled.

All groups understood the adolescents' suicide attempts as an escape from an unbearable, painful reality, as a perceived solution to problems, or as an attempt to alleviate burdensomeness. Yet, the adolescents at times expressed ambivalence regarding their intent to die, both before, during, and after their suicide attempts. It appears that they experienced a narrowing of options, with suicide regarded as the only remaining solution to cease their pain. The caregivers expressed a huge amount of confusion and uncertainty in understanding the adolescents' attempts. Despite offering various explanations, they struggled to understand the adolescents' behaviour. Overall, the three groups did not reduce their understanding of the adolescents' suicide attempts to a purely psychiatric one, linking psychiatric symptoms to what was happening in the adolescents' environment. The adolescents, caregivers, and clinicians' explanations of the adolescents' suicide attempts were intertwined with rich descriptions of their context, as I will summarise next.

What is the socio-cultural context in which adolescents in low resource environments attempt suicide?

The adolescents, caregivers, and clinicians all described how the adolescents' suicide attempts occurred within the context of a South African society that has high levels of inequality, crime, violence, and sexual abuse. All three groups described exposure to high levels of trauma in their daily lives or working environment. Despite expressing concern for the adolescents' physical safety, the caregivers described violence within the family, including physical and sexual abuse, as well as parental neglect. Yet, instances of sexual abuse were also denied by some caregivers and minimised by others. It is possible that the high levels of trauma in South African society have led to a level of desensitisation towards violence in communities, including among caregivers. Socio-economic stress, problematic substance use by parents, and the pressure of single parenting, were understood to impact on the adolescent-parent relationship and the caregivers' ability to effectively parent the adolescents. Although South Africa has been a democratic country for 26 years, socio-economic inequality persists, and is

evident among the black communities living on the Cape Flats where this research was situated. The caregivers described feeling overwhelmed in this context, with minimal emotional resources remaining to engage with the adolescents. Single mothers and absent parents also led to parentification among some of the adolescents, who took on the role of caring for their younger siblings. Some of the clinicians regarded the normalisation of suicide in contemporary culture as influencing the adolescents' decision to attempt suicide, which appeared to be aided by the ease of accessing suicidal content online. The clinicians described a health system that was informed by a biomedical understanding of suicide, and hence prioritised the mitigation of risk. This, alongside an audit culture that focused on the number of patients seen, was regarded by the clinicians as detracting from the relational security desired by the adolescents.

What ideas do participants have for youth suicide prevention and what are the participants' expressed support needs?

The adolescents, their caregivers, and clinicians all stressed that improved communication, particularly between the adolescents and their parents, was important for the adolescents' recovery, suicide prevention in general, and as something that may have averted the original attempts. Yet, some of the caregivers felt it was primarily the adolescents' responsibility to be less secretive and to be more open in their communication, while the adolescents expressed feeling misunderstood, and requested that their parents and caregivers listen to them. The adolescents appeared to be describing feeling invisible, but emphasised that families had the power through improved listening to allow the adolescents to feel seen and heard. The adolescents also stated that if their parents or caregivers had truly listened to their concerns and tried to understand their experience, this may have averted their suicide attempts. Similarly, the need for validation and belonging was mentioned by all three participant groups as essential for recovery and suicide prevention. In essence, improved relationships, especially with parents, were regarded as necessary to prevent future attempts and for youth suicide prevention in general. The adolescents also suggested that being regarded as important, and as having something of worth to offer to society, would aid their recovery and suicide prevention among youth. This aligned with the clinicians' emphasis that pro-social community initiatives and activities that include and appeal to adolescents may aid with suicide prevention and recovery. Both the caregivers and the clinicians also identified enhanced support for the caregivers as important for the adolescents' recovery and suicide prevention. Some of the caregivers desired mental health support for themselves or their families and requested advice on how to manage

their adolescents. Single mothers wanted the fathers of the adolescents to assist them with childrearing, to ease the burden on themselves. Finally, the clinicians also desired the option of accessing support for themselves, either through a support group for staff in the CAMH unit or individual therapy. They stressed that this should be provided by an independent person external to the hospital.

What were this group of adolescents' experiences of receiving mental health support services after their suicide attempt?

The adolescents valued the non-judgemental space provided by the clinicians working in the CAMH unit. They described feeling listened to and having their experiences validated. While some adolescents appreciated the containment offered by inpatient hospitalisation in the CAMH unit, others struggled with the restrictions imposed on them. They described a loss of control and autonomy over their embodied selves, which reinforced that experienced in their everyday lives. Some adolescents rebelled against this loss of control by refusing to take medication or self-harming. Those adolescents who had been hospitalised in an adult inpatient ward prior to their transfer to the CAMH unit, or had to be contained in an adult ward during their stay, expressed the sentiment that *"being hospitalised made it worse"*. Outpatient treatment was considered as imposing less restrictions and was therefore appreciated by most adolescents. Apart from the therapeutic interactions with staff during their inpatient admission, adolescents appreciated the camaraderie of others who shared similar experiences. Yet, they also described learning about suicidal behaviours from each other during their stay on the ward. Despite the occasional exposure to the self-harm of other patients, the inpatient admission to the CAMH unit seemed to offer a sense of safety (a refuge from the violence of the outside world) for some of the adolescents, but simultaneously also contributed to a loss of autonomy and agency.

9.2 IMPLICATIONS FOR SERVICE DELIVERY, PREVENTION, AND RESEARCH

In this section I discuss considerations for service delivery and research arising from the participants' accounts, my interpretation of these accounts, and my engagement with the literature. These are not definitive recommendations, but I hope that they can serve as discussion points for clinicians, researchers, policy makers, and anyone else working with South African adolescents in low resource communities.

9.2.1 Adolescent-Specific Theories Could Aid an Understanding of Adolescent Suicide Attempts

The understanding of the adolescents' suicide attempts as described by the adolescents, their caregivers, and clinicians in this study does not fully align with any current theory of suicidal behaviour. Although it is questionable whether a phenomenon as complex and messy as adolescent suicide attempts can ever be fully encapsulated by a theory, the development of adolescent-specific theories that strive to explain adolescent suicide attempts may aid our conceptualisation thereof. There is a notable lack of adolescent-specific theories of suicidal behaviour. Yet, given the developmental stage of adolescence, it may not be appropriate to simply adapt adult models. For example, the adolescents' experience of betrayal, which they described as interlinked with their suicide attempts, was situated within a particular developmental and socio-economic context, where overwhelmed caregivers struggled to protect the adolescents from abuse. The findings of this study also highlight how the adolescents' suicide attempts were understood to be shaped by contextual factors, implying that theories need to move beyond a biomedical and psychiatric understanding. The participants' accounts in this study furthermore suggest (although we cannot make causal inferences) that any theory should ideally be able to represent the nonlinear nature of the phenomenon of adolescent suicide attempts that seems to emerge from a complex system of interactions. A theory based on such notions would also imply that any interventions need to be flexible, and work within and across systems, rather than trying to focus on "fixing" any individual.

9.2.2 Adolescent Suicide Prevention Cannot Occur in Silos

The participants' accounts demonstrated that adolescent suicide attempts are complex, ambiguous phenomena, influenced by their context. This suggests that responsibility for suicide prevention cannot be solely that of the mental health care sector. Broader socio-economic factors, such as violence, poverty, single parenting, and sexual assault should be considered when designing policy and suicide prevention programmes. This implies a focus on structural and systemic change, that would require longer-term commitment, and not a politically expedient "quick fix". Ideally, development and implementation of policy should include various government departments besides health, including those concerning education, economic development, employment, public works and infrastructure, sports, art, and culture.

Given the participants' focus on relational and contextual concerns, and the commonalities of risk factors for a variety of problematic behaviours (Wagner et al., 2003), I would suggest that prevention efforts should not solely focus on suicide. Instead prevention programmes should focus on reducing the overall risk of harmful behaviours among adolescents (Roberts et al., 2010). This may be achieved by fostering a sense of belonging, resilience, and purpose among adolescents, rather than focusing on educating adolescents about specific topics such as suicide or problematic substance use. The participants' accounts also suggest the involvement of local communities in establishing youth-based programmes and activities that create a safe space and foster a sense of belonging among adolescents. The non-reductionistic nature of the phenomenon of adolescent suicide attempts also suggests that suicidology could benefit from research collaboration across a variety of disciplines.

9.2.3 It is Essential to Involve Caregivers in Treatment Following the Adolescent's Suicide Attempt

The accounts of the adolescents, their caregivers, and the clinicians all describe the importance of relationships in both the evolution and resolution of the adolescents' suicide attempts, especially the relationship between caregiver and adolescent. Communication difficulties were also understood to contribute to the adolescents' suicide attempts and were regarded as an important site for intervention by the adolescents, their caregivers, and the clinicians. These accounts therefore suggest that it is vital to include caregivers and families in treatment. Some caregivers expressed feelings of guilt, and possibly feared being perceived as inadequate caregivers. It is therefore critical to avoid blaming and shaming caregivers when engaging them in treatment. Furthermore, the possibility exists that some caregivers fear that treatment will force them to address allegations of abuse, thereby threatening familial relationships that they are dependent on for survival. Yet, there is no easy solution to this conundrum, as it is essential to protect adolescents and children from abuse, while simultaneously attempting to engage the family system in treatment.

9.2.4 The Wellbeing of Caregivers is Essential for Adolescent Suicide Prevention

The clinicians' and caregivers' accounts suggest that the wellbeing of parents and caregivers is essential for preventing adolescent suicide attempts and for ensuring the familial support

desired by the adolescents following their attempts. The caregivers and clinicians recommended that wellbeing could be enhanced through the provision of psychological and psychiatric support for parents and caregivers. Caregivers also requested input on how to manage the adolescents. Yet, the caregivers' narratives also suggest that assistance with the emotional and financial burden of childcare would alleviate the pressure placed on them.

9.2.5 Autonomy, Relational Security, and Learned Behaviours: Implications for the Health Care System

The adolescents' accounts emphasised the importance of maintaining a degree of autonomy during their treatment in the CAMH unit. This was considered important in a context where there was a lack of autonomy in their daily lives, and where suicidal behaviour could be interpreted as a reassertion of control. Although the adolescents reported that they learned about suicidal behaviours from others in the CAMH unit, they also described using self-harm to rebel against a perceived loss of control during inpatient hospitalisation. The loss of autonomy was particularly pronounced for those who experienced inpatient admission to adult wards prior to their transfer to the CAMH unit. These findings suggest the importance of adolescent-specific services, so that acutely suicidal adolescents are not admitted to general adult wards. Allowing the adolescents some choice during treatment may also enhance feelings of autonomy, and thereby contribute to engagement in the treatment. Service providers could therefore consider how to structure and design treatment, activities, and hospital settings in such a way that allows for enhanced choice and freedom, while maintaining the necessary safety. Ideally, where resources allow, adolescents should be able to choose the form and type of treatment they access.

The adolescents' emphasis on connectedness and the need for relational security also implies that it is important for the health system to function in a manner that allows for stability and physical and psychological safety. The clinicians' accounts in turn suggest how their anxiety has the potential to impact on the relational rapport with the adolescents, through the prioritisation of repeated risk assessments and the focus on suicidal behaviour at the expense of underlying concerns. As suggested by the clinicians, a safe space to discuss and reflect on these concerns and anxieties may enhance a feeling of security for both the clinicians, and by implication, the adolescents they work with.

9.2.6 Potential Areas for Future Research: Siblings, Pets, and Betrayal

The role of siblings and pets in the lives of suicidal adolescents are underexplored areas within suicidology research. The adolescents' accounts suggest the importance of their relationships with siblings, and how feeling responsible for the welfare of their younger siblings protected them from further suicide attempts. Considering that the suicidal behaviour of family members increases the risk of suicide attempts (Abrutyn & Mueller, 2014; Roberts et al., 2010), it would also be important to consider how the adolescents' siblings are coping, and whether they themselves are grappling with suicidal behaviours (and how the siblings may influence each other in this regard). The feeling of betrayal, and its salience for adolescent suicide attempts, is another potential area for research. Betrayal, especially a failure to protect the adolescents from abuse, was described as interlinked with their suicide attempts; and it would be of interest to uncover whether this also applies to other contexts.

9.2.7 Considerations for Research Ethics Committees

The potential for vicarious traumatisation exists when working in the field of suicide and suicide prevention (Chen et al., 2019; Dickson-Swift et al., 2008). Although this can impact both clinician-researchers, and those without prior experience of working in the field (Chen et al., 2019; McKenzie et al., 2017), I believe that particular consideration should be given when deciding what research tasks to assign to non-clinically trained individuals working in suicide prevention. Apart from considering the welfare of the research participants, ethics committees should also ensure that the relevant support, and where necessary, training, is implemented to minimise the risk of harm to both research participants *and* researchers.

9.3 LIMITATIONS OF THE RESEARCH

9.3.1 Causality Cannot Be Implied

The ontological and epistemological assumptions of IPA do not allow for an objective representation of reality or claims about the "truth" of a phenomenon. Knowledge can only be interpretative in nature, and is influenced by the participants' and researcher's blind spots, biases, and positioning in the world (Larkin & Thompson, 2012; Smith & Eatough, 2007; Smith

et al., 2009). Therefore, this research can make no causal claims regarding adolescents' suicide attempts. The participants' accounts are at best partial accounts. As stated by Clifford (1986), "truth" is co-created out of many conflicting narratives, resulting in many "partial truths". The accounts of the adolescents' suicide attempts were co-created in their telling and in my interpretation thereof. Despite reflecting on my biases, it is impossible to completely bracket these, or be aware of all my blind spots. For example, having previously worked in the CAMH unit in which this research was conducted meant that I empathised with the clinicians' challenges of working in the system. I may therefore have been less critical of their accounts than if I had been an outsider. Furthermore, some of the contextual and interpersonal challenges described by the participants are unlikely to be unique to suicidal adolescents or their families. This commonality also applies to some quantitative suicidology research, where risk factors are common to distressed (but not necessarily suicidal) youth (Wagner et al., 2003). The chosen research design for this study does not allow (or intend) for a determination of differences between those adolescents from the same community who have and have not attempted suicide. Ultimately, there are multiple pathways to suicide and suicide attempts. Causality cannot be implied, and recommendations cannot be regarded as definitive.

9.3.2 The (Un)reliability of Autobiographical Accounts

This research relied on first-person narratives, which raises the question of how reliable these accounts are. The unreliability of memory, lying, or silences about aspects of experience may all contribute to a particular version of the truth (Bantjes & Swartz, 2019; Gardner, 2001). We also cannot assume that the research participants have complete insight into their behaviour or motivations (Bantjes & Swartz, 2019), or that perspectives on personal behaviour remain static over time. The adolescents' suicide attempts may have been motivated by unconscious factors which they, by definition, are unaware of. Participants' accounts may have performative functions (Whitaker & Atkinson, 2019), aiming to elicit certain reactions from me, the clinical team, or other participants, or to present themselves in a favourable light. The participants' narratives are also situated within relational contexts and power hierarchies, which may have influenced the (co)construction of accounts (Gardner, 2001). For example, having previously worked with some of the clinicians I interviewed may have shaped their accounts. The intersubjective context in which the data is collected influences which narratives are privileged. For example, during the focus group some adolescents revealed information about themselves

which they had previously not shared with me. It is also possible that individuals are at times unaware of their thoughts or opinions until such time when they actively debate these with other people (Tomkins & Eatough, 2010). Finally, the question remains whether the participants were accurately able to convey their lived experience through language and photographs (Hood, 2016).

9.3.3 Untold Stories and Silences in the Research

Due to the richness of the participants' accounts, I was unable to explore all aspects of their narratives. One of these is sexuality. Three of the adolescents self-identified as bisexual and two as pansexual on the brief demographic questionnaire they completed. Yet almost none of them spontaneously raised the topic of sexuality during their interviews. I was interested in the intersection between their sexual orientation and suicide attempts, suspecting that discrimination may have contributed to their experience. When I asked the adolescents about this, most commented that although society and their families may judge them, this had not influenced their decision to attempt suicide. For example, Debbie commented:

> *"I know what I sort of believe in and I have been judged all my life, so what society really thinks doesn't really affect me because at the end of the day it's my life. So, if I want to go out with a girl, I will love a girl (laughs)."*

One participant commented that struggles around sexual orientation or gender identity may impact on *other* adolescents' decisions to attempt suicide, but this was not the case for themselves. I suspect that discrimination around issues of sexuality and gender may have contributed to the adolescents' feelings of being invalidated. Yet, in the context of high levels of trauma, it may not have been the most salient aspect that this particular group of adolescents thought of in relation to their suicide attempts.

Religion was another topic that was infrequently mentioned by the adolescents. Two adolescents briefly alluded to not conforming with their families' religious beliefs, while another related how she enjoyed assisting children at Sunday school. Both sexuality and religious beliefs are aspects that speak to identity formation during adolescence, but which the adolescents did not choose to focus on. Another silence concerns the adolescents' conceptualisation of death. Some authors posit that adolescents' suicide attempts are an effort

to master death, and to understand the nature of mortality, while still aware of the feeling of immortality present in childhood (Grandclerc et al., 2019). This group of adolescents focused on what death could offer them (an escape from their current situation), rather than on the concept of death itself.

9.3.4 The Overlap in Categories of Suicidal Behaviour

This research focused on the phenomenon of adolescent suicide attempts. Research has described differences in adolescents' experiences and motivations when engaging in NSSI and suicide attempts (e.g., Brausch & Gutierrez, 2010; Taliaferro et al., 2019). I therefore decided to focus on suicide attempts, instead of the broader category of self-harm, as I did not want to include adolescents who had *only* engaged in NSSI. However, this distinction was challenging at times. All the adolescents in this study had engaged in both NSSI and suicide attempts, and the boundaries between these at times were blurred. Past research has found a lack of consensus among clinicians in classifying episodes of self-harm as suicide attempts or not, even when definitions were provided. This was especially the case for those instances where the severity of episodes was regarded as moderate or in-between (Wagner et al., 2002). Similarly, in this research all groups of participants expressed uncertainty as to the adolescents' intent regarding some instances of suicidal behaviour. The adolescents themselves struggled with this distinction at times, for example describing self-harm that started with the intent to kill themselves, but then attenuated into NSSI. It was necessary to provide room for this ambiguity, in order to acknowledge the complexity of suicidal behaviour.

9.3.5 Characteristics of Participants

I chose not to exclude participants based on gender, although some research suggests that risk factors are gender-specific (Miranda-Mendizabal et al., 2019). The experience of sexual abuse was not reported by the two males in this research. However, relational aspects such as emotional disconnection from parents, relationships with younger siblings, and the desire to belong, were common experiences reported by the adolescents, regardless of their gender. The adolescent participants may also differ from suicidal adolescents in the community who did not access treatment at a psychiatric hospital. Another consideration is that four of the interviewed caregivers were not the adolescents' parents, and their description of the

adolescent-parent relationship was therefore from an outsider's viewpoint. The clinicians were also a unique group, as they worked in a specialist CAMH unit, and their understanding and viewpoints may therefore differ from those of clinicians working in community or general hospital settings. For example, existing literature emphasises an incomprehension of suicidal behaviour by clinicians working in a variety of health settings (M. Anderson et al., 2003; Lachal et al., 2015; Obando Medina et al., 2014). This was however not reflected by the clinicians' accounts in this study, possibly because they worked in a specialist CAHM unit and worked with suicidal adolescents on a daily basis.

9.4 WHAT IS NOVEL ABOUT THIS RESEARCH?

9.4.1 The Use of a Multiperspectival Research Design, and the Incorporation of Photo-Elicitation

I chose to use a multiperspectival research design for this study to provide a more nuanced and contextualised understanding of adolescent suicide attempts. This design allowed me to interpret the phenomenon of adolescent suicide attempts at the intersection of the lived experience of the adolescents, and those in their "lived world" (Larkin et al., 2019, p.182), namely their caregivers and clinicians. Using a multiperspectival design therefore proved particularly useful due to the strong intersubjective dimension of the experience of adolescent suicide attempts. To my knowledge, the phenomenon of adolescent suicide attempts has not previously been explored using a multiperspectival design that concerned the adolescents, their caregivers, and clinicians. The perspectives of caregivers and clinicians are also lacking in a South African, and African, context. The incorporation of photography in the research design further enhanced contextual understanding, by allowing the adolescents to capture and describe aspects of their experience outside the hospital setting that may otherwise have been difficult to convey. Overall, the use of a multiperspectival research design, combined with photo-elicitation, allows for greater transferability of the findings across similar contexts (although generalisability can never be claimed).

9.4.2 Novel Findings

The research resulted in a few novel findings. These include the description of younger siblings and pets as protecting against further suicide attempts, by seemingly contributing to a sense of relational security and validation. Here the parentification of the adolescents, who take on the responsibility of caring for and protecting their younger siblings, seems to serve a protective function. The feeling of betrayal as intertwined with the adolescents' suicide attempts is another aspect of experience that has not been examined in the literature. The feeling of betrayal is related to the lack of protection by caregivers, and their minimisation and denial of the adolescents' abuse. Other aspects of the findings that have been underexplored in the suicidology literature include the alleviation of *economic* burdensomeness as contributing to the motivation to attempt suicide; and the potential impact of clinicians' anxiety on undermining the relational rapport with the suicidal adolescents they work with.

9.5 FINAL THOUGHTS

Engaging in this research emphasised that attempted suicide is a relational act that occurs *between* people, situated within a particular context. It seems to me that it is through reconnection with others that healing can occur, both for the adolescents and those impacted by their suicide attempts. Yet, the phenomenon of adolescent suicide attempts cannot be reduced to a few explanatory factors. The participants' accounts highlight its idiographic nature, influenced by socio-cultural, economic, and historical context. Much like human nature, the phenomenon of adolescent suicide attempts remains ambiguous and complex, making the task of suicide prevention difficult and unclear, especially for clinicians (like me) who work with adolescents who have attempted suicide.

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Appendix 1: *Information Leaflet for CAMH Staff*

INFORMATION LEAFLET FOR CAMH STAFF

Title: *Attempted suicide among South African adolescents living in a low resource environment: Lived experience, situated meanings and expressed support needs*

What is the research study about?

We are trying to understand the experience of adolescents who have attempted suicide. We are interested in the adolescents, caregivers and health professionals' opinions of what they think could have prevented the suicide attempt, and their understanding of it. Each adolescent will be asked to participate in two one-on-one interviews with a researcher, and will be given a disposable camera to take photos between sessions. A group session will be held, where the researcher presents her findings to the group of adolescent participants, and asks for feedback about the research findings from the group. In addition, one caregiver and one treating clinician (e.g. doctor, nurse, OT, social worker, psychologist etc.) will be interviewed for each adolescent participating in the study.

Who are the researchers?

The principal investigator is Sonja Pasche, who is enrolled as a PhD student in the Department of Psychology at Stellenbosch University, and is conducting the research for her PhD. Her supervisor is another clinical psychologist, Dr Jason Bantjes, who is based in the same department at Stellenbosch University.

Ethical approval

The study has been approved by the Health Research Ethics Committee at Stellenbosch University, and by the Department of Health. The ethics committee can be contacted at 021 938 9677 if you have any concerns. The reference number is S16/09/171.

Inclusion criteria for adolescent participants

- Adolescents must be 13 to 18 years of age to be included in the study.
- They can be inpatients or outpatients at [redacted]'s CAMH unit.

- The adolescent should have attempted suicide during the 6 months preceding recruitment, or their suicide attempt was interrupted. If the clinician, referrer to the CAMH unit or the adolescent perceives the act as a suicide attempt or interrupted attempt, it is sufficient for inclusion.
- Adolescents should reside within the areas of Mitchells Plain, Khayelitsha or Philippi.
- Adolescents who are psychotic at the time of recruitment should be excluded from the study.

How can you assist?

It would be greatly appreciated if you could identify adolescents who meet the above inclusion criteria and ask them if they are willing to participate in the study. I can then meet with the adolescent and their caregiver at a time convenient to them to further explain the details of the study.

Contact details

You can e-mail Sonja at **sonjapasche@gmail.com** or phone her on 072 352 2932 if you have any questions or would like to inform her of potential participants (with their permission).

Appendix 2: *Information Leaflet and Assent Form for Adolescent*

PARTICIPANT INFORMATION LEAFLET AND ASSENT FORM

TITLE OF RESEARCH PROJECT: *Attempted suicide among South African teenagers*

RESEARCHERS' NAMES: Sonja Pasche[1] and Dr Jason Bantjes[1]
ADDRESS:
[1]Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa
CONTACT NUMBERS:
Sonja Pasche: 072 352 2932
Dr Jason Bantjes: 083 234 5554

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 illness and how people think and feel. Research also helps us to find better ways of helping, or treating children and teenagers who are sick.

You are being invited to take part in a research project. Please take some time to read this information, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are satisfied that you clearly understand what this research involves and what is expected from you. Your participation is **entirely voluntary** and you do not have to participate if you do not want to do so. If you say no, this will not affect you negatively in any way whatsoever. You can stop being a part of this study at any time, even if you said you would take part. If any new, relevant information becomes important during the course of the study, you have the right to be told of this.
This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** (021 938 9677). You may contact this committee if you have any questions or concerns regarding your rights. Furthermore the study will be

conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research project all about?

We are trying to understand the experience of teenagers who have attempted suicide. We are interested in the opinions that teenagers, parents and doctors have about teenage suicide attempts and how to prevent them. In total, we are aiming to interview 10 teenagers who are attending [redacted] *Hospital, 10 caregivers and 10 health professionals.*

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

You have been asked to take part because you are a teenager who has attempted suicide during the past 6 months.

Who is doing the research?

My name is Sonja Pasche. I am a clinical psychologist, who is studying towards a PhD in Psychology at Stellenbosch University. This research is for my PhD.

What will happen to me in this study?

You will be asked to talk to a researcher about your experience of attempting suicide and your thoughts about it. You will meet alone with the researcher in a private space at two different times. The researcher will also give you a camera and ask you to take pictures to help her better understand your life and thoughts. Later in the research process, a group meeting will be held where you will meet with the researcher and other teenagers. The researcher will present her findings to the group and will ask for your feedback and opinion. You will also be asked to name one important adult person in your life (e.g. your parent, or another family member), who we can ask about his/her opinions. We would also like your permission to talk to one of your doctors about their opinion. The interviews will be audio recorded. No-one besides the researcher, her supervisor and research assistant(s) will be allowed to listen to the recordings.

Can anything bad happen to me?

Talking about your experiences may make you feel upset or angry. You can stop the interview at any time. If the researcher is concerned about your safety, she will inform a doctor. If necessary, the doctor may admit you to the inpatient unit. We will keep your name and information confidential, but cannot guarantee that someone else (e.g. family member or another teenager) will not disclose your identity.

Can anything good happen to me?

Talking about your experiences may make you feel better. The results of the research can help other teenagers who are thinking about attempting suicide. You will be given money for your transport to attend the interviews.

Will anyone know I am in the study?

We will keep your information confidential. Your name will be changed in any written reports or presentations. If we want to use any of your photos, we will ask for your permission first. Only the researcher, her supervisor and research assistant(s) will have access to the information obtained. Sponsors or the research ethics committee may request access to the collected information, but this will be anonymised so that it cannot be linked back to you.

Where will the study take place?

You will talk to the researcher in a private space in the Child & Adolescent Mental Health Unit at [redacted] *Hospital at a time that is convenient for you.*

How long will the interviews take?

Two individual (one-on-one) interviews and one group interview will take place. Each interview can take up to 90 minutes.

Who can I talk to about the study?

You can phone the researcher, Sonja Pasche, at 072 352 2932; or her supervisor, Dr Jason Bantjes, at 083 234 5554. You can also talk to the Health Research Ethics Committee at Stellenbosch University at 021 938 9677 if you have any concerns about the study.

What if I do not want to do this?

You do not have to participate, even if your parent or caregiver has agreed. You can stop being in the study at any time without any negative consequences.

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 pull out of the study at any time?

YES NO

Signed at (*place*) …… on (*date*) …… 2017.

....

Signature of adolescent **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) .....…..…… on (*date*) ……...…….. 2017.

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator (*name*) ……. to explain the information in this document to (*name of participant*) ……..…….. using the language medium of Afrikaans/ isiXhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…..…….. on (*date*) ……...…… 2017

....

Signature of interpreter **Signature of witness**

Appendix 3: *Information Leaflet and Consent Form for Adolescent to Participate*

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE: *Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience, and expressed support needs*

REFERENCE NUMBER: S16/09/171

PRINCIPAL INVESTIGATORS: Sonja Pasche[1]

CO-INVESTIGATORS: Dr Jason Bantjes[1]

ADDRESS:

[1]Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa

CONTACT NUMBERS:

Sonja Pasche: 072 352 2932

Dr Jason Bantjes: 083 234 5554

_____ *(name of adolescent; hereafter referred to as "your adolescent")* is being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you and your adolescent could be involved. Also, your adolescent's participation is **entirely voluntary** and s/he and you are free to decline to participate. If you say no, this will not affect you or your adolescent negatively in any way whatsoever. You are also free to withdraw your adolescent from the study at any point, even if you gave permission for him/her to take part. If any new, relevant information becomes important during the course of the study, you have the right to be notified of this.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** (021 938 9677). You may contact this committee if you have any questions or concerns regarding your rights or the welfare of the research

participants. Furthermore, the study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

We are trying to understand the experience of adolescents who have attempted suicide. We are interested in the adolescents, caregivers and health professionals' opinions of what they think could have prevented the suicide attempt, and their understanding of it. Each adolescent will be asked to participate in two one-on-one interviews with a researcher, and will be given a disposable camera to take photos between sessions. A group session will be held, where the researcher presents her findings to the group of adolescent participants, and asks for feedback about the research findings from the group. In addition, one caregiver and one treating clinician (e.g. doctor, psychologist) will be interviewed for each adolescent participating in the study. In total, we are aiming to interview 10 adolescents attending [redacted] *Hospital, 10 caregivers and 10 health professionals.*

Why have you been invited to participate?

You have been asked to provide consent as the parent/ guardian/ caregiver of _____ *(name of adolescent). This means, that we are asking for your permission for* _____ *(name of adolescent) to participate in the study.*

What will your responsibilities be?

If you agree that your adolescent can take part in the study, it is your responsibility to ensure that s/he attends all appointments relating to the research. Your adolescent will be asked to attend 3 sessions, each lasting up to 90 minutes.

Where will the data collection take place?

The interviews will take place in a private space in the Child & Adolescent Mental Health Unit at [redacted] *Hospital at a time that is convenient for your adolescent.*

How long will the interviews take?

Two individual (one-on-one) interviews and one group interview will take place. Each interview can take up to 90 minutes.

Will you/ your adolescent benefit from taking part in this research?

There is no direct benefit for taking part in this study, although the findings from this research may be used to inform prevention of suicidal behaviour among adolescents. Some adolescents also experience a sense of relief at being able to tell their story.

Are there any risks involved in taking part in this research?

Your adolescent will be asked about his/her experience of attempting suicide, and his/her thoughts about what could prevent this in future. This may cause some emotional distress. When writing up the research results, names of participants will be removed. You and your adolescent will be asked for permission to use photos taken by your adolescent during the research. The interviews will be audio recorded. Only the researcher, her supervisor and research assistant(s) will have access to the data. Sponsors or the research ethics committee may request access to data, but this will be anonymised. Although we try to protect participants' identity and privacy as far as possible, we cannot guarantee that someone else will not disclose it.

If you do not agree to take part, what alternatives do you have?

You and your adolescent can choose whether or not to take part in this study, so if you choose not to participate, this will not have any impact on the treatment your adolescent receives.

Who will have access to the information provided during the research?

Only the researcher, her supervisor and research assistants will have access to the information obtained. The research findings will be written up and may be published (e.g. in an academic journal or book) and may be presented (e.g. at a conference). However, the participants' real names will not be used. We will ask you and your adolescent for permission to use the photos taken by your adolescent.

What will happen in the unlikely event of some form of injury occurring as a direct result of your adolescent taking part in this research study?

There is no danger of physical injury by participating in this study. Your adolescent may however become emotionally upset as a result of answering the questions. If this happens, s/he can stop the interview at any time. His/her doctor will also be informed. If the interviewer is concerned about the adolescent's safety, she will inform the psychiatric registrar, who will determine whether an admission is required or not.

What will happen if my adolescent becomes emotionally upset as a result of the research?

In the event that your adolescent becomes emotionally upset as a result of taking part in this research, his/her doctor will be informed, and the necessary support and/or treatment will be provided.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid. However, your adolescent will receive R50 for every interview s/he attends, and for dropping off the camera. Your adolescent will therefore receive R200 in total to cover transport costs. Snacks and cooldrink will be provided at the sessions.

Is there anything else that you should know or do?

- You can contact Sonja Pasche at 072 352 2932 or Dr Jason Bantjes at 083 234 5554 if you have any further questions or have any problems.
- You can contact the Stellenbosch University Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been dealt with properly by the researcher.
- You will get a copy of this information and consent form for your own records.

Declaration by parent/guardian/ caregiver of adolescent

By signing below I, …… , *(parent/ guardian/ caregiver)* provide permission for …….. *(name of adolescent)* to take part in a research study entitled, *Attempted suicide among South African adolescents living in a low resource environment: Lived experience, situated meanings and expressed support needs.*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and we have not been pressurised to take part.
- We may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- …… *(name of adolescent)* may be asked to leave the study before it has finished, if the researcher feels it is in his/her best interests, or if s/he does not follow the study plan, as agreed to.

Signed at (*place*) …… on (*date*) …… 2017.

…….. ……..

Signature of parent/ guardian/ caregiver **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.)*

Signed at (*place*) .....…..…… on (*date*) ……...…….. 2017.

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator (*name*) ……. to explain the information in this document to (*name of participant*) ……..…….. using the language medium of Afrikaans/ isiXhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…..…….. on (*date*) ……...…… 2017

....

Signature of interpreter **Signature of witness**

Appendix 4: *Information Leaflet and Consent Form for Caregiver*

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE: *Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience, and expressed support needs*

REFERENCE NUMBER: S16/09/171
PRINCIPAL INVESTIGATORS: Sonja Pasche[1]
CO-INVESTIGATORS: Dr Jason Bantjes[1]
ADDRESS:
[1]Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa
CONTACT NUMBERS:
Sonja Pasche: 072 352 2932
Dr Jason Bantjes: 083 234 5554

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

We are trying to understand the experience of adolescents who have attempted suicide. We are interested in the adolescents, caregivers and health professionals' opinions of what they think could have prevented the suicide attempt, and their understanding of it. In total, we are aiming to interview 10 adolescents attending [redacted] *Hospital, 10 caregivers and 10 health professionals.*

Why have you been invited to participate?

You have been asked to participate as you are the parent/ guardian/ caregiver of an adolescent who has attempted suicide during the past 6 months. The adolescent concerned identified you as the person they would like us to interview.

What will your responsibilities be?

If you agree to participate, you will be asked to attend one interview with a researcher, who will ask for your thoughts on the adolescent's suicide attempt and your ideas around prevention of adolescent suicide.

Where will the data collection take place?

The interview will take place in a private space in the Child & Adolescent Mental Health Unit at [redacted] *Hospital at a time that is convenient for you.*

How long will the interview take?

The interview can take up to 90 minutes.

Will you benefit from taking part in this research?

There is no direct benefit for taking part in this study, although the findings from this research may be used to inform prevention of suicidal behaviour among adolescents. You may also experience a sense of relief at being able to tell your part of the story.

Are there any risks involved in your taking part in this research?

You will be asked questions about the adolescent's suicide attempt and your thoughts around it. These questions may cause some emotional distress. When writing up the research results, names of participants will be removed. You will be given the opportunity to choose another name that the researchers can use when they write

about the research. This is to ensure that your identity remains anonymous. Although we try to protect participants' identity and privacy as far as possible, we cannot guarantee that someone else will not disclose it.

If you do not agree to take part, what alternatives do you have?

You can choose whether or not to take part in this study, so if you choose not to participate, this will not have any negative impact on you, or on the treatment received by your adolescent.

Who will have access to the information provided during the research?

Only the researcher, her supervisor and research assistant(s) will have access to the information obtained. Sponsors or the research ethics committee may request access to the collected information, but this will be anonymised so that it cannot be linked back to you. The research findings will be written up and may be published (e.g. in an academic journal or book) and may be presented (e.g. at a conference). However, the participants' real names will not be used.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

There is no danger of physical injury by participating in this study. You may however become emotionally upset as a result of answering the questions. If this happens, you can stop the interview at any time.

What will happen if I become emotionally upset as a result of the research?

In the event that you become emotionally upset as a result of taking part in this research, the health care team in the unit will be informed. You will be referred to a psychologist or another mental health practitioner at the local clinic or hospital, who will provide the necessary support or treatment.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid. However, you will receive R50 to cover your transport costs to attend the interview.

Is there anything else that you should know or do?

- You can contact Sonja Pasche at 072 352 2932 or Dr Jason Bantjes at 083 234 5554 if you have any further questions or have any problems.
- You can contact the Stellenbosch University Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been dealt with properly by the researcher.
- You will get a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..…… agree to take part in a research study entitled, *Attempted suicide among South African adolescents living in a low resource environment: Lived experience, situated meanings and expressed support needs.*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…….……. on (*date*) ……...…….. 2017.

....

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..…… on (*date*) ……...……2017.

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator (*name*) …… to explain the information in this document to (*name of participant*) ……..…….. using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…..…….. on (*date*) ……...…… 2017

....

Signature of interpreter **Signature of witness**

Appendix 5: *Information Leaflet and Consent Form for Clinician*

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE: *Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience, and expressed support needs*

REFERENCE NUMBER: S16/09/171

PRINCIPAL INVESTIGATORS: Sonja Pasche[1]

CO-INVESTIGATORS: Dr Jason Bantjes[1]

ADDRESS:

[1]Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa

CONTACT NUMBERS:

Sonja Pasche: 072 352 2932

Dr Jason Bantjes: 083 234 5554

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

We are trying to understand the experience of adolescents who have attempted suicide. We are interested in the adolescents, caregivers and health professionals' opinions of what they think could have prevented the suicide attempt, and their understanding of it. In total, we are aiming to interview 10 adolescents attending [redacted] *Hospital, 10 caregivers and 10 health professionals.*

Why have you been invited to participate?

You have been asked to participate as you are a health professional who is involved in the treatment of an adolescent who has attempted suicide during the past 6 months.

What will your responsibilities be?

If you agree to participate, you will be asked to attend one interview with a researcher, who will ask for your thoughts on the adolescent's suicide attempt and your ideas around prevention of adolescent suicide. The interview will be audio recorded.

Where will the data collection take place?

The interview will take place in a private space in the Child & Adolescent Mental Health Unit at [redacted] *Hospital at a time that is convenient for you.*

How long will the interview take?

The interview will take approximately 30 minutes.

Will you benefit from taking part in this research?

There is no direct benefit for taking part in this study, although the findings from this research may be used to inform prevention of suicidal behaviour among adolescents.

Are there any risks involved in your taking part in this research?

There are no perceived risks in your taking part in this research. Your name will be removed from the data collected and replaced with a pseudonym of your choosing so that confidentiality is maintained. The audio recording of the interview will only be available to the researcher, her supervisor and research assistant(s).

If you do not agree to take part, what alternatives do you have?

Participation is voluntary, and there will be no disadvantages if you decide not to participate.

Who will have access to the information provided during the research?

Only the researcher, her supervisor and research assistant(s) will have access to the information obtained. Sponsors or the research ethics committee may request access to the collected information, but this will be anonymised so that it cannot be linked back to you. The research findings will be written up and may be published (e.g. in an academic journal or book) and may be presented (e.g. at a conference). However, the participants' real names will not be used.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

There is no danger of physical injury by participating in this study. You may however become emotionally upset as a result of answering the questions. If this happens, you can stop the interview at any time.

What will happen if I become emotionally upset as a result of the research?

In the event that you become emotionally upset as a result of taking part in this research, you will be referred to a counsellor from the Employee Health and Wellness Programme or a private mental health practitioner, who will provide the necessary support or treatment.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid. The interview will occur in a place and at a time that is convenient for you.

Is there anything else that you should know or do?

- You can contact Sonja Pasche at 072 352 2932 or Dr Jason Bantjes at 083 234 5554 if you have any further questions or have any problems.
- You can contact the Stellenbosch University Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been dealt with properly by the researcher.
- You will get a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..…… agree to take part in a research study entitled, *Attempted suicide among South African adolescents living in a low resource environment: Lived experience, situated meanings and expressed support needs.*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……..…….. 2017.

…….. ……..

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that s/he adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .....…..…… on (*date*) ……...……2017.

....

Signature of investigator **Signature of witness**

Declaration by interpreter

I *(name)* ……..…… declare that:

- I assisted the investigator (*name*) …… to explain the information in this document to (*name of participant*) ……..…….. using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) .....…..…….. on (*date*) ……...…… 2017

....

Signature of interpreter **Signature of witness**

Appendix 6: *Interview Schedule for Adolescent, First Interview*

1. **Please can you tell me about your life and the people in it?**

   Prompt (if necessary):

   - Friends & family
   - School
   - Typical day
   - Living situation
   - Significant life events

2. **Please can you tell me the story of your suicide attempt?**

   Prompts (if necessary):

   - Precipitants
   - Method
   - Consequences
   - Reactions

3. **How do you understand or make sense of your suicide attempt?**

   Prompt (if necessary):

   - Attributed meaning

4. **What, if anything, would have stopped you from attempting suicide?**

5. **What support do you need?**

   Prompt (if necessary):

   - Coping

6. **What do you think is needed to prevent suicide amongst teenagers?**

   Prompt (if necessary):

   - Society's role
   - Desired change

Appendix 7: *Interview Schedule for Adolescent, Second Interview*

1. You were asked to take photographs that will help me understand what contributed to your suicide attempt, and to keeping you alive. All of your developed photographs are here. Please take a good look at all of them. Then please choose as many or as few photographs as you like and tell me about the meaning and significance of the photographs.
   Cues will be largely taken from the adolescent's description of the selected photos.

2. What was your experience of receiving care at the hospitals or clinics after your suicide attempt?

3. What is your experience of being part of this research project so far?
   Prompt (if necessary):
   - Likes
   - Dislikes

Appendix 8: *Interview Schedule for Caregiver*

1. **Please tell me about your relationship to *(name)*.**

2. **Please could you tell me about *(name)*'s suicide attempt?**

3. **How do you understand *(name)*'s suicide attempt?**
   Prompts (if necessary):
   - Reason
   - Precipitants

4. **What, if anything, do you think would have stopped *(name)* from attempting suicide?**

5. **What do you think could be done to prevent suicide amongst our youth?**
   Prompt (if necessary):
   - Desired change

6. **How have you coped with (name)'s suicide attempt?**
   Prompt (if necessary):
   - Support needs

7. **How have you experienced the health care system in relation to *(name)*'s suicide attempt?**
   Prompt (if necessary):
   - Own interaction with health care system

Appendix 9: *Interview Schedule for Clinician*

1. **Please tell me about your experience of working with suicidal adolescents.**

Prompts (if necessary)

- Feelings elicited

2. **How do you understand *(name)*'s suicide attempt? How does it compare with other suicide attempts you have seen?**

Prompts (if necessary):

- Reason
- Precipitants

3. **What, if anything, do you think would have stopped *(name)* from attempting suicide?**

4. **What do you think could be done to prevent suicide amongst our youth?**

Prompt (if necessary):

- Desired change

5. **How do you cope with working with suicidal adolescents?**

Prompt (if necessary):

- Support needs

Appendix 10: *Socio-Demographic Questionnaire for Adolescent*

1. Gender:

Male	Female	Other (specify)

2. Age: _____

3. Current school grade: _____

(If not in school, please tick box and provide the most recent grade completed)

Not in school

4. Ethnicity:

Black	Coloured	White	Asian	Other

5. Home Language:

Afrikaans	English	isiXhosa	Other (specify)

6. Sexual Orientation:

Heterosexual ("straight")	Homosexual ("gay")	Bisexual	Other (specify)

7. a) Have you ever intentionally hurt yourself?
(e.g. cutting, burning etc.)

Yes	No

b) If "yes", how old were you when you first hurt yourself? _____

8. How many previous suicide attempts have you made?

None	1	2	3 or more

9. How many siblings (brothers and sisters) do you have? _____

Appendix 11: *Socio-Demographic Questionnaire for Caregiver*

1. **Gender:**

Male	Female	Other (specify):

2. **Age:** _____

3. **Relationship to adolescent:**

Biological Parent	Grandparent	Family member (specify):	Other (specify):

4. **Ethnicity:**

Black	Coloured	White	Asian	Other

5. **Home language:**

Afrikaans	English	isiXhosa	Other (specify):

6. **Employment status:**

Employed	Unemployed	Disability grant	Other (specify):

7. **Highest level of education completed** _____
(e.g. Matric, grade 8)

Appendix 12: *Socio-Demographic Questionnaire for Clinician*

1. **Gender:**

Male	Female	Other (specify):

2. **Age:** _____

3. **Profession:**

Psychiatrist	Psychiatric registrar	Psychologist	Occupational Therapist
Social worker	Medical doctor	Nurse	Physiotherapist

4. **Ethnicity:**

Black	Coloured	White	Asian	Other

5. **Home language:**

Afrikaans	English	isiXhosa	Other (specify):

6. **Number of years working in your profession** _____

7. **Number of years working in the public health care sector** _____

Appendix 13: *Printout of Themes for Focus Group*

Please place stickers next to the experiences that apply to you. Name:

THEME	STICKER	COMMENTS
RELATIONSHIP WITH PARENT		
Difficult or complicated relationship with parent(s)	◯	
Emotionally disconnected from parent(s)	◯	
Absent parent(s) (not physically around)	◯	
COMMUNICATION		
Communication difficulty in family/ with caregiver	◯	
Feeling criticised	◯	
Not being heard	◯	
Suicide attempt as a form of communication	◯	
VALIDATION		
Not being validated/ seen/ heard/ taken seriously	◯	
Feeling misunderstood	◯	
BELONGING		
Feeling like an outsider/ different	◯	
Wanting to be accepted	◯	

Feeling **ISOLATED** and lonely	◯	
LOSS		
Death of family member	◯	
End of friendship/ romantic relationship	◯	
AUTONOMY		
Wanting control over my own life and body	◯	
AMBIVALENCE		
Feeling uncertain/ torn between life and death	◯	
ABUSE		
Experienced abuse (e.g. rape, sexual/ physical/ emotional abuse)	◯	
Family protected perpetrator (person who hurt me)	◯	
POVERTY (family struggling with money/ housing)	◯	
SUBSTANCE USE		
My own drug or alcohol use	◯	
Parents or family had/have alcohol/ drug problems	◯	

Irrational Thinking (my mind is my greatest enemy)	◯	
Depression	◯	
Anxiety	◯	
Bullying	◯	
School difficulties	◯	
I wanted to kill myself:		
To escape (from pain, difficulties)	◯	
Because I felt like a burden to others	◯	
It was a solution to my problems	◯	
Self-harming (e.g. cutting):		
Made me feel better (e.g. calm, less angry)	◯	
Allowed me to externalize internal pain	◯	
Social media (e.g. Facebook, WA) and internet:		
Gave me ideas of how to self-harm or kill myself	◯	
Made me feel less alone	◯	
My experience at [redacted] adolescent unit:		
Talking/ therapy helped me	◯	

Being hospitalized (inpatient) made it worse	◯	
Suicide among teenagers could be reduced:		
If teenagers feel validated/ understood/ listened to	◯	
If more awareness about suicide is created	◯	
If there were more activities in the community	◯	
Things that helped me (protective factors):		
My pets	◯	
Friendship	◯	
Extended family (e.g. grandparent, aunt etc.)	◯	
Hobbies (e.g. music, reading, skateboarding, etc.)	◯	
Reasons to live:		
Other people	◯	
My siblings (sisters and brothers)	◯	

Appendix 14: *Photography Release Form*

Release Form for Photographs

I, ……., *(name)* hereby provide permission for the photographs listed and described below to be published. This includes exhibitions, publications such as books or journal articles, and documentaries.

Description of photographs:

1. ……
2. ……
3. ……...
4. ……
5. ……
6. ……
7. ……
8. ……
9. ……
10. ……
11. ……

Signature (photographer): ……..

Signature (witness): ……

Date: ……..

Appendix 15: *Health Research Ethics Approval, Stellenbosch University*

Approval Notice

Response to Modifications- (New Application)

20-Jan-2017
Pasche, Sonja SC

Ethics Reference #: S16/09/171

Title	**Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience and expressed support needs**

Dear Ms Sonja Pasche,

The **Response to Modifications** - ***(New Application)*** received on **21-Dec-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **20-Jan-2017** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **20-Jan-2017 -19-Jan-2018**
Please remember to use your **protocol number** (**S16/09/171**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389819.

Included Documents:

Protocol.pdf

Protocol Synopsis.pdf

Appendices 1-13.pdf

CV J Bantjes.pdf

20170117 MOD- Modifications Required for HREC # S16-09-176.pdf

20170117 MOD Letter of response S1609171.pdf

Application form.pdf

CV S Pasche.pdf

Checklist.pdf

20170117 MOD PhD protocol, resubmission, S1609171.pdf

Communication from PHD reviewers.pdf

Declaration J Bantjes.pdf

Declaration S Pasche.pdf

Sincerely,

Ashleen Fortuin
HREC Coordinator
Health Research Ethics Committee 2

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Ethics Letter

29-Jan-2018

Ethics Reference #: S16/09/171

Title: Attempted suicide among South African adolescents living in a low resource environment: Contested meanings, lived experience and expressed support needs

Dear Mrs Sonja Pasche,

Your request for extension/annual renewal of ethics approval dated 16 January 2018 refers.

The Health Research Ethics Committee reviewed and approved the annual progress report you submitted through an expedited review process.

The approval of the research project is extended for a further year.

Approval Date: 29 January 2018

Expiry Date: 28 January 2019

Kindly be reminded to submit progress reports two (2) months before expiry date.

Where to submit any documentation

Kindly submit **ONE HARD COPY** to Elvira Rohland, RDSD, Room 5007, Teaching Building, and **ONE ELECTRONIC COPY** to ethics@sun.ac.za .

Please remember to use your **protocol number (S16/09/171)** on any documents or correspondence with the HREC concerning your research protocol.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005240 for HREC1
Institutional Review Board (IRB) Number: IRB0005239 for HREC2

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African

Fakulteit Geneeskunde en Gesondheidswetenskappe
Faculty of Medicine and Health Sciences

Afdeling Navorsingsontwikkeling en -Steun • Research Development and Support Division

Posbus/PO Box 241 • Cape Town 8000 • Suid-Afrika/South Africa
Tel: +27 (0) 21 938 9677

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Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Departement of Health).

Yours sincerely,

Francis Masiye,
HREC Coordinator,
Health Research Ethics Committee 2.

STELLENBOSCH UNIVERSITY
Health Research Ethics Committee
29 JAN 2018
STELLENBOSCH UNIVERSITEIT
Gesondheidsnavorsing Etiekkomittee

Appendix 16: *Health Research Ethics Approval, Department of Health*

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2017RP15_919
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University

Private Bag X1

Matieland

Stellenbosch

7606

For attention: Ms Sonja Pasche, Dr Jason Bantjies

Re: Attempted suicide among South African adolescents living in a low resource environment: Contested meanings lived experience and expressed support needs.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

[redacted]

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 27/3/2017.

Appendix 17: *List of Community-Based Organisations*

MENTAL HEALTH CONTACT LIST

The South African Depression and Anxiety Group (SADAG)

Assists people with a variety of mental health problems via telephonic counselling and referral to support groups and professionals.

Emergency line: 0800 12 13 14 OR 0800 567 567
SMS 31393

Referral to professional or support group: 0800 20 50 26

Website: www.sadag.org

Life Line

Assists people in crisis and with mental health problems via telephonic and face-to-face counselling.

Crisis Line: 021 461 1111 (09h30 – 22h00)

What's App Call: 063 709 2620 (10h00 – 14h00)

Website: www.lifelinewc.org.za

Cape Town Drug Counselling Centre

For people who want help with substance use problems.

Mitchell's Plain: 021 397 0103

Website: www.drugcentre.org.za

Childline (for under 18s)

Assists children & teens with various challenges, including abuse and bullying.

24-hour toll-free crisis line: 08000 55 555

Website: www.childlinesa.org.za