Investigations into Adolescent Non-Fatal Suicidal Behaviour at a Gauteng Public Hospital: Patient and Staff Experiences

by

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Declaration of Originality

I, Anna Maria Kritzinger (Student number: 11357542), declare that the thesis, “Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: Patient and staff experiences”, hereby submitted to the University of Pretoria for the degree Doctor of Philosophy in Clinical Psychology, has not been submitted by me for a degree at this or any other university; that it is my work in design and execution and that all material contained herein has been duly acknowledged.[1 2]

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[1] See Appendix G for Turnitin Originality Certificate.
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Dedication

Dedicated to my late father, who was supportive of my academic endeavours for as long as I can remember.

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Abstract

Increasing statistics on suicidal behaviour are a global concern, and South Africa is no exception. Non-fatal suicidal behaviour (NFSB) among adolescents specifically is also growing at an alarming rate. These trends put tremendous pressure on the health care systems responsible for emergency assistance in cases where suicide attempts result in admission to hospital. Despite this critical health resource consumption, information on health care personnel's experiences of this patient group is scarce. In addition, while intensive work has been done on the clinical management of adolescent suicidal behaviour, an understanding of their experiences in relation to the suicide attempt and subsequent hospital admission remains limited. This qualitative investigation was aimed at exploring the experiences of adolescents admitted to a Gauteng public hospital following a suicide attempt, as well as the experiences of the health care providers who take care of them following admission. The study was based on Interpretive Phenomenological Analysis, utilizing semi-structured individual interviews and focus groups as methods of investigation. Analysis of the data sets culminated in a discussion of the following combined themes: a) placement of this patient group in the hospital setting, b) a possibly impulsive element to the suicidal act, c) intent to die, d) judgement and e) a specific focus on the associated experiences of nursing professionals. The holistic exploration of related experiences provides some insight into the complexity of in-hospital health care for adolescent suicidal behaviour in the current study context, as well as factors contributing to the possible persistence of suicide risk.

Keywords: non-fatal suicidal behaviour, self-harm, adolescence, health care professionals, interpretive phenomenological analysis

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Chapter 1 – Orientation and Aim

1.1 Background to the Study

Approximately one person dies as a result of suicide every 40 seconds, with up to 20 times more people attempting it (World Health Organization, 2018d). A decade ago the World Health Organization (WHO) approximated that one million people die by suicide every year, anticipating significant increases in the years to follow (Bertolote & Fleischman, 2009).

South Africa is no exception to such concerning statistics and suicide has been known to constitute a major public health concern in the country (Schlebush, 2012). Statistics South Africa (2018) reports that 425 people died following intentional self-harm in the country during 2016 and, notably, 192 of those deaths fall into the 15-29 age group. Even though reliable statistics on suicide in South Africa are remarkably difficult to come by, it has been reported that suicidal behaviour is prevalent and increasing at an alarming rate (Bantjes & Kagee, 2013).

It has been widely documented that suicide rates among adolescents worldwide have been increasing, as is confirmed in South African publications (Cha et al., 2018; George & van den Berg, 2012; Klass, 2018; Pillay, Kriel & Moodley, 2007; Reyes-Portillo, Lake, Kleinman, & Gould, 2018; Shilubane et al., 2014). Specifically, suicidal behaviour amongst Black South African youth also seems to be on the increase (Shilubane et al., 2012; 2014). It is estimated that one in five adolescents in South Africa attempts suicide and that these numbers continue to rise (Shilubane et al., 2012). In a national survey of youth risk behaviour in South Africa, Reddy et al. (2010) reported that 20.7% of high school learners had considered attempting suicide, 16.8% had planned to commit suicide and 21.4% had made one or more suicide attempts. After comparing suicidal ideation among adolescents in five cities across the world, Cheng et al. (2014) reported that suicide ideation was the highest among female adolescents in Johannesburg. Despite these concerning statistics, research on adolescent suicidality among different South African communities remains limited.

Non-fatal suicides occur more frequently than fatal suicides (Hawton, Saunders, & O'Connor, 2012; Schlebusch, 2012). However, non-fatal suicide numbers are probably underreported, since these are largely based on admissions to hospital following non-fatal

attempts and do not include attempts that were managed outside the health context. Statistically, women engage in non-fatal suicidal behaviour at a higher rate than men do, while male numbers of completed suicides are higher than those for females (Cha et al., 2018; Kokkevi, Rotsika, Arapaki, & Richardson, 2012; Saunders, Hawton, Fortune, & Farrell, 2012). Studies indicate that non-fatal suicidal behaviour is more common in younger age groups (Goldston et al., 2015; Nock et al., 2013; Norheim, Grimholt, & Ekeberg, 2013; Timson, Priest, & Clark-Carter, 2012). This has been confirmed by research conducted in South Africa (Moosa, Jeenah, Pillay, Vorster, & Liebenberg, 2005; van Pletzen, Stein, Seedat, Williams, & Myer, 2012). One of numerous concerns when these numbers are taken into account is the fact that previous suicide attempts are one of the main risk factors for completed suicidal acts (Hawton et al., 2012; Shilubane et al., 2012; World Health Organization, 2018b). This introduces more pressure on the health care system, which is responsible for provision of services as soon as a patient is admitted to hospital for non-fatal suicidal behaviour (NFSB).

The health care system has an important role in the management of adolescents admitted for NFSB. Since they are at the frontline of receiving NFSB admissions, health care professionals are in a unique position to equip the adolescent NFSB survivor with health care and counselling that might assist with the prevention of future repetitions of such behaviour.

Several international studies have, however, recorded how health care workers may feel overwhelmed, uninformed and incompetent when it comes to the NFSB patient, which may have implications for their levels of empathy (Hughes & Asarnow, 2013; Norheim et al., 2013; Saunders et al., 2012; Timson et al., 2012). While these experiences are documented in other countries, the paucity of research on health care providers' knowledge, beliefs and attitudes in relation to suicidal behaviour in the South African context has been noted before (Bantjes & Kagee, 2013). This paucity remains evident.

Negative attitudes on the part of health care workers have the potential to impact on the quality of care for NFSB patients. This is concerning when it is borne in mind that previous NFSB attempts and deliberate self-harm acts are risk indicators for completed suicide (Shilubane et al., 2013; Timson et al., 2012). In addition, if a patient admitted for NFSB feels emotionally vulnerable, negative attitudes from professionals might further complicate an already difficult recovery process (Norheim et al., 2013). The scarcity of information on the experiences of health care among South African adolescents presenting with suicidal behaviour is significant, indicating the importance of exploration.

If it is true that negative attitudes from health care professionals have a detrimental impact on the adolescent's recovery, the quality of intervention provided by the health care

system is crucial in preventing possible successful suicides. It is significant to note that, in spite of the remarkable volume of published information on new and more effective treatment practices and management strategies for NFSB patients, the suicide death rate has not shown a decline in the past 60 years (Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015). Perhaps it is time to consider other elements in the medical management of NFSB patients, and the establishment of an accurate understanding of the experiences, perceptions and responses of health care staff in relation to NFSB may shed light on this perplexing phenomenon.

1.2 Motivation

The researcher is a clinical psychologist employed at Dr. George Mukhari Academic Hospital (DGMAH). The large numbers of adolescents with suicide attempts admitted to the hospital, often more than once, have led the researcher to identify a need to explore how adolescents experience such admission. An improved understanding of how the adolescent health care user experiences and perceives the suicidal process and subsequent hospital care could expand the knowledge base and possibly guide the development of more efficient treatment strategies for this population within the hospital.

The researcher has also noticed that some of the health care providers may experience the large numbers of adolescents who attempt suicide as overwhelming and demanding in terms of their time and professional input. Such experiences, perceptions and responses might have implications for the quality of care provided, which impacts on the success of an adolescent patient's recovery process.

Since South African literature on health care providers' views and experiences of adolescent suicidality remains scant, acquiring this information may be an important step towards cultivating informed health care professionals who have the competence to tailor interventions that accurately meet the needs of this adolescent health care user population.

On a metalevel it should be acknowledged that no previous publications combining the views of both of these interest groups (i.e. adolescent patients and health care professionals) concerning the manifestation of NFSB were found in preparation for this study. This study therefore aims to provide a unique perspective on how this phenomenon is experienced by different stakeholders in the current study context.

1.3 Aim

To investigate the manifestation and management of non-fatal suicide behaviour in a public hospital by exploring the experiences, perceptions and responses of adolescents who attempted suicide, as well as those of health care workers providing care to them upon admission to hospital.

1.4 Research Question

What are the experiences, perceptions and responses of adolescents who attempt suicide, and those of the health care workers who provide health care to them upon admission to the designated hospital?

1.5 Research Methodology

This study was conducted by means of qualitative research within an interpretive paradigm, in line with the process of Interpretive Phenomenological Analysis.

The research project will consist of two separate segments, i.e. the adolescents admitted following a suicide attempt, and the health care providers who look after them upon admission.

The aim will be to bring these two segments of experiences together in a thematic discussion that applies to both experiential groups but ultimately elucidates the phenomenon of NFSB adolescents in the hospital context.

1.6 Significance of the Study

This unique qualitative view of how these role-players experience, perceive and respond to the phenomenon of non-fatal suicidal behaviour will provide some insight into the South African reality within this context. Such an understanding may not only assist the health care

sector to tailor more effective interventions for this adolescent population, but also shed light on how health care workers may be supported to provide health care interventions that can have an impact on the ever-increasing rates of suicidal behaviour.

1.7 Outline of Chapters

This manuscript consists of the following chapters:

Chapter 1 – Orientation and Aim
Chapter 2 – Literature Review: Suicidality and Adolescence
Chapter 3 – Literature Review: The South African Health Care System
Chapter 4 – Research Methodology
Chapter 5 – Findings: Adolescent Participants
Chapter 6 – Findings: Health Care Practitioners
Chapter 7 – Discussion and Conclusions
Chapter 8 – Limitations and Recommendations

1.8 Conclusion

This introductory chapter provided an overview of some of the literature confirming the relevance of this study. Reference was also made to the dearth of South African publications having specific reference to the focus of the current study.

The motivation for the study was noted, as well as the overall aim of attempting to bring these different and unique experiences together in a relevant, contemporaneous discussion that may inform current health care practices aimed at benefiting the adolescent suicidal patient and the health care professional.

The following section will focus on existing relevant literature, with specific attention to suicidality and the adolescent developmental period.

Chapter 2 – Literature Review: Suicidality and Adolescence

2.1 Suicidality

2.1.1 Introduction.

Suicidality is a global phenomenon that continues to challenge existing knowledge bases, is manifest in unique forms among different populations and results in new presentations as the modern era unfolds. One definite area of consistency, though, is the ever-present danger of completion.

This literature review section commences with an overview of suicidal behaviour, its prominence, related definitions and risk factors, to create a context for the discussion of suicidal behaviour manifestations occurring in the adolescent developmental period.

2.1.2 Prevalence of suicide.

It has been recorded that one person dies through suicide every 40 seconds, while up to 20 times more people attempt it in that same space of time (World Health Organization, 2018d). A decade ago it was approximated that one million people die by suicide every year, with forecasts that these numbers would significantly increase (Bertolote & Fleischman, 2009). These predictions have been substantiated, culminating in estimations that global suicide rates have increased by 60% over the past 45 years (suicide.org, 2018). This constantly rising global burden of suicidality has prompted the World Health Organization to declare suicide a public health concern (World Health Organization, 2018a).

South Africa is no exception to these concerning suicide statistics, and in 2016 the suicide mortality rate was recorded as 11.6 per 100 000, which was higher than the international suicide rate at that time (World Health Organization, 2018d). It is, however, a fact that African suicide statistics are not accurate, owing to underreporting, misclassification or the hiding of suicide information for religious or legal reasons (Iemmi et al., 2016; Mars, Burrows, Hjelmeland, & Gunnell, 2014; Shilubane et al., 2013; World Health Organization, 2018c). In addition to

underreported suicide numbers, suicide attempts can also go unnoticed when socio-cultural norms sanction such behaviour, because of a lack of access to health services or the decision not to attend health care services following an attempt (Mars et al., 2014). Despite the statistical inaccuracy of information about suicide and suicide-related behaviour in South Africa, the increasing prevalence thereof cannot be discounted (Bantjes & Kagee, 2013). Specifically, suicide prevalence among Black South Africans seems to be escalating (Engelbrecht, Blumenthal, Morris, & Saayman, 2017).

Suicidal behaviour among youth is of significant concern. Suicide is noted to be the second leading cause of death in the 15-29 age group globally (World Health Organization, 2018d). In South Africa alone, 199 deaths due to intentional self-harm were recorded for the 15-29 age group during 2015 (Statistics South Africa, 2017). In 2009, a WHO suicide prevention programme established that, in South Africa, the 20-29 age group is most at risk for suicidal behaviour, with the 10-19 age group in second place (Bertolote, Fleischman, Leo & Wasserman, 2009). The increased risk of suicide during adolescence and young adulthood with specific reference to the South African population has long been documented (George & van den Berg, 2012; Pillay et al., 2007; Shilubane et al., 2012, 2014) and seems to be increasing even more among the structurally vulnerable (Patton, Sawyer, Santelli, et al., 2016; World Health Organization, 2018b).

Non-fatal suicide attempts occur up to 20 times more frequently than fatal suicides (Hawton et al., 2012; World Health Organization, 2018d). It is also widely confirmed that females engage in non-fatal suicidal behaviour at a higher rate than men do, while male numbers of completed suicide are higher than females (Fox, Millner, Mukerji, & Nock, 2017; Kokkevi et al., 2012; Puuskari, Aalto-Setala, Komulainen, & Marttunen, 2017; Saunders et al., 2012). Studies indicate that non-fatal suicidal behaviour is more common in younger age groups (Norheim et al., 2013; Timson et al., 2012). This has been confirmed by research conducted in South Africa (Shilubane et al., 2013; van Pletzen et al., 2012).

2.1.3 Suicide: Definitions.

Deliberate self-harm is an originally European umbrella term referring to both non-suicidal self-injury (NSSI) and suicidal self-injury (SSI) (Kapur, Cooper, O'Connor & Hawton, 2013). Consistently with this definition, some authors are of the opinion that there is no clear distinction between these two categories (Isometsa, 2017). Deliberate self-harm has therefore become a widely used term for adolescent self-injury, which includes self-mutilating activities

such as cutting in the absence of suicidal ideation or attempt, as well as overdose with suicidal intent (Csorba, Elek, Plener, Edit, & Eszter, 2009).

This conflation of terms causes unnecessary confusion (Iemmi et al., 2016). In fact, when considering the manifestation of non-suicidal self-injury as opposed to suicidal self-injury, clear phenomenological differences become evident (Cha et al., 2018; Csorba et al., 2009; Curtis, 2017). From a clinical point of view, these differences require specific treatment strategies and tailored interventions (Ougrin et al., 2015). Non-suicidal self-injury or frequent self-mutilating behaviour with no suicidal intent forms part of a Diagnostic and Statistical Manual of Mental Disorders (DSM) category and, as such, may require psychiatric management (American Psychiatric Association, 2013; Csorba et al., 2009; Stanford, Jones, & Hudson, 2017).

When considering suicidal self-injury, clinical manifestations can range from fatal attempts to less severe acts, such as ingestion of a seemingly harmless amount of medication with little or no intent to die (Schlebusch, 2012). The latter, also at times labelled with the outdated term *parasuicide,* introduces a unique sub-category of impulsive self-harm acts aimed at gaining attention or accessing help that appears to be on the increase globally, with specific reference to the South African community (Ani, Ross & Campbell, 2017; Schlebusch, 2012; Shilubane et al., 2013; Wold Health Organization, 2018b). Some authors have argued that the level of behavioural intent is a fluid concept that may fluctuate over time (Borschmann et al., 2017). For example, while intent to die may be present at the moment of overdosing, death is not considered to be the primary aim in most of these cases (Kraemer, 2010). Regardless of the intensity or variability of suicide intent, it cannot be ignored that the risk of completed suicide remains a reality (World Health Organization, 2018a).

The term *suicidal ideation* refers to contemplations of suicide, or a desire to take one's life (Cha et al., 2018). The suicidal process has also been described on a continuum starting with ideation and progressing to planning, the attempt itself and ultimately completed suicide (Sveticic & Leo, 2012). While some authors therefore believe that there is a process of evolution, others perceive suicidal ideation and suicidal behaviour as two distinct manifestations (Nuij et al., 2018). This debate is not within the scope of this report, but suicidal ideation is acknowledged as part of a process of suicidal behaviour that can range from lethal acts to suicide attempts with low or even no intent to die (Schlebusch, 2012).

The current study made use of Non-fatal Suicidal Behaviour (NFSB), which is a term commonly used in literature to delineate some form of suicide attempt, regardless of the intensity or presence of intent to die. This term is preferred in order to avoid the potential

confusion of terms such as *parasuicide*, *attempted suicide* and *suicidal self-injury*, while representing a broader definition of suicidal behaviour that has implications for treatment.

2.1.4 Aetiology.

The aetiology of suicidal behaviour is multi-factorial and not yet fully understood. Cha et al. (2018) group risk factors for suicidality under the broad categories of environmental, psychological and biological factors. For the purpose of this discussion, these categories will be used to delineate risk factors associated with the current study population. It should be noted that this is not an exhaustive list of all the underlying causes or contributors to the manifestation of suicidal behaviour.

2.1.4.1 Environmental factors.

This category makes reference to factors present in an individual's environment that may increase the risk for suicide.

a) Socio-economic factors/structural vulnerability. South Africa's new constitutional democracy cultivates the notion of equality and access to services. However, decades of oppression under the apartheid regime have left behind a legacy that has not yet been erased. This is where some of the social determinants of health that exist outside the health sector come into play. The compounded negative health outcomes caused by a history of discrimination, ineffective health care and negative political and socio-economical forces are widely documented (Bourgois, Holmes, Sue, & Quesada, 2017; Patton, Sawyer, Ross, Viner, & Santelli, 2016; World Health Organization, 2012, 2018c).

The term *structural violence* becomes relevant when social structures impose obstacles that tend to cause harm by preventing people from meeting their basic needs. In many South African districts, the structural vulnerability of previously disadvantaged communities remains a reality. One South African study documented the persistent racial and material inequalities of black children specifically, stressing their detrimental impact on adolescent mental health (Das-Munshi et al., 2016). This impact is evident in widespread incidence of poverty, unemployment, fragmented education, inaccessible or insufficient health care and exposure to violence (Ani et al., 2017). The heightened risk of suicide among indigenous youth across the

globe, associated with poverty, intergenerational trauma and loss of cultural identity, is widely documented (Cha et al., 2018).

Other childhood adversities are listed as exposure to abuse, domestic violence and AIDS-related parental loss (Cluver, Orkin, Boyes, & Sherr, 2015). In fact, it has been established that all forms of abuse, i.e. verbal, physical and sexual, predict suicidal behaviour (Cha et al., 2018). Lingering gender inequalities also influence adolescent health (Patton et al., 2016), and the link between marginalisation of women and subsequent suicidality has been established (Seeman, Reilly, & Fogler, 2017).

When considering the predicament of post-apartheid South African communities, influences from first world forces together with social media can place unreasonable expectations on youth during the processes of transformation and acculturation (Schlebusch, 2012). In fact, global media may be instrumental in accentuating how disadvantaged some adolescents may be in comparison to others (Patton et al., 2016).

b) Education: While the negative effect of a lack of education on an individual's health and capabilities is commonly understood (Patton, Sawyer, Santelli, et al., 2016), rising expectations and competitiveness in, for example, the area of education, can push young people beyond their coping abilities (Schlebusch, 2012). On a related note, it should be mentioned that secondary level education is associated with an increased frequency of deliberate self-harm acts, although suicide risk factors for secondary school pupils are similarly wide-reaching (Ani et al., 2017). Among members of the secondary school age group, environmental factors such as economic deprivation, educational pressure and exposure to suicidal behaviour are documented as risk factors for suicidal behaviour (Chan et al., 2018; Im, Oh, & Suk, 2017). The risk factor of previous exposure to suicidal behaviour in others introduces an element of social transmission of adolescent suicidal behaviour, which repeatedly surfaces in literature studies (Carroll et al., 2016; Chan et al., 2018; Seeman et al., 2017; Shilubane et al., 2014). When considering the profound impact of social media on adolescents who grapple with mental health problems (Carey et al., 2018), the existence of socially transmitted suicidal ideas becomes an even greater cause for concern.

In addition to the above, it is also noted that secondary school pupils struggle with risk factors for suicide that are related to substance use and sexual activity (Im et al., 2017). However, the advantages of secondary education in terms of cognitive and mental health, especially for girls who have access to secondary education, cannot be disregarded (Patton, Sawyer, Santelli, et al., 2016).

c) Cultural. The global impact of fragmentation of the family unit has been widely noted (Patton, Sawyer, Santelli, et al., 2016). South Africa is no exception to these manifestations of cultural discontinuity and displacement as more and more rural dwellers move to cities in search of better futures and education (Bantjes & Kagee, 2013). Cultural and indigenous obstacles to better education for girl children also remain in some South African communities (Patton, Sawyer, Santelli, et al., 2016). Health workers and traditional healers may have an important role to play here (Bantjes & Kagee, 2013) in easing the stress of such transitions.

2.1.4.2 Biological/physical factors.

Suicidal behaviour seems to be strongly associated with psychiatric illness in developed countries (Bantjes & Kagee, 2013; McLouglin, Gould & Malone, 2015; Nuij et al., 2018; Schlebusch, 2012; Sveticic & De Leo, 2012). Indeed, records of depressive disorders in conjunction with suicidal behaviour are widely available (Im et al., 2017; James, Reddy, Ellahebokus, Sewpaul, & Naidoo, 2017; Patton, Sawyer, Santelli, et al., 2016; Stubbing & Gibson, 2018). In addition to environmental and psychological factors, biological aspects also play a role in in the development of psychiatric conditions, and as such deserves closer consideration (Nagy, Vaillancourt & Turecki, 2018).

This recorded link between a psychiatric condition and suicidality is, however, not necessarily a causal one (Bantjes & Kagee, 2013). Emerging opinions that suicidality may not automatically indicate psychopathology have caused controversy. More and more publications confirm that, in some instances, the suicide attempt may be an impulsive act aimed at escaping or accessing help in situations of crisis beyond an individual's coping repertoire (Ani et al., 2017; Kraemer, 2010; Shilubane et al., 2013; World Health Organization, 2018c). A recent New Zealand study investigating the explanations of adolescents for youth suicidal behaviour noted their opinion that suicidality is a normal reaction to overwhelming challenges, continuous pressure, emotional affliction and a need for help (Stubbing & Gibson, 2018). In addition to these normalised aetiological factors, reference is then made to the view that mental disorders could also contribute to suicidal ideation. Studies show that environmental factors, childhood adversities, lack of interpersonal skills, and cognitive, personality and socio-economic challenges in association with a trigger incident may lead to suicidality, rather than the existence of a mental disorder (Bantjes & Kagee, 2013; Bruwer et al., 2014; Nuij et al., 2018).

One South African study, for example, found that most young people included in the research into suicidal behaviour had not, in fact, been diagnosed with a mental disorder (Ani et al., 2017). One Australian study found that psychologically 'normal' adolescents, that is, those not presenting with pathological levels of anxiety or depression, presented with the second largest number of self-harm profiles (Stanford et al., 2017). While the participants in the latter study may have been restricted by a lack of access to mental health resources to identify existing mental health problems, the possible absence of a mental disorder cannot be discounted.

2.1.4.3 Psychological factors.

While psychological factors are considered separately, it should be noted that the suicide risk factors mentioned above all culminate in psychological implications with the potential to lead to suicidality. A number of psychological aspects have been linked to suicidal behaviour, such as problematic family dynamics, insufficient problem-solving skills, absent parents, neurological correlates, substance abuse, financial problems, relationship break-up, aggression, feelings of sadness or hopelessness and impulsivity (Im et al., 2017; James et al., 2017; Schlebusch, 2012; World Health Organization, 2018a). Affective complications such as a lack of self-confidence, cognitive processes with specific mention of impulsivity and social challenges contributing to feelings of isolation or loneliness are cited as psychological risk factors for suicide (Cha et al., 2018). The psychological impact of social processes as a risk factor for suicide is reiterated when considering one South African study which confirmed that 57% of NFSB admissions reported relationship difficulties as the trigger for the suicide attempt (Ani et al., 2017). The link between exposure to childhood adversities and subsequent suicidal behaviour has also been recognised (Cluver et al., 2015).

2.1.5 Conclusion.

Risk factors for suicidal behaviour are far-reaching and often dictated by the adolescent's unique lived experience. The factors discussed here provide some insight into the aetiological context of the current study population, but also demonstrates the importance of continued exploration.

2.2 Adolescence

2.2.1 Introduction.

The developmental stage of adolescence marks a turbulent phase of development leading to adulthood. Unique properties of the adolescent stage may result in typical behavioural manifestations that can also be evident in suicidal presentations.

This literature review section will focus on definitions and distinctive adolescent traits, as well as the manifestation of suicidal behaviour specifically applied to this developmental period. The section will conclude with a literary overview of adolescents' experience of health care.

2.2.2 Definition/age range.

Adolescence represents a unique developmental stage situated in the complex period of transition from childhood/puberty to adulthood. While adolescence roughly encompasses the second decade of life, a single specified age range does not exist. According to WHO (2018c), *adolescence* is specified as the ages of 10–19 years, the *youth* category includes the ages of 15–24 and *young people* are identified as 10–24-year-olds. It is impossible to delineate a specific age of onset for the period of adolescence, as the onset of puberty differs from one person to another. The end of adolescence is also fluid, because it is supposedly signalled by the achievement of independent employment, financial independence and life partnerships, which varies significantly among different cultures and contexts (Patton, Sawyer, Santelli, et al., 2016). Associated challenges, such as longer tertiary education, difficulty securing employment and other difficulties, contribute to longer delays in reaching the financial independence associated with the end of the adolescent period (Patton, Sawyer, Santelli, et al., 2016). The impossibility of identifying a designated age range is also evident in different documented age specifications. While the age of adolescence used to be identified as 14–21 years ("Adolescence", 2011), this range was recently noted as 11–21 years ("Adolescence", 2018). For the purpose of the current study, the inclusion criteria for the age of adolescence were specified as 13 to 21 years, in order to accommodate potential participants from entry into secondary school until the age of majority specified in the previous definitions.

2.2.3 Foundations for future health trajectories.

Adolescence is perceived as the healthiest part of life, during which foundations for health trajectories across the life-span are established (Patton, Sawyer, Santelli, et al., 2016). The achievement of sufficient knowledge, skills and healthy habits during adolescence appears to be a critical requirement for effective coping in adulthood (Patton, Sawyer, Ross, et al., 2016; Reyna, Chapman, Dougherty, Confrey, 2012). It therefore follows that problems related to cognitive, physical and/or emotional development during this stage may have implications later in life.

2.2.3.1 Neurological functioning.

The adolescent brain is characterised by intense desires to pursue sensation or excitement (McLouglin et al., 2015; Steinberg & Chein, 2015). While the resultant quest for rewarding experiences is pronounced, the neurological inhibition of dangerous or inappropriate cravings is still in a process of maturation that continuous into adulthood (Borschmann et al., 2017; Icenogle et al., 2017). The resultant immature cognitive control systems may therefore lead to risk-taking and impulsive behaviour (Borschmann et al., 2017; Steinberg & Chein, 2015).

Even though there is a widely-confirmed connection between risk-taking behaviour to achieve what is perceived as a reward and a tendency to act impulsively to achieve that reward (Borschmann et al., 2017; Steinberg & Chein, 2015), neurological implications for impulsivity are more complex. Romer, Reyna & Satterthwaite (2017) identify different forms of impulsivity in relation to action and choice. They argue that impulsivity in the sense of not considering the consequences of a decision may be applicable to the general adolescent group, while choosing a more limited but immediate reward over a more extensive reward that is held back, is not typical of adolescent neurology (Romer et al., 2017). Indeed, impulsive behaviour with limited consideration of its consequences represents the form of impulsivity relevant to this investigation.

2.2.3.2 Cognition and affect.

While adolescence marks the achievement of advanced cognitive competence, that competence may fail the developing individual when it comes to reasonable decision-making and management of intense emotions (Patton, Sawyer, Santelli, et al., 2016; Reyna et al., 2012). Although these powerful emotions, desires and resultant risk-taking behaviours are functional in the adolescent’s process of development, they can jeopardise mental, physical and social

well-being (James, Reddy, Ellahebokus, Sewpaul & Naidoo, 2017). This introduces a higher risk for mental health problems (Patton, Sawyer, Santelli, et al., 2016). In fact, the significant emotional and behavioural changes associated with this developmental period, in addition to a possible inability to express emotional distress, may complicate the accurate recognition of mental health problems in this age group (Paruk & Karim, 2016).

On a related note, it has been recorded that adolescents tend to suppress the disclosure of personal details as part of the regular development towards managing information autonomously (Herrera, Benjet, Mendez, Casanova, & Medina-Mora, 2017). To be precise, personal information may be kept secret from all their significant others – not only parents (Corsano, Musetti, Caricati, & Magnani, 2017). Literature also notes that, in addition to striving for independence, adolescents who do manage to express emotional discomfort may do so in vague terms (Paruk & Karim, 2016). These aspects further complicate timeous detection and management of mental health problems or other risk factors. Crises that are neglected during the adolescent stage have been noted to have the potential to develop into aggravated difficulties in adulthood (Patton & Borschmann, 2017).

2.2.3.4 Environment.

The context in which an adolescent functions also carries significance for his/her development (Reyna et al., 2012). The development of the adolescent brain is notably affected by culture and experience (Romer et al., 2017).

Adolescent developmental tasks may be facilitated or interrupted by aspects in the adolescent's context. For example, a normative increased need for independence may pose challenges to the closeness of the parental relationship (Patton et al., 2016). Loss of parental presence is noted as a risk factor for suicidal behaviour, which demonstrates the importance of parental support (Im, Oh & Suk, 2017).

On a different environmental level, it is recorded that poorer health trajectories are associated with premature independence and leaving school early (Patton et al., 2016b). It follows then that not all adolescent challenges can be outgrown (Patton & Borschmann, 2017).

2.2.4 Adolescence and suicide/self-harm.

2.2.4.1 Prevalence.

Adolescent self-harm behaviour is an increasingly concerning global phenomenon. While the numbers are alarmingly high, they are not accurate reflections of the actual extent of the problem. In 2014, a United Kingdom publication made reference to the *iceberg model of self-harm* and specified that, for every adolescent who dies by suicide, 34 adolescents attended health care services following a self-harm incident and 555 adolescents admitted to unreported self-harm in their community (McMahon et al., 2014). In 2017, these numbers were reported to have risen to 370 NFSB hospital admissions and 3 900 secretive community self-harm incidents for every adolescent death by suicide (Geulayov et al., 2018). These figures not only confirm an unsettling increase in suicidal behaviour among the adolescent age group but also indicate that large numbers of adolescent suicide attempts remain hidden from the health care sector, presenting risks for completed suicide (McMahon et al., 2014). It is significant to note that these statistics applied to mostly adolescent girls who engaged in self-poisoning (Geulayov et al., 2018).

A recent Australian study established that 16.8% of adolescents had engaged in some form of self-harm during a six-month period preceding the study, mostly in the form of a secretive, single episode of NFSB (Stanford et al., 2017). While the prevalence of suicidal ideation is understood to increase rapidly between the ages of 12 and 17, it is documented that a third of adolescents who have suicidal ideation will attempt suicide (Nock et al., 2013). Goldston et al. (2015) argue that the foundations for suicidality are laid down during adolescence and suicide attempts following late adolescence are re-attempts in most cases.

An earlier South African study considering suicidal behaviour specifically found that 19% of high school students had seriously contemplated suicide, while a similar number of 18.5% had attempted suicide (Shilubane et al., 2013). A more recent South African publication recorded that the highest number of recorded NFSB incidents occur in the 15–30 age group (Ani et al., 2017). These statistics seem to be consistent with international trends. It is estimated that 1 to 2 suicide deaths occur per hour in South Africa, with up to 20 times more attempts (Schlebusch, 2012). While the numbers are notoriously inaccurate, it was previously recorded that a third of all NFSB hospital admissions in South Africa involve children and

adolescents (Schlebusch, 2012). Again, this trend of increasing NFSB admissions among youth is confirmed on other continents (Klass, 2018).

2.2.4.2 Adolescent attributes as risk factors for suicidality.

When considering the neurological realities of the adolescent developmental period as discussed above, the strong connection between a tendency to act impulsively and NFSB attempts has been noted when considering the – often short – space of time between thoughts of suicide and action (Royal College of Psychiatrists, 2015; Stanford et al., 2017). In fact, Stanford et al. (2017) stated that impulsivity may even facilitate NFSB, in the sense that time for consideration of alternative coping mechanisms or the possible consequences of self-harm is severely limited.

In addition, the previously discussed limited capacity to manage strong emotional reactions, together with attempts to self-manage while striving for autonomy, seems to further contribute to high numbers of school-age adolescents attempting suicide (Herrera et al., 2017; Valois, Zullig, & Hunter, 2015).

2.2.5 Implications of adolescent self-harm.

Some authors believe that self-harm in adolescence is a form of risk behaviour that has the potential to derange the normal process of development into psycho-socially well-adjusted adults (Borschmann et al., 2017; James et al., 2017). Others are of the opinion that efficient support during the adolescent phase can assist young people to outgrow brief mental health challenges associated with suicidality (Patton, Sawyer, Santelli, et al., 2016). The latter view has implications for how the health care sector meets the needs of the adolescent NFSB patient.

2.2.6 Adolescent non-fatal suicidal behaviour and health care.

Due to the previously discussed fact that the adolescent developmental period keeps getting elongated by delayed financial and social independence of young people, it is documented that the current generation of adolescents is the largest in the history of the world (Patton, Sawyer, Santelli, et al., 2016). Despite the fact that long-term health trajectories in terms of physical, cognitive, emotional, social, economic and health-related well-being are laid down during this developmental period, adolescents have until recently been excluded from global health and social policies (Patton, Sawyer, Ross, et al., 2016). In reaction to this, the WHO has specified

eight global standards aimed at the improvement of the quality of health services available to adolescents (Nair et al., 2015):

Standard 1: Adolescents' health literacy: This standard makes reference to adolescents' knowledge regarding their own health and available health resources.

Standard 2: Community support: Here reference is made to the involvement of significant others such as caregivers and other members of the community.

Standard 3: Appropriate package of services: Services should fit the needs of the adolescent population.

Standard 4: Providers' competencies: Health care providers should demonstrate competence to respond to adolescent needs, including confidentiality, provision of information and respect.

Standard 5: Facility characteristics: Health care facilities should accommodate adolescent needs in terms of operating hours, cleanliness, confidential work space, etc.

Standard 6: Equity and non-discrimination: No discrimination on the basis of economic status, gender, age, culture, etc. may be allowed.

Standard 7: Data and quality improvement: This standard makes reference to the effective collection and management of data in order to improve quality of services.

Standard 8: Adolescents' participation: Adolescents should be involved in decisions about their own health care.

These standards are envisioned to empower adolescents to participate in their own health care in terms of planning and evaluation of services, while also stressing the importance of equipping health care providers to provide efficient adolescent interventions that are based on respect, confidentiality and non-judgmental attitudes.

Since the adoption of these global standards, evidence of successful implementation has been limited, and adolescent-specific needs remain largely unmet by health care services (Royal College of Psychiatrists, 2015; Sawyer et al., 2012). While infectious and sexual concerns are better controlled in some countries – freeing up resources to consider mental health manifestations such as suicidal behaviour – gains in global adolescent service provision are not maintained (Patton, Sawyer, Santelli, et al., 2016). *Youth friendly services,* an initiative focusing on sexual and reproductive health and overseen by the Department of Health, were implemented in South Africa approximately a decade ago, but little evidence of the execution thereof is available (Geary, Webb, Clarke, & Norris, 2015). The main challenges associated

with this lack of application of youth-friendly health services are noted to be insufficient knowledge and skills among health care practitioners who provide services to adolescents, and inadequate facilities where services that meet adolescents' needs can be provided (Geary, Gomez-Olive, Kahn, Tollman, & Norris, 2014).

2.2.6.1 Placement in a hospital setting.

The question of assigning space for adolescent service provision is a tricky one. Adolescent in-patients can be experienced as disruptive in a paediatric setting (Kraemer, 2010; Royal College of Psychiatrists, 2015), and paediatricians are not necessarily equipped to work efficiently with this age group (Coles & Greenberg, 2017). On the other hand, it has been established that adolescent needs are unique and different to those of an adult population. The South African situation is simply that the relatively small numbers of adolescents who attend clinics and other health care services do not justify dedicated spaces that are furnished to meet their expectations (Geary et al., 2014). In in-hospital settings, where adolescents do not feel comfortable, presenting problems may remain hidden in an attempt to accelerate discharge (Idenfors, Kullgren, & Renberg, 2015).

2.2.6.2 Health care workers' competence and attitude.

It has been documented that admission following NFSB represents an emergency point where an adolescent and his/her significant others may be more open to receiving help from clinicians (Patton & Borschmann, 2017). It is therefore important that the health care sector uses this opportunity to commence timeous treatment for health care concerns and prevent future suicidal behaviour (Schlebusch, 2012).

Clinicians, however, often express concerns regarding their competence to manage adolescent patients (Patton, Sawyer, Santelli, et al., 2016). The previously discussed neglect of health care programmes aimed at adolescents also seems evident in a lack of training and knowledge of health care professionals who provide services to this age group (Patton et al., 2016). Feelings of incompetence and a lack of knowledge may negatively impact health care professionals' attitudes, which has implications for how the adolescent patient experiences health care (Geary et al., 2015).

Earlier studies recorded that adolescent self-harmers may feel that they should be able to cope by themselves, that self-harm does not deserve serious consideration by health care

services, and that there is a fear of being labelled "attention-seekers" (Fortune, Sinclair, & Hawton, 2008). These perceptions may contribute to an unwillingness to seek help for suicidal behaviour, or confusion about where to turn (Rowe et al., 2014). More recent studies have noted concerns on the part of adolescent health care users that health care services do not provide sufficient information or privacy and that health care professionals are experienced as judgmental (Geary et al., 2015; Rowe et al., 2014). European studies confirm that adolescents perceive the health care services that they received to be of poor quality, provided by clinicians with negative attitudes (Owens, Hansford, Sharkey, & Ford, 2016). These opinions are reiterated by paediatric psychiatrists expressing their concerns regarding the exposure of already distressed young patients to negative health care experiences (Royal College of Psychiatrists, 2015). Such negative experiences have implications for future help-seeking behaviour (Idenfors et al., 2015). South African literature on how adolescents experience health care services is scant.

In addition to inhibiting help-seeking, negative experiences of health care are also noted to intensify the feelings of shame and worthlessness that may have led to suicidal behaviour in the first place (Owens et al., 2016). Isolation and having no-one to talk to without feeling judged may lead to feelings of loneliness and, ultimately, greater suicidality (McAndrews & Warne, 2014). When the possibility of lingering suicidal ideation even after the suicide attempt and subsequent hospitalisation is considered (Wolff et al., 2018), negative health care experiences may be even more detrimental.

Adolescents are at an age where they can engage meaningfully with the health care system in order to communicate their needs and expectations (Patton, Sawyer, Santelli, et al., 2016). Provision of efficient treatment at this early stage is crucial to prevent intensified psychological problems and suicidality during the adult stages (Patton & Borschmann, 2017).

2.2.7 Conclusion.

Adolescence is a developmental stage that carries the potential to establish firm foundations for future well-being. However, age-related vulnerabilities may limit individuals' ability to function optimally now and in future. Suicidal behaviour in adolescents is a reality that requires tailored interventions from a health care sector that may be falling short.

2.3 Chapter Conclusion

This chapter considered the extent of suicidal behaviour, related definitions and the aetiology of suicide in South Africa. A discussion followed that focused on the developmental stage of adolescence, as well as related neurological, cognitive, affective and environmental attributes. Suicidal behaviour in adolescence was considered, in addition to adolescents' experience of health care globally, but also with specific reference to the South African situation. Publications on suicidal adolescents' experiences of health care in the South African context are limited and require exploration to guide envisaged improvements of health care to this age group.

Adolescents' vulnerability to presenting with suicidal behaviour is clearly documented in unprecedented high NFSB statistics, with specific reference to the South African situation. Previous suicide attempts are a significant risk for completed suicide and, as such, place increasing demands on the health care system. However, the health care system may have overlooked the adolescent patient group, resulting in a lack of knowledge and resources to assist them sufficiently. The current study aims to gain insight into how adolescents experience NFSB-related hospital admissions as a start to addressing this shortfall.

Chapter 3 – Literature Review: The South African Health Care System

3.1 Introduction

In this chapter the South African health care system and its unique challenges will be considered. Attention will be given to the four health care professions that form part of the current study.

The demands that NFSB patient care places on health care providers may have implications for how they experience this patient group. NFSB patients at the adolescent stage may add further complexity to such experiences. Exploring existing knowledge on health care workers' related experiences is crucial and will be attempted in this section.

3.2 Political Framework of the Hospital Context

The South African constitution prescribes an all-encompassing commitment to realising every citizen's rights to health (Eyles, Harris, Fried, Govender & Munyewende, 2015). This follows decades of legislated racial discrimination depriving the majority of South Africans of efficient health care services. The current constitution aims to reverse the legacy of that injustice (Mayosi & Benatar, 2014). However, 20 years after democracy, significant inequalities regarding health and access to health care still exist (Eyles et al., 2015). The social and economic determinants of health, which reside outside the health care system, perpetuate South Africa's challenging current health situation (Mayosi & Benatar, 2014). Many believe that these determinants should be addressed as a national priority before the health care system can truly be strengthened to the level of service envisioned in the constitution.

The public health sector, which is funded by general tax, is based on a district health systems approach (Rowe & Moodley, 2013). While the aim is equitable provision of health services to all, the sector fails to deliver owing to the political and economic context in which it functions (Eyles et al., 2015). Frequent reports in the media attest to the fact that corruption

continues to have a crippling effect on attempts to improve health care to all (Rispel, de Jager & Fonn, 2016). The impact of this can be seen in a variety of systems within the health care context, for example, infrastructure: in the majority of public health care institutions, facilities are dysfunctional and/or run down due to a lack of funding, resources are mismanaged, and a general sense of neglect is evident (Mayosi & Benatar, 2014). These challenges also have negative implications for human resources employed by the National Department of Health, ultimately leading to poorer health outcomes for the majority of the South African population who are dependent on these services for health care (Rispel et al., 2016).

It is widely noted that approximately 30% of the country's doctors serve in the public health sector, which provides health care services to around 84% of the South African population (Mayosi & Benatar, 2014). The country's nursing crisis is also evident in numerous publications citing concerns such as shortages of nurses, inadequate numbers of nurses qualifying, international migration, low staff morale and sub-optimal performance of nurses working in the health care field (Rispel, 2015; Rispel & Barron, 2012). In summary, public health care challenges in the South African context centre around the availability of health care, poor staff attitudes and inadequate numbers of human resources (Eyles et al., 2015).

These concerns impact negatively on the morale of public health workers and support staff at all levels (Rispel et al., 2016). The implications for the quality of patient care are evident when considering health systems researchers' increasing concern with the culture of the organisation (Jung et al., 2009). It is then inevitable that the health care user bears the brunt of these contextual dysfunctions, ultimately experiencing long waiting times, unhelpful comments and negative attitudes from health care staff (Eyles et al., 2015). It seems that both staff and patients may be falling victim to a system that does not uphold personal rights or acknowledge the expression of needs (O'Connor & Glover, 2017). Until these contextual challenges can be resolved, the only solution seems to be that health care workers will have to find a way to cope effectively under difficult circumstances and work together to preserve the patients' dignity (Eyles et al., 2015).

3.3 Medical Professions involved in the Current Study

South African medical professionals from the following four categories of health care workers took part in the current study: medical doctors, nurses, clinical psychologists and social workers. These professions were selected based on their essential roles in the multi-disciplinary team responsible for the treatment of NFSB patients. The following section provides a brief overview of their respective scopes of practice.

3.3.1 Medical doctors.

Members of this category of professionals are generalists in the field of medical health care. Medical doctors are required to register with the Medical and Dental Board of the Health Professions Council of South Africa (HPCSA). South African Schools of Medicine have encompassed the components of community health and primary health care to ensure local relevance in the country's health care context (University of Pretoria, 2018).

Medical professionals are expected to meet different requirements in order to do their work effectively, as is set out in the following roles and key competencies (Medical and Dental Professions Board, 2014):

3.3.1.1 Health care provider.

This role requires patient-care that is ethical, comprehensive and optimal; the implementation of interventions that are therapeutic, preventive and promotive; and seeking consultation from other health care professionals where required.

3.3.1.2 Communicator.

Among other key competencies, this role requires the medical doctor to establish rapport with his/her patient and provide information appropriately.

3.3.1.3 Collaborator.

This role mainly refers to the medical doctor as a member of the multi-disciplinary team.

3.3.1.4 Leader and manager.

Medical doctors are often required to lead multi-disciplinary teams and manage the treatment of their patients.

3.3.1.5 Health advocate.

This role sets the expectation that the medical doctor will promote the health of communities and individuals.

3.3.1.6 Scholar.

The doctor is required to remain academically active.

3.3.1.7 Professional.

The medical doctor's personal behaviour should reflect an ethical stance.

Apart from general opinions on how South African health workers experience the health care context, literature does not contain much information on how medical doctors in South Africa experience their profession or related duties.

3.3.2 Nurses

Nurses form the largest category of health care providers in South Africa (Rispel, Blaauw, Chirwa & deWet, 2014). The nursing profession consists of three categories as set out by Rispel et al. (2014).

3.3.2.1 Professional/registered nurses.

Members of this group of nursing professionals possess a nursing degree or diploma, which they would have obtained after the completion of four years of training. They manage wards or departments. Some of their duties include keeping records, advising doctors on patient conditions, receiving instructions regarding treatment and controlling supplies, equipment and medicine. They also train nursing students.

3.3.2.2 Enrolled nurses.

Members of this category of nurses undergo two years of training to prepare them for the profession. They perform more basic nursing care within the limits of their professional category. They function under the supervision of a registered nurse.

3.3.2.3 Nursing assistants/auxiliary nurses.

Members of this group of nurses receive training for a period of one year. Training can be obtained at an approved training hospital, such as the hospital where the current study was conducted. After the successful completion of that training process, they receive a one-year training certificate. Their duties are less specialised and focused on basic nursing procedures and general care of patients. They also work under the supervision of registered nurses.

As mentioned earlier, nursing in South Africa is in crisis. Related concerns that are raised include an apparent declining interest in the profession of nursing, the absence of a proper caring ethos and the perception that nurses' rights are not upheld (Rispel, 2015). These challenges seem to have permeated the entire nursing spectrum, as is evident in the insufficient numbers of nurses trained, which leads to staff shortages and ultimately burn-out and low staff morale. The inevitable result is sub-optimal performance and a disregard for nursing ethics, contributing to the poor reputation of nursing in the country (Rispel, 2015). In fact, studies confirm the often negative perception of nurses held by community members, as well as negative opinions on the quality of care that they provide (Rispel & Barron, 2012).

Investigations identified some of the nurses' difficulties, including workplace constraints, poor working conditions and insufficient remuneration (White, Phakoe & Rispel, 2015). Again, nurses' morale is negatively affected by general challenges in the public health sector, namely health system deficiencies, human resource challenges and a perceived lack of

support from hospital management (Munyewende & Rispel, 2014). In the current context, where the political agenda is focused on protecting patient rights, some nurses have reported the sense that patient rights carry higher priority than those of nurses (Eyles et al., 2015; White et al., 2015). Other publications cite reports of nurses being maltreated by patients, expectations to fulfil functions that are not part of their professional scope, such as porter, and exposure to infections in the absence of regulated isolation rooms (Rispel & Barron, 2012). These experiences were confirmed in a recent report that public nurses or health workers in South Africa are placed in challenging working contexts without sufficient equipment, yet they are held accountable if problems arise (Rispel et al., 2016).

3.3.3 Clinical psychologists.

The Psychological Society of South Africa (PsySSA) specifies that the vision of psychology in the country should be relevant in response to the needs and well-being of society (Psychological Society of South Africa, 2018, para.4).

The practice of psychology in South Africa consists of different categories:

- Clinical psychology
- Educational psychology
- Industrial psychology
- Neuropsychology
- Forensic psychology
- Research psychology
- Counselling psychology
- Psychometric psychology

This study incorporated clinical psychologists, since this category is employed in public hospitals by the Department of Health. The requirement for registration as a clinical psychologist is a master's degree in clinical psychology and a minimum one-year internship, both at accredited training institutions (Cooper, 2014). In addition, the HPCSA requires clinical psychologists to pass a board examination and complete a Community Service year.

Literature on how psychologists experience their work in the South African context is scarce, as is the case with psychologists' reactions to NFSB patients. Psychological publications focus mainly on psychological treatment procedures and effectiveness in the treatment of NFSB patients.

3.3.4 Social workers

The International Federation of Social Workers (IFSW) defines the profession as follows:

> … a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work… [Social work] engages people and structures to address life challenges and enhance well-being (International Federation of Social Development, 2018, para.2).

Social work in South Africa is regulated by the South African Council for Social Service Professions (Department of Social Development, 2018). The requirement for registration is a four-year Bachelor of Social Work degree. Social workers are qualified to do counselling and therapy, provide education and assist clients in making connections with available resources. The focus of social work is on the person in his/her context, and work is based on the principle that improvement in a person's social functioning will lead to a better quality of life (Cournoyer, 2016).

While literature on the experiences of social workers in South Africa is limited, authors do acknowledge international social professional challenges related to the nature of the work. These include difficulties such as heavy work load, insufficient time to perform tasks optimally and a lack of resources (Jessen, 2010). Reference is also made to social workers' struggle in relation to their professional status, indicating some social workers' sense that their expertise in certain areas of the profession is not always acknowledged (Jessen, 2010).

3.4 Health Care Professionals and NFSB

3.4.1 Potential to add value.

Research notes that people who eventually commit suicide had significantly more contact with health care workers, including hospital doctors, psychologists, psychiatrists and social workers, in the last few months before their death than before (Ahmedani et al., 2014; De Leo,

Draper, Snowdon, & Kõlves, 2013). This confirms that health care workers are critically positioned to contribute to a reduction in NFSB rates and ultimately reduced numbers of suicide deaths. Yet, it seems that this potential to prevent future suicidal behaviour may be under-utilised, owing to hospitals' modus operandi for the management of NFSB patients (Bantjes, Kagee, McGowan, & Steel, 2016). In Ireland it has been documented that medical admission has not been proven to reduce the risk of repeated self-harm attempts, despite the high cost of such treatment (Carroll et al., 2016). This is confirmed in other publications, questioning the benefit of treating physical injuries while the causal suicidal behaviour may be neglected (Tynan, 2013). Health care workers all over the world have access to significant volumes of publications on new and more effective treatment practices and management strategies for NFSB patients, yet the suicide death rate has not shown a decline in the past 60 years (Ougrin et al., 2015).

3.4.2 Health care workers' attitudes.

The way in which health care professionals approach and prioritise an NFSB patient has important implications for the patient's level of motivation to take part in the treatment of his/her suicidal behaviour (Lindgren, Svedin & Werkö , 2018; Norheim et al., 2013). In fact, unhelpful health care personnel may actually add to the distress of a NFSB patient (O'Connor & Glover, 2017). A previous review found that little effort was made to generate feedback from NFSB patients in relation to their perceptions of the quality of the care they received from their health care system (Taylor, Hawton, Fortune & Kapur, 2009), which indicates that health care delivery was not influenced by information from the health care users. The limited number of qualitative explorations of the experiences of people – with specific reference to low to middle income countries - -who exhibit suicidal behaviour has been noted (Bantjes et al., 2016).

It is a well-known fact that NFSB numbers are on the increase, and general hospital staff are increasingly burdened by demands from this patient population (Saunders et al., 2012). This is also true in paediatric hospital settings (Klass, 2018). Literature on health care workers' attitudes towards NFSB constantly makes reference to the potentially confusing fact that doctors and nurses are trained to provide medical treatment as opposed to a psychological intervention that may be required by the patient who attempted suicide (Conlon & O'Tuathail, 2012; Timson et al., 2012). Patients presenting with NFSB due to psycho-social problems as opposed to a diagnosed mental illness may ask whether they should even be in the health care system if they do not have a physical condition (Smith et al., 2015). Possibly in relation to this,

the treatment of NFSB patients in the health care context still seems to have a low priority (Norheim, 2013; Tynan, 2013).

When considering existing publications on the attitudes of staff towards NFSB patients, reactions such as anger, irritation, helplessness and questions around the NFSB patient's entitlement to receiving health care are documented (Norheim et al., 2013; Saunders et al., 2012). This entitlement (or lack thereof) is related to the complex reason for admission in the sense that the NFSB patient is both the perpetrator and the victim of a potentially fatal action – an implication which has the potential to significantly impact the health care provider's reaction (Smith et al., 2015).

Other emotions experienced by health care workers include powerlessness, a sense of futility, moral judgement, but also empathy (Conlon & O'Tuathail, 2012; Lindgren et al., 2017). Regarding the sense of powerlessness, literature makes reference to clinicians' ambiguous feelings around empathy and responsibility to care for the vulnerable NFSB patient while being unable to control the patient's suicidal actions (Smith et al., 2015). This discrepancy could understandably leave the clinician feeling conflicted, which would probably impact the relationship with the patient. Smith et al. (2015) make further mention of the fact that health care workers may end up feeling quietly guilty for having these conflicting views, or they could add to the stigma suggesting that NFSB patients are attention seekers, abusing resources that have been allocated to treat medical conditions. In fact, the issue of stigma in relation to NFSB is well documented, and mental health practitioners are not necessarily an exception (Kraemer, 2010). These emotional reactions have the potential to impair clinical judgment, which does not support the health care worker's ability to provide an efficient intervention. Patients may end up feeling judged, which has implications for their willingness to participate in treatment as well as future help-seeking behaviour (Lindgren et al., 2017). The necessity of investigating the knowledge, beliefs and attitudes of health care workers in relation to suicidal behaviour therefore becomes crucial, in order to enable efficient health care for NFSB patients (Bantjes & Kagee, 2013).

3.4.3 Insufficient understanding of NFSB.

An extensive body of knowledge has been published on the clinical management of suicidal behaviour over the years, yet health care workers are still not clear about the foundations of suicidal behaviour or what really constitutes effective treatment thereof (Smith et al., 2015). Suicide risk assessment is an essential skill in the health care provider's treatment

protocol for NFSB patients. Suicide prevention efforts can only be effective if risk of suicide is accurately identified and treated (Ahmedani et al., 2014). However, Smith et al. (2015) question the efficacy of such risk assessments, in the sense that future suicidal tendencies can ultimately not be known. They also comment that such assessments may be perceived as a superficial therapeutic strategy, aimed at giving the health care worker a false sense of control in a confusing treatment context, in addition to the provision of paperwork to protect against possible medico-legal consequences (Lindgren et al., 2017). Indeed, the threat of being investigated if something goes wrong is an anxiety-inducing reality of working in a health care context (Smith et al., 2015). Staff members' need to take control and limit risk as a response to their own uncertainty in the treatment of NFSB patients has also been recorded (O'Connor & Glover, 2017). Health care personnel may ultimately end up ignoring the clinically required procedure of exploring the suicidal incident when they are focused on managing the suicidal risk (Awenat et al., 2017), which is confirmed in operating procedures which note that the patient has shown remorse and promised not to repeat the behaviour prior to approval of discharge (Tynan, 2013). The resulting short-term hospitalisation of NFSB cases (especially among the youth) is increasing, while the efficacy thereof appears to be questionable (Hughes & Asarnow, 2013).

3.4.4 Predominance of NFSB hospital admissions.

Recent years have seen a global increase in numbers of suicide-related hospital admissions, with one American source reporting that numbers almost tripled between 2008 and 2013 (Klass, 2018). In South African public hospitals, the reality is that there is an overwhelmingly high need for health care in the presence of significant resource constraints (Eyles et al., 2015). This adds pressure to health care workers to discharge patients as quickly as possible in order to free up bed space (Bantjes et al, 2016). This practical limitation has significant implications for the medical treatment of NFSB patients, who may be presenting with a psychological condition as opposed to a physical illness (Awenat et al., 2017). The White Paper for the transformation of the South African health system specifies integrated care for patients admitted following self-harm behaviour, but the practical implication is that psychiatric care responsibilities are added to the work requirements of already overwhelmed primary health care staff (Bantjes et al, 2016). The high incidence of NFSB admissions to South African hospitals therefore adds further pressure (Shilubane et al., 2014). International studies confirm that the impact of admission to a medical ward in NFSB cases is not well

understood, and proof that it reduces the risk of repeated suicide attempts remains limited (Carroll et al., 2016). If medical admission is simply used for stabilising the suicidal patient without resolving the suicidal behaviour, the high associated costs may not be justified (Hughes & Asarnow, 2013; Carroll et al., 2016).

3.4.5 Improvement of health care services to NFSB patients.

A previous study concluded that NFSB patients' perceptions of care were mostly negative, because they felt excluded from decisions that were made in relation to their treatment and also had a perception that staff lacked the knowledge to assist them sufficiently (Taylor et al., 2009). Indeed, research confirms that increased knowledge and professional skills contribute to the more positive and effective treatment of NFSB patients within a health care setting (Saunders et al., 2012; Timson et al., 2012). Training should probably tap into suicidality, general mental health and even psychiatry (Lindgren et al., 2018).

In addition to knowledge and skills, access to clinical supervision is also flagged as an essential requirement for the competent treatment of NFSB patients, which may assist health care workers who feel that they are not supported in working with this challenging patient group (Awenat et al, 2017; Saunders et al., 2012). Logistical solutions such as confidential interview spaces have also been identified as possible solutions to NFSB treatment challenges (Conlon & O'Tuathail, 2012).

Health care workers seem to agree that psychologists and social workers play an essential role in the treatment of NFSB, yet literature on how these two professional groups experience NFSB patients remains scarce (Norheim et al., 2013). Exploration of the psychological meaning and implications of the suicide attempt seems to be at the crux of its medical management (Awenat et al, 2017). When NFSB behaviour is viewed as a psychological condition that can be improved with appropriate medical management, health care staff seem to approach it with a more positive attitude (Awenat et al, 2017).

O'Connor and Glover (2017) investigated the emotional implications for health care personnel working with NFSB patients and reflected on the fear and distress that these patients might evoke. They argue that no amount of NFSB information or training can resolve such intensely negative reactions, but the only solution is the provision of a containing work context that provides sufficient support and supervision – ultimately leading to the sense of confidence that is required in the effective treatment of NFSB patients (O'Connor & Glover, 2017).

3.5 The Debate around NFSB as a Psychiatric Responsibility

NFSB is not specifically catered for in a general hospital context. This creates a predicament that health care specialists sometimes hope to resolve by assigning the NFSB cases to psychiatric care.

Despite the previously mentioned White Paper specification of integrated care for NFSB admissions (Bantjes et al., 2016), the question whether NFSB patients are more suited to a psychiatric context surfaces repeatedly. It should be noted here that research confirms that suicidal behaviour does not necessarily imply the presence of a mental illness diagnosis, as discussed in Chapter 2 (Ahmedani et al., 2014; Ani et al., 2017; Saunders et al., 2012). There is some debate about possible reasons for the absence of a psychiatric diagnosis, such as that NFSB patients are often too young to have met the criteria or simply do not have access to the required mental health expertise (Ani et al., 2017). Either way, psychopathology is not a prerequisite for NFSB presentation.

General hospital workers do, however, seem to have the opinion that psychiatry is more sufficiently geared (and trained) to treat the NFSB population (Norheim et al, 2013). The availability of time to explore and reflect on NFSB seems to be a crucial requirement in the effective treatment of this patient population, a luxury that is not always available in a medical ward (O'Connor & Glover, 2017). Studies confirm that psychiatric staff tend to be generally more empathic towards NFSB patients (Bantjes et al., 2016; Saunders et al., 2012). Some authors ascribe this ability to empathise to the psychiatric professional's personal preference to work, or interest in working, with this patient group, and to the probability of obtaining more related knowledge and possible access to supervision (Saunders et al., 2012). This leads to an important conclusion that is widely noted in literature on the treatment of NFSB: improved training and access to supervision and support seem to be the key, not only to improving attitudes towards NFSB patients, but also to achieving higher levels of optimal and efficient care (Norheim et al, 2013; Saunders et al., 2012; Timson et al., 2012).

Different studies on psychiatric staff members' experience of suicidal behaviour, however, noted similar emotional challenges for general medical staff, such as sadness, uncertainty about the legitimacy of NFSB patients' needs, professional vulnerability, stigmatisation of suicidal behaviour and not feeling supported (Awenat et al., 2017; Kraemer, 2010). With reference to clinical supervision, some authors confirmed the idea that it could assist with the efficacy of the therapeutic management of NFSB patients, yet access to

supervision seemed either not available or not implemented – even in the psychiatric space (Awenat et al., 2017). NFSB patients' reports confirm that admission alongside psychiatric patients may in fact add to their psychological distress and attribute an additional stigma of mental illness (Bantjes et al., 2016; Carroll et al., 2016). On a related note, the decrease of suicide risk in response to psychiatric admission remains questionable (Shilubane et al., 2014). The psychiatric management of NFSB patients does not, therefore, seem to be the ideal solution to all these challenges.

3.6 Health Care and Adolescents

During the first decade of the new millennium, the World Health Organization (2012) investigated the possibility of launching new global initiatives aimed at improving the mental health and psychological functioning of adolescents in particular and identified the following pitfalls in health care programmes aimed at adolescents:

- Programmes are aimed at adults or children, which means that adolescents fall by the wayside.
- The scientific evidence that informs initiatives aimed at the adolescent developmental stage is limited, thus reducing the efficacy of such interventions.
- Initiatives are fragmented, poorly coordinated, under-funded and ill-informed.
- There is a general lack of understanding of what exactly adolescents need in order to maintain psychological well-being (World Health Organization, 2012).

Research confirms that the placement of young adults/adolescents in hospital should be age-appropriate to ensure the optimal promotion of health (Sawyer, Ambresin, Bennett, & Patton, 2014). Adolescents have developmental aspects that are different from those of adults and younger children, requiring different skills and competencies from staff and flexibility in the use of health resources (Sawyer et al., 2014). This is important, because the philosophy of care differs greatly. Paediatric interventions are for example more focused on the inclusion of the family, whereas in adult health care the focus is more on the disease itself (Barling, Stevens & Davies, 2014).

Adequate staff knowledge and a positive attitude towards NFSB adolescent patients is crucial for the effective management of this patient group (Timson et al., 2012). One study found that adolescent patients particularly value feeling respected by competent clinicians who

communicate treatment procedures clearly (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). Sensitive communication in an attempt to understand the meaning of NFSB is vital. This will also lead to a reduction of the misconceptions and/or stigma associated with this patient group.

In the case of treating adolescent NFSB patients, a protocol designed specifically for this patient group is essential: it should specify inclusion of caregivers, while still honouring the adolescent's informed consent process (Taylor et al., 2009). Also, when reflecting on the adolescent's psychological journey to autonomy and related reduction of personal disclosure, their insistence on confidentiality becomes comprehensible and deserving of consideration (Herrera et al., 2017; Paruk & Karim, 2016).

Health care providers should therefore be sensitive to tensions that are related to the developmental stage that might undermine the treatment process.

3.7 Conclusion

This section started with a brief summary of the political framework of the South African health care sector, touching on some of the political dilemmas impacting on its functioning. This was followed by a focus on each individual health care professional group included in the current study, providing some background to the profession and their scopes of practice. The discussion then turned to the management of NFSB: difficulties experienced, as well as possible solutions to these challenges. The question of psychiatric placement was considered before a specific focus on the adolescent patient's health care needs.

There can be no doubt that NFSB poses complex and unique challenges that the health care system may not be equipped to address at this time. It is crucial to investigate these challenges in order to inform NFSB treatment to the point of mitigating suicide risk.

The next chapter considers the methodology of the current study, with reference to the research process that was followed.

Chapter 4 – Research Methodology

4.1 Introduction

This chapter focuses on the philosophical starting point of the current study and delineates how the interpretive phenomenological analysis (IPA) research design was incorporated to meet the aims of this investigation. Since the current study was essentially based on two projects, namely the adolescent and health care provider experiences of NFSB and related admission to hospital, these projects are discussed separately, demonstrating the steps of the research processes.

This section also contains excerpts from the researcher's reflective journal, shedding light on the researcher's experiences, while demonstrating a constantly reflective stance aimed at achieving a level of empathic neutrality.

The chapter concludes with a discussion on the trustworthiness of the study, as well as ethical considerations.

4.2 Paradigmatic Point of Departure

This study was crafted within the qualitative research tradition, being an investigation of a phenomenon (non-fatal suicidal behaviour) by focusing on the meanings that the people involved (adolescents and health care workers) ascribe to it. This is in line with Denzin and Lincoln's (2011) description of a qualitative research inquiry.

In keeping with this tradition, the study made use of an interpretive paradigm. This is linked to Immanuel Kant's earlier writings related to the understanding that knowledge can be derived from interpreting or reflecting on experiences, as opposed to having experienced something directly (Ormston, Spencer, Barnard, & Snape, 2013).

This study is based on the idea that reality is a concept with different truths (Khan, 2014). Specifically, the concept of subtle realism as coined by Blaikie (2007) formed the foundation

of this inquiry. This refers to the idea that independent reality can be accessed through interpretations (Cresswell & Poth, 2018). This study is aimed at capturing the complex reality of the experience of adolescents who attempt suicide and their health care providers.

4.2.1 Research Design: Interpretative Phenomenological Analysis (IPA)

The qualitative research approach at the core of this study is interpretative phenomenological analysis (IPA). This approach is appropriate for the current study, since it is firmly situated in the discipline of psychology and aimed at exploring how participants make sense of what they have experienced (Smith, Flowers & Larkin, 2009). In this case, the experience under consideration is NFSB of adolescents and the health care providers responsible for their medical treatment after admission to hospital.

4.2.1.1 Theoretical foundations of IPA

IPA is based on three central elements (Smith et al., 2009), namely Phenomenology, Hermeneutics and Idiography.

a) Phenomenology. During the early 1900s the philosopher Edmund Husserl wrote about the epistemological importance of a phenomenological or descriptive psychology to truly capture the essence of human experience, as opposed to positivist ideas about conducting research to reveal causalities (Husserl, 1973). The focus, therefore, is on the essence of the experience, free from any judgment by the observer. In the phenomenological tradition, the aim is to discover and describe the meaning attached to an idea, to uncover meanings contained in conversation and text. In order to achieve this, the researcher aims to gain true closeness to how a participant understands an experience by helping him/her to reconstitute something that they have lived through (Seidman, 2015). The focus, therefore, is on description and interpretation of the lived experience, not explanation (van Manen, 2014). The IPA researcher employs this lens to elucidate the phenomenon under investigation.

b) Hermeneutics. In later years Martin Heidegger built on this philosophy and developed the hermeneutic concept of 'Da-sein' which postulates that being human is always situated in a 'Life-world' (Heidegger, 1962). Here Heidegger referred to the situated reality of human

experience, stressing the significance of the context or world in which meaning is created (Van Manen, 2007). The core of hermeneutics centres around interpretation as a tool in uncovering how a contextually bounded person makes meaning out of an experience, which is also the aim of IPA (Smith et al., 2009). This is achieved through the use of language and texts.

It is, however, important for description to lead to knowledge and meaning through interpretation (Van Manen, 2014). Knowledge is produced when exploring and understanding meanings that people ascribe to experiences (Creswell & Poth, 2018; Ormston, Spencer, Barnard & Snape, 2013). The significance of an experience is therefore shared with others (Marshall & Rossman, 2016). In this paradigm, knowledge is produced interactively, where both the participant's and the researcher's interpretations are important. Researchers strive to assist the participant to reconstitute the lived experience. However, researchers always bring their own philosophical assumptions and values to such reconstitution (Berger, 2015; Creswell & Poth, 2018). The hermeneutic/phenomenological tradition considers lived experiences to be part of a context which the researcher also becomes part of through conducting the research inquiry (Morehouse, 2012). It follows then that the researcher has to reflect on her understanding of the world in order to be able to enter the world of the study participants and clearly understand the meanings that they assign to experiences (Wojnar & Swanson, 2007). The researcher, therefore, has to accept the reality of her own pre-conceptions and strive towards objectivity.

When attempting to manage the researcher's preconceptions and biases, Husserl's concept of 'bracketing' may be considered (Laverty, 2003). This activity requires the researcher to identify her judgments in relation to the research project and 'bracket out' these biases in order to be free from her own preconceptions and therefore open to what is being investigated (Laverty, 2003). Heidegger, however, argued that interpretive research that is not affected by the judgment or influence of the researcher does not exist (McConnell-Henry, Chapman, & Francis, 2009). He made reference to the concepts of "fore-structure", "fore-conception" and "fore-having" to acknowledge the preliminary personal perceptions with which a researcher approaches a search for understanding (Heidegger, 1962). In fact, the researcher also exists in the world, and her pre-conceptions give rise to the initial research question and her ability to interpret (Smith et al., 2009; van Manen, 2007). Reaching a stage of being completely judgement-free is, therefore, not considered possible. Within the IPA approach it is recommended that an analytic and constantly questioning approach be taken to the researcher's pre-understanding and the material under exploration, a process which never reaches completion (Smith et al., 2009). In the current research study, therefore, the researcher

engaged in constant reflection on her own perceptions and experiences of the research process, ultimately striving for empathic neutrality.

c) *Idiography*. In addition to the phenomenological and hermeneutic philosophical assumptions forming the basis of an IPA investigation, the idiographic principle must also be adhered to. Smith et al. (2009) postulate that the idiographic lens aims to understand the particular details of an individual experience within a specified context. Since the focus here is on providing a thick description of unique experiences, an idiographic approach requires significant attention and analysis of each individual case before attempting a comparative analysis aimed at identifying themes that are shared (Smith, 2004). For this reason, it is recommended that IPA samples may consist of small, homogenous groups, thus enabling a detailed idiographic exploration (Smith-Gowling, Knowles, & Hodge, 2018).

When considering the different levels of information that are contained in this study, the concept of the *hermeneutic circle* is introduced (Laverty, 2003). Here reference is made to the ongoing dynamic process of understanding individual parts before moving towards an understanding of the whole, and back again, thus creating a more in-depth understanding that takes place on different levels (Laverty, 2003). This circular process of engaging with the data supports the iterative, non-linear process of IPA analysis, which is ultimately aimed at understanding how unique people make sense of their experiences (Smith et al., 2009).

This complex interaction demands inquiries that move dialectically between inductive and deductive processes (Marshall & Rossman, 2016). In the beginning of the process, the researcher made use of existing theoretical publications in planning the research, which was a more deductive process. While collecting the data and initially engaging with the process of analysis, however, the main focus was on the transcripts and relevant contextual information, in an attempt to accurately understand the participants' experiences of their realities. This was a more inductive process, which also allowed flexibility in order to be open to unexpected messages (Smith, 2004). This study relies heavily on the information provided by the participants. Even later in the research process, when focusing on themes she had identified, the researcher continuously aimed to remain close to the participants' interpretations of what they had experienced. As the analysis approached completion and the researcher prepared for the discussion of results, newly acquired knowledge was linked to existing theories (Ormston et al., 2013). Here the researcher's interrogative stance, which is aimed at making a contribution to existing literature, comes to the fore (Smith, 2004).

4.2.1.2 Conclusion.

IPA does not provide a prescriptive set of principles on how to conduct a psychological research project. Since the IPA's epistemological assumptions resonate with the vision of the current research project, the IPA method was used as a foundation for the study.

4.3 Research Question

4.3.1 Reflecting on the formulation of the research question

As a clinical psychologist employed at a tertiary-level South African hospital, I noted that adolescent NFSB patients were admitted to the hospital on a regular and ongoing basis. Since clinical psychotherapy forms part of the treatment protocol for this patient population, I often saw NFSB adolescents for clinical psychology interventions. A number of concerns were noted in relation to the NFSB referrals:

- 'Para-suicide' referrals were received on an ongoing basis and had to be prioritised because of their short stay in hospital. The understanding was that they had to be seen on the same day that the referral to Clinical Psychology was received, because they might be discharged before we reached them. This implied additional pressure in an already packed schedule. The unpredictability of when the referrals might come through also added to the strain.
- Staff members seemed annoyed with the high numbers of 'para-suicide' referrals, a feeling that appeared to be shared by different members of the multi-disciplinary team.
- Adolescent NFSB patients were at times re-admitted for the same reason.
- Adolescent NFSB patients in general appeared anxious to leave the hospital as quickly as possible.
- No statistics were available within the hospital with regard to NFSB admissions, their ages or other demographic details.
- No research had been recorded on this population group.

I started to think about the investment of resources on the part of the hospital when it comes to the high number of adolescent NFSB patients, as well as the patients' insistence on

leaving the hospital as soon as possible. In addition, I often noted quick yet significant mood improvements (I associated suicidality with a depressed mood at the time). My questions concerned how health care workers experience this patient population, as well as how the patients experience the process from suicide attempt to hospital treatment. These thoughts, among others, prompted me to conduct an investigation.

4.3.2 Formulating the research question.

IPA is noted to be an appropriate approach when the aim of the research is to understand how people make meaning out of, or perceive, a personal experience (Smith & Osborn, 2003). Since the aim of this study was to explore how adolescents who attempt suicide make sense of their experience, between attempting suicide and being treated in the hospital context, as well as how health care professionals experience working with these patients, this approach was deemed most suitable. In keeping with the IPA's inductive approach, research questions should be broad, thus enabling the flexible exploration of a specified phenomenon. The research question, therefore, was:

What are the experiences, perceptions and responses of adolescents who attempt suicide, as well as those of the health care workers who provide health care to them upon admission to the designated hospital?

True to the IPA character, the researcher had to be flexible and creative in finding ways to apply the theoretical assumptions and methodological ideas to a psychological study on NFSB among this unique population presenting at the research site.

4.4 Research Context: Dr. George Mukhari Academic Hospital

Dr. George Mukhari Acadamic Hospital (formerly known as Ga-Rankuwa Hospital), was built in 1972. It is known to be the second largest hospital in Africa and houses 1 650 beds. It a tertiary level public hospital, providing teaching opportunities for the neighbouring Sefako Makgatho Health Sciences University (formerly known as Medunsa).

It is situated in Ga-Rankuwa, a township north of Pretoria, which forms part of the Gauteng Province. The area carries the legacy of apartheid imbalances, as is visible in

significant economic inequality (Misago, 2010). Labour migration into the area has been contributing to already existing social problems including high rates of unemployment, poverty, crime and substance abuse (Department of Social Development, 2016). This rapid increase in numbers has also added to inadequate access to health care.

Ga-Rankuwa is home to a diverse group of people speaking different languages such as Setswana, Sepedi, isiZulu, isiXhosa and Xitsonga. Increasing numbers of youths from the area enrol at institutions of higher learning, and while transformation plans in the township are impeded by social problems and poverty, the area also carries significant potential for growth.

While Dr. George Mukhari Academic Hospital is situated in the North Western part of the Tshwane District, the Hospital accommodates patients from an immense catchment area, extending as far as the neighbouring provinces of North West and Limpopo and even outside of South African borders. The Hospital is hence under constant pressure to provide health care and discharge as soon as possible, to make space for an impossibly long line of patients waiting to be assisted.

The tertiary level status of the Hospital implies the availability of medical specialists, as is evident in the following list of services provided by the hospital (Official Dr. George Mukhari Hospital Facebook page, 2018):

Products

Surgical Cluster

General surgery

Orthopaedics

Plastic surgery

Neurosurgery

Urology

Cardiothoracic surgery

Paediatric surgery

Ear, Nose and Throat (ENT)

Medical Cluster

Internal medicine

Family medicine (including Emergency unit and level 1)

Mental health (Psychiatry)

Community Health

Cardiology
Neurology
Gastroenterology
Nephrology
Dermatology

Critical Care Cluster
Trauma unit
Intensive Care Unit (ICU)
Theatre
Anesthesiology

Mother and Child Cluster
Obstetrics & Gynaecology
Paediatrics

Diagnostic Cluster
Radiology
Nuclear medicine
Clinical pharmacology

Allied Services
Clinical Psychology
Pharmacy
Physiotherapy
Occupational therapy
Speech therapy
Human nutrition
Radiography
Social work

The training aspect of the Hospital includes different levels of health care providers, ranging from students to interns, registrars, medical officers and consultants. The Hospital, therefore, also aims to support research and innovation. Dr. George Mukhari Academic

Hospital employs a significant number of health care providers tasked with the duty of health care provision to its steadily increasing patient population.

4.5 Data Collection Time Line

Ethical approval from the University of Pretoria was confirmed on 20 May 2016 (APPENDIX E). On 3 October 2016 final written permission by the Director of Clinical Services to conduct research at Dr. George Mukhari Academic Hospital was confirmed (APPENDIX F).

The data were collected over a 6-month period between January and June 2017. The following tables indicate specifics:

Table 1

Individual adolescent interviews

Participant number	Date (DD/MM/YYYY)
1.	24/01/2017
2.	30/01/2017
3.	31/01/2017
4.	06/02/2017
5.	13/02/2017
6.	20/03/2017
7.	29/03/2017
8.	11/05/2017
9.	30/05/2017
10.	05/06/2017

Table 2

Focus groups and medical doctor interviews

Focus group/ interview	Date (DD/MM/YYYY)
Nurses	23/03/2017
Social workers	28/03/2017
Interviews with medical doctors	17/05/2017
Clinical psychologists	22/06/2017

4.6 Adolescent Sample

4.6.1 Participant selection.

Smith and Osborn (2003) recommend the selection of a homogeneous group who are willing to participate and for whom the phenomenon under investigation has significance. The sampling for this study was therefore *purposive*. Purposive sampling allows the intentional selection of participants based on their ability to shed light on a phenomenon identified by the researcher (Robinson, 2014). The sample of participants was homogeneous in terms of the shared developmental stage, an experience of NFSB and subsequent hospital admission. In purposive sampling, availability, willingness to participate and the ability to communicate meaningfully are essential (Etikan, Musa & Alkassim, 2016).

As discussed earlier, the idiographic principle of IPA necessitates the use of smaller sample sizes that allow detailed descriptions of individual stories. For this reason the aim was to work with a small homogeneous group of adolescent participants.

4.6.1.1 Inclusion criteria.

The following inclusion criteria were used for the selection of participants:

- The participants should be in-patients at Dr. George Mukhari Academic Hospital who had been admitted because of attempting suicide.
- They should be between the ages of 13 and 21 inclusive.

- They should be able to communicate in a language that is understood by both the participant and the researcher. In this context the language used was English.
- They should be willing to provide informed consent to participate. In the case of an adolescent who was younger than 18 years, informed assent had to be obtained from the participant, as well as proxy consent from a parent or legal guardian.

4.6.1.2 Reflecting on the age range inclusion criterion.

The ages of 13 to 21 years were selected as representative of the adolescent stage, since no fixed age range exists (please see related discussion in Chapter 2). The lower limit of 13 years allows inclusion of adolescents at the approximate beginning of secondary school, until the age of majority.

It should be acknowledged here that the age group of 13 to 21 years is quite broad and may have resulted in differing levels of maturity among participants. Such differences, however, can be accommodated in an IPA investigation where the aim is to understand experiences and not to compare or generalize.

4.6.1.3 Reflecting on language as an inclusion criterion.

Language is a contentious issue. Heidegger made reference to an expressive ontology where people find ways to disclose their social worlds (Smith & Osborn, 2009). While language is determined by one's culture, people's stories go beyond what is culturally significant. Smith (2004) considers the limitations of language and concludes that the copiousness of data gathered is not reliant on socio-economic determinants, as long as the phenomenon under investigation has significant meaning to the participant. He recommends greater involvement on the part of the researcher to keep the discussion flowing if necessary and the use of professional skills to enable effective communication. As reflected earlier, this recommendation was followed.

In terms of the socio-political context of the current study, participants and/or their relatives may have previously found themselves marginalised and without their own voice in apartheid South Africa. Also, languages of the oppressor may have been imposed on them in different forms and contexts, which may have had implications for conversations in the current study. It is also a fact that some participants may have been more comfortable expressing themselves in their mother tongue.

I nonetheless believe that using English as a medium for this study is justified for the following reasons:

- The participants and I had a variety of home languages: even if one indigenous language had been identified, it would not have accommodated all the participants.
- All the participants were either attending secondary school or had attended secondary school, which implies a certain level of English language proficiency. It should be noted here that secondary school attendance was not an inclusion criterium, but upon reflection it probably contributed to the process of communication.
- Some of the participants were more fluent or eloquent than others, as would be expected. It should be noted that I sought clarification in cases where a word or phrase seemed unclear or confusing during the interviews. Clarification was also provided in instances where participants seemed confused or unsure about the question.
- Excluding participants from research because of their language would be another form of marginalisation. They hold a wealth of knowledge, and it was worth trying to find some common grounds to communicate and get an understanding of their experience. This population deserves to be heard.

4.6.1.4 Identification of potential participants.

The identification of potential participants was achieved as follows:

- Since the researcher is a clinical psychologist at the hospital, she is a member of the clinical psychology team assigned to treat patients in the medical wards. As such, the researcher belongs to a *WhatsApp* group on which all new hospital referrals are posted. The clinical psychology team and the administrative manager at the psychology department were kind enough to indicate the ages of 'para-suicide' referrals on this WhatsApp group. If the researcher saw a referral for a 'para-suicide' patient between the ages of 13 and 21, the referral would be identified as a potential participant.
- One of the clinical psychologists on the team would indicate that he/she would consult with the referred patient and commence individual psychotherapy, as is the treatment protocol.
- Depending on the researcher's availability and schedule, she would go to the ward and make contact with the referred adolescent 'para-suicide' patient. If the patient was willing to hear her out, the researcher would then introduce herself and provide information about the study. The patient would be invited to take part in the study by participating in an interview with the researcher.

- If the patient was willing to participate, the researcher would ask to make an appointment for the interview, bearing in mind that 'para-suicide' patients are discharged as soon as possible and in most cases that meant that they might be leaving on the same day. It should also be noted here that the participants preferred to have the interview immediately in most cases.
- In terms of the response rate, it should be noted that all the participants who were approached by the researcher were willing to participate.
- The researcher would then find a more confidential space where the interview could be conducted.
- When the researcher and the participant had found a room where they could sit and speak comfortably, the informed consent process would be initiated (discussed later). If the consent process was successful, the interview would be conducted.
- If a patient was not willing to participate, that decision did not affect his/her hospital treatment in any way; their decision was respected, and the researcher left the ward.

This interview process occurred separately from the patient's psychotherapeutic sessions that would still continue with the assigned clinical psychologist, regardless of the patient's participation in the research project.

4.6.1.5 Reflecting on the identification of participants.

Time was of the essence, and the process had to take place very quickly. In most cases, 'para-suicide' patients only stay one night in hospital. If they are found to be physically well (which they are in most cases) and had made some kind of contact with the psychologist and/or social worker, the patient would be discharged. It therefore often happened that, by the time I got to the ward, the potential participant had already been discharged. I realised that I had to act quickly to reach potential informants before they left. This also had significant implications for aspects of the consent process, as will be discussed under ethics.

- The good response rate may have been a result of the contextual reality of being in the ward, as opposed to a specific interest in the research topic. In most, if not all cases, the adolescents indicated that they were bored in the ward. They were mostly in adult medical wards where the patients were seriously ill, therefore they usually did not have company in the wards. There was no other stimulation such as television available. Most of them seemed to enjoy a different activity, i.e. participating in this research project.

4.6.2 Qualitative interviews.

In keeping with the interpretive nature of the study, the researcher made use of qualitative interviews in order to come to an understanding of how adolescent NFSB patients make sense of the phenomenon of a suicide attempt and subsequent hospital admission. Van Manen described the researcher's quest accurately when he wrote: "The aim of phenomenology is to transform lived experiences to a textual expression of its essence" (1990, p.36). The researcher, therefore, used the interviews to assist the participant in the reconstitution of the lived experience (Seidman, 2015).

Interviews were semi-structured to ensure that they were flexible enough to allow space for accurate understanding (Wahyuni, 2012) and to remain sensitive to the social context in which the inquiry took place (Ormston et al., 2013). From an IPA perspective, the semi-structured interview provides a guide that the researcher can adapt to establish rapport with the participant, follow the participant's lead and probe where necessary in order to understand (Smith & Osborn, 2003). Although the qualitative nature of the inquiry required more open-ended questions and allowed the participant space to explore, the interview schedule highlighted some of the focal points that the researcher kept in mind while conducting the interviews. This schedule also allowed some consistency among the different interview processes. However, the person-centred nature of the interviews required a deliberate focus on the participant and his/her unique discourse. After all, the participant is the *experiential expert,* and the idiographic focus requires attention to individual detail (Smith & Osborn, 2003).

In the researcher's ongoing attempts to manage her own biases, care had to be taken not to focus on aspects of the interview information that confirmed her own experiences (Smith-Gowling et al., 2018). Constant reflection and supervision were applied to manage this aspect.

Again, no specified steps in the development of a semi-structured interview are prescribed within the IPA approach and the researcher adapted the technique to elucidate how the participants experienced attempting suicide and being admitted to hospital.

4.6.2.1 Interview structure.

The interview structure consisted of two sections: Section A and Section B.

Section A was focused on gathering relevant background information. The aspects that were asked included the following:

1. Age of the participant
2. Gender
3. His/her highest academic qualification

This gave an indication of the participant's level of academic functioning. This was also relevant to establishing if his/her English language acquisition was sufficient for participation in the study.

4. His/her current grade/tertiary education year/occupation
5. Home language
6. The area where he/she lives
7. Who the participant lives with at home

This question was aimed at developing an understanding of the participant's support structure: their family or the people that they live with in cases where the family is not close.

8. How things are at home

This general, open-ended question could be instrumental in gaining essential information with regard to the participant's socio-economic situation, as well as possible conflictual relations that may set the context for the NFSB act. It also set the tone for the more open-ended Section B.

It should be noted here that any discussion that emanated from the previous questions would be allowed and included in the interview.

Section B focused more on the phenomenological character of the study. The questions here were open-ended and general and included the following:

- What brought you here? What were things like before coming to hospital? How did you end up here?
- How are you feeling currently? How have you been feeling?
- Tell me about being in hospital. What has it been like for you to be here? Tell me about your journey in the hospital. How do you perceive this ward and aspects thereof? How did you experience the treatment you received?
- Was it helpful to come to hospital? If so, how?

These were the main questions directing the conversation towards the focus of the study. Additional elements that were used and expanded on as they came up in the conversation included, but were not limited to the following:

- Method of suicide attempt
- Previous attempts and/or suicidal ideations

4.6.2.2 Reflecting on the interview structure.

As a clinical psychologist, I am trained to establish rapport. This skill was employed to create a comfortable interview space for participants to participate.

The intention was to keep the questions simple and easy to comprehend. I attempted to start with more neutral questions during the stage of establishing rapport before moving on to more personal ones.

While some of the adolescent participants were more talkative than others, I had to probe and clarify often. For example, when asking the participant to talk about how they experienced the hospital, some of them would reply "fine", and leave it at that. This would require further probing in an attempt to truly understand the experience of being in hospital.

During the interview process, there were lighter moments where both the participant and I would be laughing. There were also more difficult ones where the participant would be in tears or upset. Being a clinical psychologist, I had to be careful in such instances to contain emotions without attempting any psychotherapeutic intervention. I would, therefore, pause the interview and allow time for emotional containment. During these silences I would offer the participant a tissue and provide basic reflections such as the observation that what the participant was sharing was painful for her. Once the participant was calmer, I would recommend further discussion of that topic with her assigned therapist. I would ask permission to continue the interview once the participant was calmer and willing to do so.

After going through this process, I have come to the conclusion that my profession contributes both strengths and weaknesses to my abilities as a researcher.

4.6.2.3 The interview process.

- Participants who agreed to take part in the study by providing informed consent (which will be discussed under ethics) were interviewed by the researcher individually.
- The researcher took time to make sure that the participant was at ease at the beginning of the interview.
- The Interview Protocol was used as a guide during the interview process, but the participant was allowed space to relate his/her experiences in whichever way he/she preferred.
- The interviews were audio recorded with the permission of the participant.

- Participation or the choice not to participate in the study did not affect the hospital treatment process in any way. The participant still continued with the therapeutic process with the clinical psychologist appointed for this purpose. This was made explicit to participants.
- After each interview, the recorded interview was transcribed for the purpose of analysis. The researcher transcribed the interviews herself. Additional notes such as relevant non-verbal behaviour of participants and explanations regarding interruptions from outside were also noted in the transcripts.

The researcher conducted ten individual interviews with adolescents admitted for NFSB. Different IPA theorists recommend small samples of 5 to 10 interviews, in order to maintain the idiographic focus of an IPA study (Smith, 2004; Smith-Gowling et al., 2018). Each interview was approximately one hour long.

4.6.2.4 Reflecting on the interview process.

- I found the guiding structure of the interview useful during the interview process. In accordance with Smith and Osborn's recommendations (2003), I memorized the guiding questions and used them in a flexible manner to allow the participant to tell her story while staying focused on the research topic.
- Some of the participants were less talkative, providing one-syllable or vague responses, in which cases it helped to have some direction. There were also conversations where the participant was talkative and focused on one particular element that was unrelated to the research project, in which case the interview protocol assisted to keep the discussion focused. In these cases, I also encouraged the participant to discuss that particular issue further with their assigned clinical psychologist.
- It should be acknowledged here that using a semi-structured interview does imply certain inherent methodological limitations and that other methods may have been more culturally applicable, such as storytelling. For the purpose of this investigation, however, trying to find a balance between providing some structure while still allowing space for unique disclosure of the personal experience seemed to work well.
- It rarely happened that interviews proceeded and were concluded without any interruptions. No private spaces are available in the ward and, while nurses were kind enough to assist by allowing the interview to take place in a room in the ward, it was inevitable that staff members needed to fetch things from the room. While this impacted on the process, I

tried to manage these interruptions in order to ensure continuity. For example, I would request the participant to wait until confidentiality had been restored before she continued, while making a mental note of what she was talking about in case she forgot. It should also be noted here that the participants generally did not seem annoyed by such interruptions, which could be attributed to the fact that they had been staying in the ward and understood the set-up. It is possible that an irritability with regard to interruptions was only true in my experience.

4.7 Health Care Provider Sample

The participant selection and data collection process for this group of participants differed from those for the adolescent group, and the presentation is therefore structured differently.

4.7.1 Method of data collection: Focus groups.

Focus groups can be identified as small groups of people interacting with each other in an informal way, with the facilitation of the researcher (Wilkinson, 2011). Such interaction presents a unique method of data collection that is recorded and analysed. Data can, therefore, be collected from multiple participants at the same time (Braun & Clarke, 2013). Although the focus group session is an interview, individual members are not required to answer specified questions. Instead, the facilitator/moderator introduces topics and the group members listen to each other's opinions and voice their own, and in this way data based on the group members' views on a particular topic may be collected (Patton, 2002). Since the principle is for the researcher to observe regular processes of interaction, the data received is perceived to be more 'naturalistic' than one would get from the interview technique (Braun & Clarke, 2013).

This data collection technique uniquely lends itself to acquiring information on how health care providers experience adolescent NFSB patients. The focus group setting would hopefully provide a safe space where health care providers of the same profession could voice their opinions in as much detail as they were comfortable with, agree or disagree with their peers and in this manner provide invaluable information about their subjective experiences of the phenomenon under investigation. The researcher, therefore, has access to a wide range of

views, perspectives and understandings of how the health care workers make meaning of adolescent NFSB and clinical management.

4.7.1.1 Reflecting on the use of focus groups.

It should be noted that focus groups did not use to be synonymous with IPA studies because of the difficulty of employing the phenomenological perspective on a complex interactional process (Smith et al., 2009). Focus groups have, however, been employed in a growing number of IPA studies and have been found useful when the research question requires more voices to be included in a data collection opportunity. I used focus groups in this project for the following reasons:

- A focus group discussion was a good fit with the focus of the current research question: to gain an understanding of how health care providers who work with adolescent NFSB patients experience and perceive this patient group.
- The focus group dynamic enabled me to include more voices in the project, presenting a larger perspective from the participants – in their place of work where this phenomenon is encountered.
- In attempting to maintain the idiographic focus, I developed a coding system that enabled linkages between what a particular participant had said and his/her biographical or contextual information – while still honouring anonymity. (The coding system is discussed later on). This made it possible to consider a phenomenological detail when it emerged in the text, therefore avoiding a nomothetic approach where data is transformed in a way that findings cannot be traced back to the individual voice that provided it in the first place (Smith et al., 2009).

4.7.1.2 The focus group guide.

The process for developing the focus group guide was similar to that for developing the semi-structured interview schedule. The guide specified certain topics that were used to facilitate or direct the focus group process. Since the aim was to get focus group members to discuss the research topics among themselves, the guide was not strictly adhered to. It merely provided guidance in order to keep the conversation focused on the research topic.

a) The focus group guide

Welcome

- Thank participants for availing themselves
- Acknowledge that they are busy
- Point out that their opinion is valuable

Introduction

- Research question and topic
- Length of discussion: not more than two hours
- Permission to record

Issues of confidentiality

- Please do not discuss focus group discussion content outside the session
- Information will be stored and managed confidentially

Ground rules

- Do not interrupt others.
- If you want to say something, please do.
- If you prefer not to answer, that is your choice.

The focus group guide included the following topics:

1. Please tell us about working in this hospital.
2. How do you understand your roles in the treatment of ‘para-suicide’ patients?
3. Please discuss the experience of working with ‘para-suicide’ patients and how/if that experience is different when working with adolescent ‘para-suicide’ cases.
4. How do you feel about/perceive/understand adolescents admitted to hospital following a suicide attempt?
5. Please consider challenges when providing treatment to adolescent NFSB patients.
6. What would improve your experience in this regard?
7. Any additional thoughts/questions.

b) Demographic information form. All focus group members were requested to complete the demographic information form (see Appendix D). This form was included in the data collection process to allow an understanding of the contextual lived realities of the participants, thus maintaining an idiographic focus.

The demographic form focused on the following topics:

- Profession of participant, as well as where he/she was trained and when they qualified.
- The participant's age, gender, home language and marital status.
- Whether they have children, how many and what their ages are.
- Current residence.
- Where in the hospital they are based.

The demographic form was completed with the consent form.

4.7.2 Focus group participants: nurses.

4.7.2.1 Identification of participants.

The following inclusion criteria were used for the purposive selection of participants:

- The researcher is a clinical psychologist employed by the hospital. She is therefore known to the nursing staff who work mainly with NFSB patients, i.e. Ward 35.
- The researcher met with the Unit Manager at Ward 35 and provided information with regard to the following: ethical clearance for the research project provided by the University of Pretoria and the Management of Dr. George Mukhari Academic Hospital; the aims of the study; how the nurses would fit into the inquiry: the envisioned focus group and the purpose thereof.
- The unit manager then indicated that the researcher would be allowed to meet with the Ward 35 nursing team in the morning, after the hand-over meeting between night and day staff. The nurses normally had a meeting after the hand-over and the researcher was allowed to use that time.
- The nursing focus group consisted of most of the nursing staff members on duty in Ward 35 on that morning, i.e. six. One nursing staff member had to keep an eye on the patients.

4.7.2.2 Reflecting on the identification of potential participants (nursing group).

- It was difficult to get the unit manager to commit time to the study. She reported that they were short-staffed in the ward and were therefore always busy. It was impossible to excuse nurses from their duties to take part in a research discussion.

- I also offered to arrange the focus group when the nurses were not on duty and therefore more relaxed/focused, but the nurses were not willing to commit their personal time – which is understandable.
- I therefore had to make do with the time allowed, while the participants were still responsible for carrying out ward duties.

4.7.2.3 Focus group process.

The group was scheduled to start at 07h00 and be finished by 08h00 so that the nurses could resume their duties in the ward. The hand-over meeting lasted longer than the unit manager and researcher had anticipated. This meant that some of the focus group time was lost and the group only started at 07h20. The researcher waited until the participants were available. The group continued until later than the agreed time.

The focus group meeting had to be held in the ward: the nurses indicated that they could not leave the ward/patients alone and had to be available if required. When the researcher and nurses had gathered around the table, the researcher took time to introduce herself, provide information about the study and specify the ethical process.

The biographical information and consent forms were handed out and the group members were given time to read through the information, ask questions if anything was unclear and complete the form if they felt comfortable doing so. All the nursing staff members present signed the forms and indicated a willingness to participate in the study.

The session was therefore conducted around a table in the ward. This had numerous implications for the quality of the research discussion.

4.7.2.4 Reflecting on the nurses' focus group process.

- It was extremely difficult to focus on the discussion: people were walking in and out of the ward. Some of them were staff members such as cleaners, porters and nurses from other wards, while others were patients or family members. The constant distractions made it very difficult to create a safe space in which experiences could be shared.
- There was no sense of confidentiality. At one stage there were two visiting family members sitting in the 'waiting area', which is a bunk right next to the table where the focus group discussion took place. They seemed to be listening to the discussion and I had to request

that they move to a different place. Patients and staff members also walked past the table to access the bathrooms.

- Group members were called away from the group at times to attend to queries from staff members or patients. In these instances, the unit manager indicated that the group had to keep going, since we needed to finish so that people could return to their stations. Some group members, therefore, missed certain topics of discussion.
- The group process was also stopped twice when visitors to the ward requested assistance at our table. In these cases, one of the focus group members excused themselves from the discussion to attend to the inquiry.
- All these aspects, as well as the general noisiness of the ward, had implications for the clarity of the recording.
- Some of the focus group members were wearing face masks, since the focus group session took place inside the ward. This also had implications for the recording. They did remove the masks during the focus group session.
- The unit manager was updating administrative tasks during the group discussion and at times interrupted the process with an administrative statement/question. When questioned about this, she indicated that the work had to be done: she could not wait for the group to finish.
- It should be noted here that the focus group members did not seem particularly motivated to participate in the group. Even after the study had been explained and consent had been provided, there seemed to be a lack of energy in the group. It was interesting to note that the two professional nurses were more motivated and interested than the enrolled and auxiliary nurses.
- Many of the focus group members used the space to voice complaints about their working conditions, management and how the patients treat them. In these instances, I acknowledged their concerns and tried to move back to the focus of the study.
- It was difficult for me as the facilitator to get them really engaged in the process. Some reasons for this may have been the lack of confidentiality, the distractions and the difficulty in hearing members clearly. The group never reached a stage of openly and spontaneously sharing their experiences – probably due to all the interruptions, a lack of privacy and the inconsistency in members' presence.
- The group consisted of participants of different ages, genders, cultures and levels of experience.

4.7.3 Focus group participants: social workers

4.7.3.1 Identification and inclusion of participants.

The researcher called a meeting with the social work manager of the hospital. During this meeting, the following information was provided: ethical clearance for the research project provided by the University of Pretoria and the Management of Dr. George Mukhari Academic Hospital; the aims of the study; how the social workers would fit into the inquiry; the envisioned focus group and the purpose thereof.

The social work manager agreed to allow her staff to join in the research project and took it upon herself to identify six social workers who

a) had experience in working with 'para-suicide' cases; and
b) were willing to participate in the research project.

The social work manager also arranged for a time and a venue for the researcher to meet with the social workers.

4.7.3.2 Reflection on identification and inclusion of participants.

- There was a limited number of social workers employed by the hospital. As long as the participants had been exposed to working with NFSB patients, they were invited to join the focus group.
- All invited social workers joined the group.

4.7.3.3 Focus group process.

The researcher met with the social work focus group at 14h00 in one of the social worker's offices. Everyone sat around a table to have the discussion.

The researcher introduced herself and explained the aims of the study. Then she discussed the ethical process. The biographical information and consent forms were handed out and potential participants had time to read through the forms, ask questions and sign if they were willing to participate. All the social workers present signed the consent forms and confirmed their willingness to take part in the research.

4.7.3.4 Reflecting on the group process.

- The room allowed a confidential discussion and the group members were physically comfortable.
- The audio recording was clear.
- The group was able to focus on the topics at hand.
- A pleasant sense of rapport was established where colleagues were able to openly share, laugh and address serious topics in a congruent manner.

4.7.4 Focus group participants: clinical psychologists.

4.7.4.1.Identification and inclusion of participants

Since the researcher is a clinical psychologist in the hospital, she invited members on her team to participate in the study. Apart from being a clinical psychologist (registered or in training), the inclusion criteria were:

- experience working with ‘para-suicide’ patients; and
- a willingness to be part of the focus group.

Potential focus group participants were individually approached by the researcher. If they indicated an interest in participating, the following information was provided:

- Ethical clearance for the research project provided by the University of Pretoria and the Management of Dr. George Mukhari Academic Hospital;
- The aims of the study;
- How the clinical psychologists fit into the inquiry: the envisioned focus group and the purpose thereof.

The researcher stopped inviting participants when six clinical psychologists had undertaken to take part in the study.

4.7.4.2 Focus group process.

The group convened in the researcher’s office at a specified time, where she explained the aims of the study and the ethical considerations. The biographical and informed consent forms were handed out and potential participants were given time to read through the material, ask questions, complete and sign the forms if they were willing to participate.

All the potential participants agreed to take part in the study.

4.7.4.3 Reflecting on the focus group process.

- The office allowed a confidential discussion.
- The audio recording was clear.
- The group members were comfortable.
- It should be noted here that the contents of this focus group discussion reflected realities of my daily working environment and pointed out experiences related to NFSB patient treatment that I could identify with. For this reason, I focused on the research objective by not participating in the discussion, but rather facilitating the group by introducing topics, providing summaries and asking for clarification.

4.7.5 Individual interview participants: medical doctors.

4.7.5.1 Identification and inclusion of participants.

a) First attempt (20 March 2017).

The researcher approached a doctor in Ward 35 to establish how she should go about arranging a focus group for the medical doctors. At first, she spoke to an intern doctor, who indicated the following:

- The doctors in the ward rotated approximately every two weeks to different wards.
- There were two intern doctors assigned to the male patients of Ward 35 and two intern doctors assigned to the female patients of Ward 35 at any given time.
- These intern doctors were overseen by a qualified doctor, mostly in his/her community service year. This doctor would be the person whom the researcher had to ask for assistance with organising a focus group.

The researcher approached this doctor and introduced herself. The aims of the study were explained, and the doctor quickly responded with some of her experiences in working with adolescent NFSB patients, such as the gender distribution, typical reasons for the suicide attempt and their moods in general. She also specified that the doctors did not have time to "go deeper", which is why they referred patients to the social worker and psychologist.

When the researcher explained the need to conduct a focus group with the doctors, the doctor made it very clear that they did not have time to sit down and discuss this. She provided

a quick list of things that she had to do on the ward, concluding that she had no time for research projects. She made it clear that she was available to discuss patient treatment when necessary, but that she would not take part in a focus group.

b) Second attempt: May 2017.

After spending time collecting other data elements for the study, the researcher again approached the medical doctors working in Ward 35. By this time there was a different team of doctors. The researcher spoke to the doctor in charge and explained the aims of the study. She also disclosed the first encounter with the medical team and reflected that she understood that time was an issue. She therefore offered to accommodate the doctors in any way that would make it possible for them to provide input into the study.

The doctor expressed a willingness to take part, but again stressed the shortage of time:

- There were five doctors who had to assess and treat some critically ill patients in a matter of hours.
- In between consulting with patients, nurses, providing treatment and prescriptions and doing other administrative tasks, their daily hours in Ward 35 were full.
- After completing their work in the ward, they had other duties to see to, such as clinics.
- Trying to arrange a meeting in their off-duty time was not feasible due to personal responsibilities.

For these reasons, the doctor and the researcher came to the agreement that doctors would be seen individually to discuss the focus group topics with the researcher. This meant that the other doctors could continue their rounds while the researcher was speaking to one member of the medical team. While this did not constitute a focus group discussion as was envisioned for this study, it did allow the researcher to gain some insight with regard to the medical practitioners' experience of adolescent NFSB patients.

4.7.5.2 Data collection process.

The doctor indicated a time when the researcher could come to meet them at Ward 35. He specified a Tuesday morning.

There was one cubicle in Ward 35 that happened to be empty. Although the noises of the ward were still evident and staff members came in to fetch things at times, it allowed a confidential discussion.

The researcher met with the supervising doctor first. Thereafter she had individual sessions with the other three doctors who were on duty that day.

When the doctor arrived for the discussion, the researcher would introduce herself and provide information about the study. She would then discuss the ethical matters and give the potential participants the demographic information and consent forms. They had time to read through the consent form and ask questions. If they were willing, they signed the consent forms and completed the biographical information. All four doctors indicated a willingness to participate in a discussion, as long as it did not last too long. The interviews with doctors were therefore no longer than 30 minutes each.

4.7.5.3 Reflecting on the doctors' interviews.

- While it was clear that different doctors had different attitudes towards the current research project, the challenges around time and work pressure were obvious during all the discussions. I experienced the interviews as hurried.
- The element of discussion/dialogue among participants was lost because of the individual discussions. However, some insight into the doctors' experience was acquired.
- The supervising doctor wore his face mask throughout the discussion. He was the only one who did that.
- On a personal level, it should be noted here that I anticipated that doctors would be impatient or less empathic with this patient group. I was pleasantly surprised by the amount of empathy and understanding that they communicated when talking about NFSB adolescents. In addition, all of them had some command of psychological knowledge and training that informed their work with this patient population. All of them made reference to the rational understanding that the suicide attempt must have been the result of unresolved psychological problems and for that reason they should not be judged, even if their subjective feelings reflected the opposite.

4.7.6 General reflection on the focus group sessions.

- The social work and psychologist focus groups achieved an enabling sense of rapport and camaraderie, where colleagues openly shared, laughed and addressed serious topics with authenticity. The nurses' group never got to that stage – probably due to all the interruptions,

a lack of privacy and inconsistency in members' presence. The doctors never had an opportunity to experience the group dynamic.

- In all the focus groups, the group members were very polite and allowed each other space, while not hesitating to express themselves if they disagreed with someone.
- Apart from identifying themes, providing summaries when the process got stuck and asking for clarification if something seemed confusing, I did not feature in these sessions.
- All the groups had a variety of ages, genders, cultures and levels of experience, which added a rich quality to the discussions.

4.8 Data Analysis

4.8.1 Transcripts.

The researcher transcribed the interviews. Smith and Osborn (2003) specify that the complete interview, including statements by the participant and the researcher, should be included in the transcript. In addition, transcripts should note non-verbal details such as laughing, silences, crying and false starts.

To enable an idiographic understanding of how the different voices fit into the recollections, without disclosing any identifying information, codes were implemented as follows:

- Adolescent interviews were numbered 1 to 10. Each participant was identified as P with the interview number, so that it would be evident how different participants contributed to the narrative account of the findings. For example, P1 refers to the participant in the first interview. This made it possible for the researcher to associate individual contextual details with excerpts in the discussion.
- For health care worker individual interviews and focus group transcripts, the coding was assigned as follows:

The medical doctors were D1 to D4 (i.e. four doctors participated).

The nurses were N1 to N6 (i.e. six nurses participated).

The social workers were S1 to S6 (i.e. six social workers participated).

The clinical psychologists were C1 to C6 (i.e. six clinical psychologists participated).

By using this coding system in the transcripts, the researcher was able to link information from the demographic form, such as age, years of experience and whether the health care worker has children, to comments made during the focus group and individual interview discussions without compromising anonymity.

Great care was taken to ensure the accuracy of the transcripts. This was achieved through careful and focused initial transcription, recording all verbal information, but also noting observations during silences, non-verbal reactions from participants, interruptions, etc. This process was followed by a second reading and listening to the audio recording to confirm accuracy. Once the researcher was confident that the discussion had been accurately captured, time was spent editing the document, changing spacing to make it more reader-friendly and incorporating the above-mentioned coding system.

4.8.2 Atlas ti 8 qualitative research software package.

This is a qualitative data analysis tool, originally developed in the late 1980s (Contreras & Friese, 2017). It is a software package that assists the researcher in keeping track of codes and code groups, allowing quick access to different information documents (i.e. transcripts in this case), as well as searches for specific themes and related quotations. It also facilitates the creation of reports containing themes, quotations and notes.

4.8.2.1 Reflecting on using Atlas ti 8.

- I purchased the software and consulted with a research and analysis software specialist, who provided training on the use of the software.
- Tutorials on how to use the software were accessed via the internet, in addition to training provided as part of the software package.
- After creating the first project (focusing on adolescent participant data), importing the first transcript and completing the analysis which resulted in a preliminary list of themes, I went back to the software specialist to confirm that my procedure was correct.
- Thereafter he was available telephonically. However, the software is quite user-friendly, and I was able to proceed smoothly.

4.8.3 Data analysis: Interpretive Phenomenological Analysis (IPA).

The phenomenological aim of the study was to uncover the essence of how the phenomenon under investigation is experienced (Eatough & Smith, 2017) by understanding how participants made sense of their experiences. The key assumption was that people are able to disclose their worlds despite limitations of material conditions, cultural and linguistic processes. The participant here becomes the *experiential expert* (Smith & Osborn, 2003), sharing a story about a lived experience.

The IPA allows creativity on the part of the researcher, while maintaining a persistent focus on the subjective experience of the participant (Eatough & Smith, 2017). While the qualitative and phenomenological traditions resist the specification of steps or recipes to do an analysis, the following method of analysis described by Pietkiewicz and Smith (2014) was found to be truly suitable for the researcher's current process:

4.8.3.1 Multiple readings and making notes.

This process started when audio recordings were transcribed, since it entailed carefully listening to the discussions and recording the information.

Once all the transcripts had been completed, the researcher started with the first adolescent participant interview transcript by reading and re-reading and making notes. This was done on a hard copy of the transcript document. A line-by-line analysis was followed in order to identify anything and everything that shed light on the participant's experience.

4.8.3.2 Transforming notes into emerging themes.

In the Atlas software program (Atlas ti 8), a project was created in which all the adolescent participants' transcripts and codes would be analysed and stored. The first adolescent transcript was then imported into the Adolescent project.

The researcher started out by coding every concept that arose from the transcript notes. This process of detailed analysis was followed to ensure that no experiential material was lost. In keeping with the idiographic focus of the study, this process was completed before moving on to the second participant transcript. 39 codes were recorded in Transcript 1.

The researcher then moved on to a hard copy of Transcript 2, reading, re-reading and making notes. Code names that had been identified in the first transcript were used for similar

themes in Transcript 2, while taking care to note and code all new emerging thoughts. After this process 53 codes were noted. The second transcript was then imported under the Adolescent project and the coding process continued. This idiographic procedure was followed with each transcript.

With regard to the health care providers, the same procedure was used:

- Each focus group hard copy transcript was read and re-read, and notes were made.
- After this process, the transcripts were imported under a different Atlas project: Health care providers.
- The same procedure was followed and by the end of a line-by-line analysis of the nurses' focus group transcript, 32 codes were recorded.
- The researcher then repeated this process with the social workers', psychologists' and doctors' transcripts.

4.8.3.3 Seeking relationships and clustering themes.

Here the researcher grouped related codes together to form themes and sub-themes. The requirement was to list themes, identify convergences and divergences and link these to the transcript texts (Smith & Osborn, 2003). In structuring the themes in preparation for the writing-up process, Pietkiewicz and Smith (2014) indicate that themes that do not form part of the emerging thematic structure, or themes with an insufficient base for textual validation, may be excluded.

a) Adolescent participant data.

In order to structure the high number of codes from the adolescent interviews, the codes for each transcript were listed and then divided into code groups or higher-order themes. A code group is a group containing related codes. For example, the code group of "feelings about the attempt" contained codes such as regret, shame, guilt and relief.

After creating code groups and assigning all the relevant codes, the researcher went back to the quotations to ensure that the groups and codes were accurate in accordance with the texts. This was a lengthy process and codes and code groups were refined as the analysis continued.

After this process was concluded, the code groups were clustered into three main categories or superordinate themes:

1. Intra-psychic, relational and contextual factors prior to the suicide attempt (four code groups):

- depressive symptoms,
- developmental stage/adolescence,
- socio-economic context and
- victimisation.

2. The suicide attempt itself (six code groups):

- reason for attempt
- intent
- history of attempts
- method of attempt
- consequences of the attempt
- feelings about the attempt

3. The ensuing hospital experience (four code groups):

- admission
- feelings of ambiguity related to the hospital stay
- placement in the ward
- experiences of health care staff

- The Atlas software was then used to create a code book, containing all the quotes, codes and code groups. The book for the adolescent participant project was 155 pages long. In the end, each of the three categories contained between 90 and 205 quotes from all 10 participants.

b) Health care provider data.

A similar coding process was followed with the health care provider data, adding up to a total of 54 codes. These codes/subordinate themes were grouped into code groups/themes. While each profession had a code group, groups were also created for other codes/sub-ordinate themes that may have been shared among professional categories. After all the code groups were created, these were clustered into four categories/superordinate themes:

1. Adolescent developmental period
- Adolescence (code group/theme)

2. Hospital context
- Hospital-related codes
- Staff-related codes

3. NFSB-related experiences
- Intervention
- Observation
- Response

4. Profession-specific observations
- Clinical Psychology
- Medical Doctors
- Nurses
- Social Workers

The Atlas software was again used to create a code book, which contained the quotes, codes and code groups. The book for the health care provider project was 274 pages long.

c) Reflecting on creating two projects

It was necessary to differentiate between the coding system for the adolescents and the one for the health care providers, because their experiences occurred from two different points of view. For example, an adolescent may have commented that her family was worried about her, which would be grouped under consequences of the attempt. If health care providers commented that an adolescent's family were concerned about her, the meaning of the code would be an observation and not a personal experience. It was therefore necessary to analyse the data in two different software projects.

d) Reflecting on thematic structure

- I started out with an initial coding system that incorporated every new thought from the adolescent transcripts. These codes were clustered into code groups in accordance with

published IPA study analytic processes. Codes/sub-ordinate themes and code groups/themes that were relevant to the emerging thematic structure were then grouped under the identified categories/superordinate themes. Some of the codes and/or code groups were relevant under more than one superordinate theme.

- I have 14 code groups/themes under my adolescent participant project findings, because all these themes contribute to a detailed understanding of the adolescent experience. My intention was to stay close to the idiographic nature of the inquiry and illuminate the complexity of the phenomenon. I can see, however, that the higher number of themes means that there is less space to discuss each. For this reason, the final discussion will be more selective and focus on a smaller number of combined themes that have significance in relation to the scope of the study. This is consistent with Smith's (2011) recommendation to discuss 4-5 themes in order to do justice to each.

4.8.3.4 Writing up the results.

Smith and Osborn (2003) recommend a deep engagement purely with the data before moving on to linkages with extant literature. For this reason, the two findings chapters contain narrative accounts of data from the transcripts and interpretations based on that. After each individual case has been considered, the researcher can look for similarities among experiences, or for uniqueness (Eatough & Smith, 2017).

Quotations from the transcripts were used throughout this process in order to achieve the following:

- To provide a narrative account of participant experiences
- To ensure that the reporting of results remain close to the reported experiences of participants, therefore providing an accurate reflection of the lived experience
- To elucidate the researcher's interpretations

The large number of participants included in this study necessitated a narrative account that focused on aspects that all or some of the participants had in common (Smith et al., 2009). Specific unique experiences that elucidated the phenomenon were also included.

After finalisation of the two findings chapters, the discussion chapter was written. The aim of the final discussion was to complete the hermeneutic circle by incorporating all the

relevant sources of information: both of the participant data sets and contextual information, researcher's observations and extant literature (Smith et al., 2009).

Because of the nature of the current study, which consists of two projects, sub-ordinate themes/codes from both projects were incorporated to illuminate the final combined discussion.

The themes selected for the final discussion were impulsivity, intent, judgement, nurses and placement.

The following diagram summarises the relevant themes in relation to the discussion. The size of the blocks reflects the density of the themes.

Table 3

Relevant code groups/themes in relation to discussion themes

Theme	Code	Count
Impulsivity	Adolescence	28
Intent	Adolescence	51
Intent	Consequences	16
Intent	Depressive symptoms	42
Intent	Feelings re attempt	3
Intent	History of attempts	16
Intent	Intention	23
Intent	Method of attempt	18
Intent	Observation	26
Intent	Response	21
Intent	Victimisation	16
Judgement	Feelings re attempt	48
Judgement	Health care experience	55
Judgement	Observation	43
Judgement	Response	59
Nurses	CP	2
Nurses	Health care experience	9

Nurses	Hospital	16
Nurses	Intervention	9
Nurses	Nurses	37
Nurses	Observation	14
Nurses	Placement	7
Nurses	Response	9
Placement	CP	13
Placement	Health care experience	55
Placement	Hospital	22
Placement	Observation	13
Placement	Placement	35

4.9 Trustworthiness

When considering the *rigour or trustworthiness* of the current research project, the following criteria were considered: credibility, transferability, dependability and objectivity (Guba & Lincoln, 1989). When these formerly positivist concepts are applied to qualitative research studies, the researcher considers the credibility, transferability, dependability and confirmability of the project (Morse, 2015).

4.9.1 Credibility.

This element of trustworthiness assesses whether the findings of the study are a true reflection of reality. Shenton (2004) specified the following elements that contribute to the credibility of the current study:

a) The research methods of semi-structured interviews and interpretive phenomenological analysis are well-established in the qualitative research arena. While a semi-structured interview may at times reduce the spontaneity of the respondent, some guidance was necessary to ensure a focus on the research topic and some form of consistency among the different narratives.

b) The researcher is a clinical psychologist at the hospital where the study was conducted and as such she is familiar with the context in which the research took place. As a clinical psychologist, she has also worked with adolescent NFSB patients on a therapeutic basis in the past, providing her with some preliminary insight into the phenomenon under investigation. The background and experiences of the investigator, therefore, enabled her to manage the interviewing process professionally. In terms of data analysis, the researcher was able to pick up subtle nuances and non-verbal messages, adding to the richness of the data. (Ethical implications will be discussed later). As a clinical psychologist who is a part of the research context, the researcher continuously strived to manage her own biases through reflection in the form of written records, as well as supervision. Care was taken not to focus on findings confirming her own expectations.

c) Triangulation of the data was achieved through introducing additional data sets: transcripts of interviews were recorded, but also demographic information that could shed some light on the background and point of view of participants. Numerous informants were included in the study through different methods of individual interviews and focus group sessions. This variety of data sources contributed to the depth of the data collected. Adding the views of professionals who treat NFSB adolescents contributed a different kind of significance to the understanding of this phenomenon.

d) The researcher accessed objective peer feedback in the form of supervision, feedback from a research consultant and conference presentation.

e) In addition to commentary from stakeholders outside the research process, the researcher also engaged in constant reflection on the process, her experiences and thoughts.

f) Throughout the discussion of the findings, quotations from the data sets were used to illustrate how the actual experiences of respondents informed the research report at every step.

g) Software was used to structure the process of analysis and keep track of emerging themes.

h) Discussions of the existing body of knowledge in relation to the research topic demonstrate how the current project contributes to existing literature. While no publications on studies conducted around this research question in the current context exist, significant effort was made to ensure an investigation mindful of existing knowledge.

4.9.2 Transferability.

This study was conducted on adolescent in-patients and employees at Dr. George Mukhari Academic Hospital and hence illuminates their experiences in this specific context. However, transferability cannot be completely excluded, because examples of people's experiences can identify commonalities with the broader group (Stake, 1994). Qualitative researchers acknowledge that if there are different reports confirming a common experience, such reports can be accepted as a true representation of that reality (Ormston et al., 2013). The analytic process in this study was based on the central assumption that there is a significance to an experience that is shared with others (Marshall & Rossman, 2016). The onus to transfer knowledge to other contexts/experiences is therefore on the reader (Shenton, 2004). In order to enable the reader to pick up on resemblances with other contexts, the researcher provided a detailed description of the data, context of the study and research methodology, as well as the limits of the current study in terms of aspects such as the number of participants and data collection methods. More studies in different contexts are needed to build on this initial imprint of the phenomenon under investigation.

4.9.3 Dependability.

The lived experiences reported in this project are unique to the individuals who participated. While the researcher hopes that other investigators may repeat the project in other contexts, the results may not be the same. Yet, the detailed discussion of and reflection on the research process and results may render this phenomenon in a way that may be conceded by others (Morse, 2015).

4.9.4 Confirmability.

Triangulation of data sources was useful to gain an understanding of the experiences of different participants as opposed to that of the researcher herself. In terms of her own biases, the researcher engaged in an ongoing process of reflection throughout the research process. Some of these reflections are listed below:

4.9.4.1 The researcher as a clinical psychologist.

Being an experienced clinical psychologist potentially added to the credibility of the investigation through competence in conducting interviews. In this sense, the interviewer was able to establish rapport, follow up on cues, ask for clarity where necessary, identify and discuss non-verbal messages, understand and contain intense emotional reactions while keeping the process focused on the topic under investigation. However, being a therapist made it difficult at times to remain a neutral observer in instances where participants felt overwhelmed by emotions. During those moments, the researcher made a conscious effort to stop the interview, to allow space for the emotion by handing the participant a tissue and allowing silence. The researcher would then recommend that the participant take this issue up with her assigned clinical psychologist and then ask for the participant's permission to continue with the interview. Being a clinical psychologist had its strengths and limitations.

While the methodological shortcomings of using a semi-structured interview to investigate a lived experience are clear, the researcher's ability to explore relevant comments may have added to the objectivity of the recorded data. Even though the structure was used to ensure consistency and focus on the aim of the research, unique individualities were acknowledged and explored.

In order to gain an accurate, objective impression of how clinical psychologists experience NFSB patients, the researcher also interviewed a focus group of clinical psychologists to record their thoughts.

4.9.4.2 A white woman interviewing black African adolescents.

The cultural implications here are significant. Based on the possibility that political constructs previously imposed by the apartheid system still remain, adolescents may have felt obliged to heed the researcher's request to participate or answer questions. The researcher tried to manage this by being explicit in the informed consent process in the sense that they did not have to participate and there would be no negative consequences if they declined. The adolescents in the study were, however, surprisingly cooperative. It is possible that they enjoyed the encounter.

There was also a concern that language might be a problem. However, all the participants were able to communicate in English and the researcher clarified comments that were unclear. This discussion was elaborated in a section on reflection earlier in this chapter.

Further reflections on the research process and techniques are recorded elsewhere in this chapter.

4.10 Ethical considerations

4.10.1 Ethical clearance.

Ethical clearance was obtained from the University of Pretoria (APPENDIX E). Written permission from the management of Dr. George Mukhari Academic Hospital was also obtained prior to the data collection (APPENDIX F).

4.10.2 Access to psychotherapy.

It is protocol in the hospital that NFSB or ‘para-suicide’ patients are seen by a clinical psychologist prior to discharge. Regardless of whether a potential participant agreed to take part in the research or not, he/she would still follow the prescribed psychotherapeutic process with an assigned clinical psychologist. Any indications that a participant felt emotionally overwhelmed or unsettled could therefore be referred to the treating clinical psychologist.

For focus group members, the option of referral to the Employee Wellness therapist was made available if anyone felt upset or unsettled by elements of the focus group process.

4.10.3 Access to a social worker.

NFSB patients also consult with a social worker prior to discharge. Any social issues that might surface during the individual interviews could therefore be referred to the treating social worker.

4.10.4 Access to a psychiatrist.

While a psychiatric consultation is not standard procedure in the treatment of NFSB patients, this referral option was available if necessary.

4.10.5 Confidentiality and anonymity.

All information gathered was treated confidentially. It should be noted here that there were challenges to the confidentiality of the nurses' focus group, which was reflected on in the nurses' section of this chapter.

All the participants remain anonymous. Care was taken to code demographic information and quotations in such a way that personal details of the participant could be linked to his/her narrative without compromising anonymity.

4.10.6 Ethical matters related to conducting the interviews.

4.10.6.1 Consent for participation in the study: participants who were 18 years or older

Adolescent NFSB patients who indicated a willingness to participate in the study joined the researcher in a more confidential space such as a nurse's office. The researcher then provided information about the focus and goals of the study, ethical implications, anonymity, and the right not to participate. Then the participant was given a consent form, providing information about the researcher and the study. After this had been read, the researcher inquired if everything was clear and if the participant had any more questions. If necessary, the participant's questions would be discussed. The participant then signed the form if they were comfortable doing so. (Consent forms in APPENDIX A to D).

4.10.6.2 Consent for participation in the study: participants younger than 18 years.

If a potential participant indicated a willingness to participate in the study and she or he was younger than 18 years, the researcher would follow a similar procedure to the one discussed above. In addition, however, the researcher would explain to the potential participant that she was legally required to acquire consent from the potential participant's parent/caregiver. If the potential participant gave the researcher permission to call her caregiver, the researcher made the phone call with the potential participant in the room. The researcher then introduced herself and explained what the study entailed. If the caregiver gave

verbal consent over the phone, the researcher explained that the consent form would have to be signed and that the caregiver would find this form when he/she got to the ward.

The signed proxy consent forms were collected from the sister in charge of the ward the next morning. Participants' interviews could only be used in this study if the signed proxy consent form had been received by the researcher.

If the caregiver provided verbal consent, the potential participant would receive more information and the consent form, as discussed under a). If he/she was willing to take part in the study, he/she would also sign the assent form.

4.10.6.3 Reflecting on the informed consent process during this data collection.

While it is not ideal to commence data collection before the written proxy consent is provided, this verbal consent arrangement had to made for the following reasons:

- Visitors were only allowed in the wards at specified times, and even during visiting hours it could not be confirmed that the caregiver would be able to visit the participant.
- Some family members were far away from the hospital, maybe even in different provinces.
- NFSB patients who are physically healthy are usually discharged as soon as possible – often on the same day, to make space for new admissions, which meant that time was extremely limited.

It was made very clear to potential participants that the decision whether or not to participate in the research would not have any impact on the treatment that they received in the hospital: the psychological, social work and medical consultations would continue as specified regardless of their decision.

Although consent to record the interview was stipulated in the consent form, the researcher again asked for verbal permission before recording the interview.

4.10.7 Ethical matters related to focus group participation.

After providing information about the study, potential participants would use time to read through the consent form, ask questions and sign if they were willing to do so.

It was verbally reiterated that all information would be stored and managed confidentially and that all participation would remain anonymous.

Verbal consent to record the discussion was also confirmed before starting the recording.

Focus group members were thanked for their time. They were requested not to interrupt others, to speak up if they had something to say and that it was acceptable to remain quiet about matters on which they did not want to contribute.

Focus group members were requested to treat the content of the session confidentially.

At the end of each session, focus group members were invited to speak to the researcher if they felt upset or uncomfortable following the discussion of NFSB among adolescents. If anyone had felt they needed assistance in this regard, the researcher would have referred them to Employee Wellness professionals. No-one reported the necessity for such referral.

4.11 Conclusion

This chapter provided insight into the research process from the theoretical starting point to the methodology that was employed. The process of analysis was also discussed, followed by consideration of the trustworthiness of the study. Ethical implications were considered. Thoughts on the researcher's reflective process were noted throughout the discussion.

The following two chapters will be dedicated to the findings that were obtained during this process.

Chapter 5 – Findings: Adolescent Participants

5.1 Introduction

This chapter represents findings from the adolescent interviews and transcript data. The thematic structure provided a framework for the inclusion of narrative accounts from the individual participants' stories. While remaining close to the data, relevant interpretations are indicated.

5.2 Biographical details of participants

5.2.1 Gender of participants.

All the adolescent participants in this study were female. While it was not an inclusion criterion that participants should be female, the researcher did not come across potential male participants during the time of data selection.

5.2.2 Ages of participants.

The participants' ages ranged from 13 to 21 years, which happened to be the range of ages specified in the inclusion criteria. Five of the ten participants were 17 years old, the rest were respectively 13, 15, 16, 18 and 21 years old.

5.2.3 Home languages of participants.

The participants spoke a number of different languages at home. See Table 4 for the language distribution.

Table 4

Number of Participants by Home Language

Language	Count
Ndebele	1
Sepedi	2
Sesotho	2
Setswana	5

5.3 Analysis of Transcripts

The analysis of the ten adolescent interview transcripts resulted in a total of 83 codes. These codes were grouped into the following three superordinate themes/categories:

1. Intra-psychic, relational and contextual challenges prior to the attempt
2. The suicide attempt
3. The hospital experience

Diagram 1 illustrates the three categories.

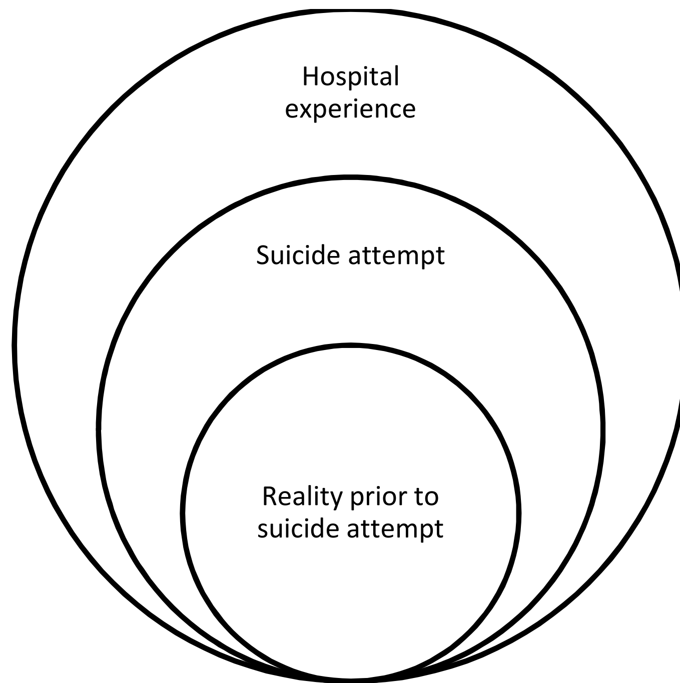

Figure 1. The Three Categories of Codes ranging from Psychological Reflections to Experiences in the Hospital Context.

5.3.1. Intra-psychic, relational and contextual challenges prior to the attempt.

This category consists of themes related to how the individual participants experienced their lives prior to the suicide attempt. This element is relevant, because the phenomenological point of view acknowledges that the participant is culturally and historically situated in a specific context, which directly contributes to the meaning she attaches to her experiences. It was therefore necessary for the researcher to gain some understanding of how she perceived her life prior to the suicide attempt. In a way, providing some context as to what the participants were faced with prior to the focus point of this current study sets the stage for the suicidal incident that led to her hospital admission.

5.3.2 Suicide attempt.

This category is focused on aspects related to the suicide attempt, such as the reason for the attempt, intent, the possible presence of a previous history of suicide attempts, the method of attempt, consequences of the attempt and the participant's feelings about the attempt.

5.3.3 Hospital experience.

The third category is focused on the participant's experience of being in hospital and receiving medical care post suicide attempt.

5.4 Discussion of Findings under each Category

5.4.1. Intra-psychic, relational and contextual challenges prior to the suicide attempt.

Under this category, 27 codes were identified. These codes were collated into four main themes that relate to the participant's contexts prior to the suicide attempt. The four themes are:

- Difficulties associated with the developmental stage of adolescence
- History of emotional suffering
- Socio-economic context/structural vulnerability
- Victimisation

5.4.1.1 Aspects indicative of challenges associated with the adolescent developmental period.

The adolescent developmental period is known for intensity of emotions, as discussed in Chapter 1 of this document. On a related note, some of the participants reported experiencing extreme feelings of anger.

P2: What I can say about myself…it's like…when I get angry too much … about the situation, like, the only option that I see…like killing myself is the only option. That's what I see when I am so…when I'm angry. And so this time, yes, I was so very angry. Just like the last time. So like I thought that killing myself would be the better option, if I could… Yes.

This 17-year-old participant was relaying her overwhelming anger after a misunderstanding and subsequent break-up with her boyfriend. She explained that she had lost her temper: "…so that's when I freaked out and threw my phone on the floor." The phone broke. This incident is followed by the suicide attempt, indicating a desperate intensity of emotion that seems uncontrollable. The decision to attempt suicide in relation to feelings of anger was also echoed elsewhere:

P7: But I become angry when they say those things. I feel like killing myself, because they just say bad things about him.

The reported feelings of anger towards significant others may provide some insight into the interactional difficulties that entered the discussions. It is significant to note that most of the participants in the current study indicated that relationship problems were a reality for them.

5.4.1.2 History of emotional suffering.

Some of the participants reported experiences of intense sadness.

P10: *…every night I would go to bed crying. I'd cry myself to sleep every day. So with that, I kind of isolated myself from the others. I kept on bottling up my feelings, didn't open up to anyone and I just pretended like I was okay. So if anyone asked like I'm okay, okay, okay, so…yeah.*

I: Hm… But you were not okay?

P10: I was not okay. Sometimes it would even get worse where I would even go to the bathroom just to cry. I would even spend three hours there, just crying.

Here the participant (17 years old) talks about significant levels of dejection that seem to have persisted over a period of time. Her comment that she used to cry herself to sleep "every day" communicates something about the consistency of her misery. She also indicates that while the sadness seemed to be part of her daily life, it would overwhelm her at times, where she had to physically remove herself in order to cry. It may be possible that the reported persevering melancholy was indicative of a persistent low or even depressed mood.

Another significant detail from this citation is the apparent need to keep her sadness secret. There is an element of insight into the implications of “bottling up” feelings, which could lead to being overwhelmed. She also noted the conscious decision to put on an act that she was doing well, thus keeping her significant others at a distance and isolating herself in the process.

This need to keep the painful emotions secret was also echoed by other participants:

P9: *I've spent weeks in my bedroom, not going outside and people didn't know…*

I: While you were still in school?

P9: That was during the holidays. And when I had to go to school, I just did that, I went. But you know, with my depression… I feel like it's a monster, because I'm really good at hiding it when I'm around people. They can't really see what I am going through. But when I'm alone…that's when everything comes out.

I: So when this happened, it was a surprise for everyone. They had no idea.

P9: They had no idea that I wanted to kill myself.

Again, the intensity and duration of a persistent low mood is reported here, as well as the secrecy and resultant isolation. She diagnoses herself with depression and refers to this “monster” that haunts her in moments of solitude. This 17-year-old participant also confirmed that the low mood had been a reality for her for a number of years, dating back to her school days (she is currently in tertiary level education). It is significant to note her statement that she continued to perform what was required of her. This indicates an element of resilience despite the challenges she faced, which may also have contributed to her current advanced level of education.

Some of the participants reported the existence of prior suicidal ideation.

I: *Is that the first time that you thought about…wanting to be dead?*

P1: No, it's not the first time… [silence]

I: It's something that comes into your head sometimes?

P1: [Nods] Yes.

I: Okay. So, is this the first time that you did this?

P4: yes.

I: You've never done it before?

P4: I always think of doing it, but…I just couldn't.

I: Okay so is the suicide something that you have been thinking about for a while?
P9: I've always thought about it, but I never really acted on it until…like…that day.

It seems to be a reality that some of the participants have been living with for a while: the possibility of suicide. The fact that they are included in this study confirms that they did eventually attempt it.

Another aspect that may have contributed to feelings of sadness, is loss and bereavement.

I: And…when your mom passed away…. what happened to her?
P4: She was sick. I don't know what…what killed her, but she was sick. Yes. [silence]
I: Is that still difficult for you?
P4: [silence] [nods after a while]

This participant's mother passed away due to ill health in 2005, but the loss is still a reality to her. The psychological implications of this loss are complex, but her mother's absence also significantly contributes to her feeling alone, unsupported and unwanted, which eventually led to her suicide attempt.

While only one participant made reference to her HIV (Human Immunodeficiency Virus) positive status, this is a reality of the current South African health context and as such deserves closer consideration.

I: You took your ARVs?

P10: Yes. Why… [laughs] Well... Okay, [silence] so when I was young…when I was actually in the sixth grade, my mom told me that I was actually HIV positive. And at that time…like my life…well, I just feel like I didn't have a normal life like my other cousins and my siblings. I was the only child with HIV in that family, so it was hard for me to communicate with them. So every night I would go to bed crying…

This participant was admitted after overdosing on her antiretroviral medication. Her recollections illustrate that she received the news of this life-changing diagnosis at a very young age and for her it meant that she was different. Her life would never be "normal". She was

not able to connect to her loved ones because of this otherness and the feelings of dejection seem to have started there.

5.4.1.3 Socio-economic/socio-political reality.

The socio-economic reality is also significant when considering the participants' contexts of existence prior to the suicide attempt.

I: Can I ask you…why did you not go back to school to finish?

P4: When I was living with my grandmother, I was not concentrating at school, because I had to do some work at home before I got to school…[silence]

I: Like cleaning and cooking and stuff?

P4: Yes, and took my aunt's child to crèche.

This participant left school in Grade 11 because of her domestic responsibilities at home. She has since been trying to find a way to complete her matric, but her abusive father was not willing to finance this return to formal education. She is unemployed and experiences her situation as utterly disempowered.

I: So what do you normally do at home during the day? How do you spend your days?

P4: I'm looking for some job sometimes, but I'm staying with my sister's child…she's four years old. That's what I do. I don't do nothing. I just…

I: You just...?

P4: I just sit around.

The last sentence echoes a sense of uselessness. This is a young 21-year-old woman with the potential and time to further her education, but her socio-economic situation prevents her from emancipating herself.

When considering the socio-economic and socio-political realities of the participants in this study, financial constraints are also a powerful determinant.

P2: First time, I was not happy about the situation at home. Yes, because like, I remember that at that time…hmm…it was also financial problems at home. So I thought like maybe to kill myself…it would probably be better. So, yeah.

I: Okay, but then after that… I mean, I think the financial problems are still there?

P2: Yes.

I: Or how did you… Were things better after this for you? Did you feel better?

P2: Um…what can I say? I can say like…I accepted the situation, that this is how it is. This is how we live at home.

This participant reported how financial constraints at home affected her mood and even drove her to suicidal ideation and her first suicide attempt. For her current suicide attempt, she cited different reasons. She explained that she had come to a point of accepting the cards she had been dealt. This reinforced an internalised sense of disempowerment in relation to her socio-economic situation.

5.4.1.4 Victimisation.

It was significant that a number of participants shared the experience of being victims of abuse. While some of the emotional experiences under this theme may overlap with the theme of emotional suffering, the significance here is that participants were victimized in some way.

I: Can you tell me about the first time [you attempted suicide] …?

P3: It was in 2015, I had a fight with my stepdad.

I: While you were still living with them?

P3: Yes. Then he beat me and I got angry and I told him that he is not my dad, like my dad would never beat me, he can't do that. And then he got angry… [silence].

I: He got angry?

P3: Yes, and beat me more.

I: He beat you more?

P3: Yeah, and throw me against the walls…

This 18-year-old participant started relating the story of extreme physical abuse as just another example of her contextual reality, in which she is the victim. Her vulnerability and powerlessness became clear when reporting how she ineffectually tried to tell her perpetrator that he did not have the right to treat her like that. There seemed to be a sense of futility in trying to protect herself and she ended the recollection with a statement that he was throwing

her against the walls. This exposure to physical violence was echoed by another participant (17 years old):

P6: And he told me he was going to kill me…
I: And where did he hit you? On your body?
P6: On my face.
I: On your face. While your grandmother was there watching?
P6: Yes. [silence] [crying]

From both these participants' stories, the sense of helplessness was clear. In these instances, violence was directed at them from a significant other. When they eventually attempted suicide, the violence towards them came from within.

Reports of violence were not limited to physical attacks.

P4: My father was speaking to someone on his phone. And he didn't see me, that I was listening. He talked like…he doesn't want me again. I'm just…he feels like I'm not his daughter. And he doesn't want me around him anymore. That's when I started to think what to do…. [Very impactful, strong emotions in participant: difficult not to reflect]
I: Okay… I mean, what did you decide?
P4: To kill myself.

This participant reported repeated verbally abusive incidents of rejection from her biological father, which had been going on for years. The deep hurt that this young woman experienced was very clear during the interview. When an attempt was made to comprehend the extent of her emotional pain, her suicidal ideation made sense. She knew that no-one wanted her. One participant also reported witnessing violence towards her family:

P10: With my mom…sometimes… Because my mom… She lives with this…person. He hates me. Over the past years he has been beating my mom [voice is shaking: crying]
I: Physically?
P10: Physically, in front of my siblings. And when I'm visiting them, he will make nasty comments about me not belonging there… [cries].

In these incidents of victimisation, the sense of not being safe in the daily living environment and a related need to escape or access help becomes understandable.

5.4.2. The suicide attempt

This category contains all the themes that are related to the suicide attempt itself. Related codes were grouped together under the following 6 main themes:

- Reason for the attempt
- Intent
- History of attempts
- Method of attempt
- Consequences of the attempt
- Feelings about the attempt

5.4.2.1 Reason for the attempt and intent.

The reasons for the attempts that surfaced during the conversations could mostly be traced back to some kind of conflictual situation.

P7: I just wanted to leave my mom in peace. This is not the first time my mom gets me angry. Even my father said I don't have a space in his heart.

This 13-year-old participant commented on a long-standing conflictual relationship with her mother and then went on to report that her relationship with her father was not much better. The current overwhelming conflictual situation indeed seems to have been part of a history of problems that this participant has been trying to deal with.

P7: For me at home…the things there are so bad… When they talk to me, they just shout…Yesterday, that's the time I tried to kill myself because of the life that I'm living.

Here the participant refers to the "…life that I'm living", indicating that these conflictual matters that were overwhelming her to the point of attempting suicide had been there for so long that they had become an integral part of her lived experience.

The issue of a relationship break-up was also reported by some of the participants as a reason for the suicide attempt.

P2: Okay. I'm here because I did an overdose of pills, so I end up being here. And the reason I did the overdose of pills, is because why I can say my boyfriend dumped me, yes. So like I decided to kill myself.

The end of this 17-year-old participant's relationship caused significant distress for her, to the point of attempting suicide. While there is an element of impulsivity evident here, it is clear that there was a build-up of conflict and other problems pushing her to this point.

The presence of impulsivity was also noted in other conversations and as such deserves closer consideration. The following 16-year-old participant described her unexpected, unplanned suicidal act:

P5: ... When I got home, I watched TV. Something came into my mind that they don't care. And I went to my room, slept maybe two minutes. Then I went back to their room, looked at my mom's room, I went straight to the wardrobe and picked up some pills and I drink them. Then I got dizzy.
I: What pills did you drink? Do you know?
P5: I don't know.

This excerpt clearly illustrates the lack of planning that went into her attempt. Later in this interview the researcher inquired about the possible prior presence of suicidal ideations and/or behaviour, which the participant denied. This was her first thought of suicide and she immediately went through with it.

Another participant who ingested poison explained her impulsive attempt as follows:

P6: ...And then my grandfather saw my face. And I was crying. He asked me what's wrong. I told him everything, that my father beat me. He went to my father and said to my father: Why did he beat me before talking to him? He told my grandfather that it has nothing to do with him. He should go to his house. So when I was in the kitchen, words that he was talking to my grandfather...I didn't like it. So I decided to take paraffin and drink.

Upon further inquiry about her intention and prior suicidal ideation, this participant explained that this was the first time the thought of suicide had entered her mind, although the physical abuse that triggered it had occurred before.

"Stress" was also reported as a reason for the suicide attempt shared by some of the participants:

I: And…why did you drink the pills?

P3: I had a lot of stress.

I: So may I ask you what brought you to that point where you felt like you wanted to be dead?

P9: I was just feeling overwhelmed with my life. You know, I felt like I couldn't deal with the situations that I'm faced with…the ones that I'm currently facing. So I felt like the only solution was to find a way out and at that time, it made sense to just die.

The latter participant spoke about feeling overwhelmed by expectations and her perceived inability to cope with these challenges. Dying seemed to be her only way out of her problems. While she did report an intention to die, there is also an indication of a need to escape. Even though the need to escape may have been due to overwhelming academic expectations, consistent conflict or physical danger, the idea of escaping surfaced numerous times and from different participants in the data set.

I: And…what did you…what was your intention…did you want to be dead? Or did you want to…what did you want to…?

P1: I just wanted to be dead. To get away from my brother.

I: Okay. You would rather be dead than be there with your brother…that's how strongly you felt?

P1: Yes.

This excerpt clearly captures the predicament of needing to escape so badly that the 17-year-old participant was no longer able to distinguish between the need to be free from an abusive brother and a wish to not live any more. With another participant the need to escape her pain was also evident:

P4: My father was speaking to someone on his phone. And he didn't see me, that I was listening. He talked like…he doesn't want me again. I'm just…he feels like I'm not his daughter. And he doesn't want me around him any more. That's when I started to think what to do….

I: Okay… I mean, what did you decide?

P4: To kill myself.

I: You wanted to be dead?

P4: Yes.

I: That was your intention?

P4: Yes.

This participant shared her story of being forced to leave school in order to focus on her domestic responsibilities. Her mother had passed away and her father did not want her, yet she was completely financially dependent on him. She expressed a history of feeling hopeless and longing for death. In this excerpt the participant expressed her sense of feeling rejected, unwanted and hurt to the point that she drank tablets and furniture oil with the reported intention to die. Again, her need to escape this excruciatingly painful situation was clear, but the wish to not live any more also felt real in the heaviness of recounting her experience. It is possible that the wish to escape emotional pain and the wish to stop living merge at some point. However, later in the conversation she did acknowledge the absence of suicidal ideation at the time of the interview, as well as a hope that she could prove her dismissive father wrong.

The following participant spoke strongly about her wish to escape this world:

P7: He talked to me. I thought of dying. There is nothing to live for in this world. I thought maybe it was a mistake that I was born…I can't live this life. He said: Why? I said because it's a mistake that I came into this world…

Here is a sense that she has been thinking about her life as a mistake for a long time. There seems to be a depth to her misery that explains her need to escape this existence. However, upon closer investigation her low intent to actually die, as opposed to a desperate need to be heard, becomes clear:

P7: …I cried and cried. I was doubting to take those pills. I thought let me not take them, I slept…I was scared. I took those pills. I took two of them. Then I slept.

In this extract the participant describes her grief and the related suicidal ideation. However, her uncertainty at going through with the suicidal act is clearly communicated, in addition to taking a negligible dose of tablets. While her distress was clear, her intent was not to end her life at this point.

Another participant revisited her initial suicidal thoughts in relation to a need for help.

P10: So every day I would just not sleep and just study, study, study. But I don't understand anything. So it just so happened that on Thursday, last week Thursday, I started having suicidal thoughts. And I told my friend, but I was like joking and I was like… I'm going to kill myself if these teachers do not help me. And then we laughed and all. But after that, it just became more and more frequent.

I: The thoughts?

P10: Yeah, the thoughts.

The level of suicidality here started out less intensely as a cry for help but seemed to evolve. What is clear, though, is that while the initial thought may have started out innocently or jokingly, continued pressure or distress could nonetheless have led to lethal consequences.

Another participant literally asked for help by reporting her suicide attempt:

P2: So, like, I was seeking for a knife in the house, first I was alone. I tried to kill myself, but I felt like if I take the knife, this is going to hurt my grandma so much. So I decided to take her pills and drink them. So like I drank her pills and yes… Then when she came back from church, then I told her that… Granny, sorry that I drank your pills and she was like: "How many did you drink?" … "I don't know". And that's why…that's how I ended up here.

This participant's initial thoughts of using a knife to kill herself says something about the seriousness of her wish to be dead. She reportedly changed her mind in an attempt to soften the experience for her grandmother, but it is possible that she was not convinced that she wanted her attempt to be lethal, even at that stage. In an apparent moment of impulsivity, she took some of her grandmother's pills, without registering how many she was taking. While waiting for her grandmother to return, she seemed to regret what she had done. She

immediately reported the attempt and apologised for it, thus receiving the help that she needed. In this case, the participant did not seem convinced that she wanted to end her life.

While low or no intent to die dominated the current data set, the occasional presence of suicidal ideation at the time of the interview was also recorded.

I: Okay, so even now you feel like you want to be dead? If you go home now…will you try and kill yourself again?

P7: Yes. [nods]

I: Is it? You will?

P7: Because they don't want me to do the thing that I want to.

This participant clearly states that the reason for her ending up with NFSB in hospital is not resolved and she may choose to attempt suicide again if she does not get her way. In this instance, the participant's parents wanted her to end her relationship with a much older man. The possibility that she was using her NFSB to manipulate her significant others in a situation where she felt completely powerless existed. Nonetheless, the risk for suicide remained.

Similar feelings in relation to a continuing intolerable lived experience was also cited by another participant as a remaining reason for suicidality:

P4: I don't want to live with my father. I just want to go, because if I continue to live with my father, I will end up dead.

I: You think you will do this again, if you go back to him?

P4: [nods]

Again, this participant confirms that if she faces the same stressors again, she will follow the same course of action.

5.4.2.2 History of attempts.

For some of these participants, this was not their first attempt at suicide.

I: Is it the first time that you tried to kill yourself?

P8: No.

I: How many times have you tried?

P8: It is the second time. The first time was in grade 9, when I drank an overdose of pills.

This participant was 15 years old and in Grade 10 at the time of the interview. It has therefore been a year since her first attempt, at which time she was treated at a local clinic. At her second attempt, she drank rat poison and landed up in hospital, indicating that the second attempt may have been more serious. This process of progressively having more serious attempts was also reported by another participant:

I: Is this the first time that you did it?

P9: Um…it's my second attempt. But the first attempt was…what can I say about it…it was just…trying it out. I don't really know how to put it but I was very young, I didn't really understand what I was doing.

The implication here is that this time it is more serious. The participant describes her first attempt as a need for attention, whereas her intention in the current attempt was to die. It is also noteworthy that while the first attempt was significant in that it probably laid the foundation for a more sophisticated second attempt, it remained a secret and no-one knew about it. This secrecy of a suicide attempt was also reported by other participants:

I: But you didn't get admitted to the hospital?

P2: No.

I: And did the family know what you had done?

P2: They didn't know about it.

I: They didn't?

P2: Okay, but my grandmom just said that some of her pills are missing. And I said I don't know, I didn't see them. So, yeah.

While the intensity of the attempt here also appears less severe, it is nonetheless significant in setting the stage for an attempt that eventually saw the participant admitted to hospital. It is also significant that the participant chose to hide the attempt, which links back to comments around not talking about their difficulties, as was reported under the first category. Another participant also reported secrecy with regard to a previous attempt:

I: What did you do?

P3: Drank pills again.

I: And did you…go to hospital?

P3: No.

I: What happened to you?

P3: Like I am the only one that knows about this whole thing. I didn't tell my mom that I tried to kill myself.

This tendency not to share the fact that her problems were overwhelming her seemed to keep her in a vulnerable position where she eventually ended up attempting suicide again.

5.4.2.3 Method of attempt.

When considering the method of attempt, it should be noted that all the young women in this study used a method of ingestion. These ingestions ranged from overdosing on medication to ingesting toxic substances such as rat poison or furniture oil. The intensity of the attempts also varied from ingestion involving concerning toxicity levels with the potential to cause organ failure, to negligible amounts of pharmaceuticals that barely required a health care intervention.

5.4.2.4 Consequences of the attempt.

After considering the reason for the suicide attempt, intention, history of attempts and method, the discussion will now move the focus to the consequences of the attempt.

P5: That's why I wanted to kill myself, because it's the only way that I can fit in. In my friends' relationships and at home and at school….

I: You also feel like you can't fit in at home?

P5: No… They comforted me yesterday when they came, they said they will go and buy me a cell phone and all those things.

I: Okay, so after you were admitted, they said that they will get you the things that you want?

P5: Hm. [nods]

This participant indicated the reason for her attempt as financial: not having access to a cell phone and other material things that she values as a member of her peer group. This excerpt confirms that her suicide attempt was instrumental in gaining those material things she was asking for but never received. In another conversation, the participant illustrated how her suicide attempt had led to her getting the support that she needed:

I: And…how did you mother react? Your family…what did they say about this thing that happened to you?

P1: They just told me not to do it again. It's not a good thing to do. And they just told me that…they'll keep my brother away from me for a while. That's why I will live with my auntie.

These were the words of the participant who felt victimised by her brother. During the years leading up to the suicide attempt, her complaints had fallen on deaf years, but her suicide attempt seemed to bring home to her family the danger she was experiencing. Therefore, they stepped in to rescue her. Again, the suicide attempt seemed to have been instrumental in getting what the participant needed, which was physical safety.

For some of the participants the suicide attempt was a way to acquire confirmation from their families:

P1: Yes, and they just told me they love me and that they didn't want me to die and that they need me…yes.

I: And then when you woke up in hospital and you saw you are still alive?

P5: I was not really sure that I was alive... Then my sister came to me and said: …we love you so much. Don't do that to yourself!

In both instances the participants perceived their loved ones as uninterested and unsupportive prior to the suicide attempt, but their love and appreciation for the participants were confirmed after the scare of suicidality.

It was significant, however, to note that while family members who are probably more supportive could react to the suicide attempt by providing comfort and care to the patient, this was not always the case.

P4: Yesterday when my sister went to tell him that I took an overdose of pills, he said: Why doesn't she just die?

I: He said that?

P4: [crying]

This is an excerpt from a conversation with a participant who has been a victim of verbal abuse from her father for a very long time. This was also what pushed her to attempt suicide. In this case, her perception that her environment is unsupportive and hurtful seemed to have been confirmed. Her suicide attempt did not change anything.

5.4.2.5 Feelings about the attempt.

Feelings of confusion following the attempt were evident in some conversations:

I: So, when you drank the paraffin, you felt like you wanted to be dead and now you're not dead. How do you feel about that now?

P6: You are asking that question, but I don't know. [Silence] I'm so confused.

I: You're feeling confused?

P6: Yes. [silence]

This participant was not sure if the suicidality was resolved or not. She needed to make sense of what she had been through and probably needed assistance to do that.

Most of the participants made the point that they regretted hurting themselves and that the suicidality was completely resolved.

P2: [Laughs] It's so not cool to see yourself here, because like…ugh…what can I say? Yeah, it's not good to be here. And like…now I see that I have made the very biggest mistake of my life and I could have saved that time and done something important with my life…so, yes. Yes, it's not good being here… [referring to hospital admission post suicide attempt]

I: You feel different now about being dead…or being alive?

P2: Now like…I feel like yeah, I've been given a second…another…a third chance, even. [laughs] to live again. And…I'm not gonna do this again.

I: Is it?

P2: I'm not gonna do this again! Like never.

P9: I somehow feel like it was necessary. I feel like this had to happen for me to change and to live life differently. If this had not happened, I don't really think I would have thought about it in that way and to change. So because I failed, the suicide… I feel like I have a second chance.

This participant reports a reaction following the suicide attempt that is at a different level than mere absence of suicidal ideation. She reports an appreciation for life that she had not experienced before. She talks about her plans to make the most of this "second chance", a sentiment that was echoed elsewhere in the adolescent data set.

While some of the participants reported symptoms indicative of depression prior to the suicide attempt, as mentioned earlier, most of the participants reported a significant improvement of mood and a complete absence of suicidal ideation following the attempt.

P3: Yeah, I think I have to concentrate on my studies. And I have to focus on something that can keep me busy, like maybe writing my assignments.

I: Okay. How do you feel today? How are you feeling now?

P3: I am well.

P5: Yeah. Things are not just better. Actually, they are great! [smiling]

I: How are you feeling today?

P5: I am feeling great.

When considering the feelings of optimism about the future and related absence of suicidality that were recorded during some of the interviews following the suicidal behaviour, the conclusion may be drawn that some of the participants in this study did not present with a persistently depressed mood that might warrant a diagnosis of depression.

5.4.3. Hospital experience.

The last category under the adolescent participants' experiences is the hospital experience. Codes were grouped under the following four main themes:

- Admission
- Feelings of ambiguity related to the physical hospital stay
- Placement in the ward
- Experiences of health care staff

5.4.3.1 Admission.

As noted under the previous category, all the participants in this study ingested some kind of toxic substance prior to their hospital admission. It therefore makes sense that some of the participants shared the experience of either feeling dizzy upon admission to hospital or being completely unconscious. They were therefore not always completely aware of how they ended up in hospital.

P9: Um… I remember only a few things. I think I was unconscious. When I regained consciousness, I realized that I was in hospital. I couldn't understand what was going on and I tried to run away, and they grabbed me. But after that I was sober and I could see what was going on. I could understand.

This participant recalls an attempt to run away but being prevented from doing so by nurses. She reports that once the substances had cleared from her system, she was able to understand what was happening to her. This initial confusion formed part of some of the other participants' reports as well. Arriving in a confused state and feeling shocked or disoriented upon the realisation that they were in hospital may have significance when considering how individuals experience their hospital stay.

5.4 3 2 Ambiguity about being in the hospital space: advantages and disadvantages.

There was a consensus among participants that being in hospital is not a pleasant experience.

P2: [Laughs]. Oh… Being here like…to tell the truth, it's boring…and I don't wanna see myself being here again. It's so not cool to see yourself here, because like…ugh…what can I say? Yeah, it's not good to be here.

This participant expressed a general dissatisfaction with being in hospital. However, upon closer investigation, participants were able to list advantages to physically being in hospital. One such advantage was the perception that the hospital provided physical safety from dangers outside.

P1: It was nice. Okay, I was not on…nobody had talked to me like…I was away from my brother…and I felt a lot of safe…safer.

For this participant, physically being in the ward meant safety from an abusive brother. Being removed from their everyday lives and put in this hospital space also helped some participants to look at their situations differently.

I: Um…do you think that coming to the hospital helped you?
P1: Yes.
I: How did it help you?
P1: It makes me refresh my mind…
I: Refresh your mind?
P1: Ja… and stop overthinking about it… Ja. And just…just that.

I: So, do you think that it helped you to come here?
P2: Yes. [immediate answer]. It helped me, because like here I am, I am talking to you and like that thing…is just gone out of my mind. Yes. It actually helped me to come here.

These two participants share the experience that coming to hospital meant relief from the constant rumination about their problems that had led to the suicidal ideation. While their concerns may not have disappeared, they seem to experience some relief.

This change of perspective on life was also communicated in other ways:

P9: Yes. This hospital showed me that there are people going through worse. So I've seen people receiving bad news, people crying… People are really going through tough situations and that has made me appreciate being alive.

5.4.3.3 Placement in hospital.

All the NFSB patients who are not critically injured are placed in an adult medical ward. When reflecting on the ward itself, a number of participants voiced their feelings that they felt out of place.

P8: It used to be lovely, because every time I came to this hospital, I went to ward 7, where there are kids. And we used to have fun, because we were chatting and now I sit alone all day. And when I want to wash I just go to the sink alone. Always alone.

This participant recounts prior experiences in the hospital when she had been admitted to paediatric wards for a different medical condition. She recalls her experience in the paediatric ward as sociable and "fun". She contrasts that experience with the current one where she feels extremely lonely.

P7: I think…maybe I'm just a child that I could be here, I must go. But the other side of me says it's fine that I'm here. But I feel like I'm in the wrong place at the wrong time.

This participant reflects on her feeling that she has not been placed correctly. While some of the adolescent NFSB patients reported feeling out of place in an adult ward, the fact that this ward houses critically ill adults adds another level of concern.

I: Okay, but what is it like for you to be here?
P7: It's not nice…being with people who are very, very sick…

I: Okay. How has it been here in this ward, ward 35?
P4: It was a little bit difficult to see the people there, because they are very sick. I thought then…I wanted to help them. It was hard…

This clipping communicates the participant's sympathy for the suffering of her fellow-patients. Her comment that it was "hard" also says something about her finding it difficult to be there. This also introduces a new concern that she is faced with, while her own reason for admission and psychological healing should the focus of her attention.

I: And what is it like for you in the ward?

P9: I feel out of place, because I'm not sick. There are a lot of people…people that are dying. People coughing up blood. People can't walk. So I feel like I'm out of place. I really feel the need to go home.

Again, the matter of incorrect placement is reiterated here, but the intensity of the disease burden in the ward also seems to add to the participant's need to get out of hospital urgently. Apart from witnessing adults grappling with serious illnesses, some of the participants also reported an acute awareness that they are being exposed to contagious diseases.

P9: I think I have to do tests now to see if I have TB. I think they have TB…everyone is coughing! I don't know if it's flu or what…

These are the concerns of a participant who came into hospital physically healthy, apart from the suicide attempt. Her concern about her physical health adds a new dimension to an already long list of concerns that she is faced with. She is clearly trying to make sense of what she experiences around her, without guidance or support.

The issue of face masks also came up in some of the discussions:

P10: I'm the only one in the ward who is not coughing. I have a weak immune system. But they do not give me a mask, so I feel like it's okay for them. They just invite the diseases. I don't know if the other patients have tuberculosis or what[so]ever, but they do not give me a mask to wear, at least to protect myself. I just feel like okay…

I: Hm… So they didn't offer you one?

P10: They didn't.

Again, this passage illustrates new concerns that the participant has to deal with. She comments on the fact that her immune system is already compromised and that the hospital staff are aware of this, but still precautions are not taken to protect her from possible infection.

5.4.3.4 Experiences of treatment by hospital staff.

When patients arrive at the hospital, the first line of treatment is admission at casualty where initial investigations are done. Because NFSB patients are generally not physically ill, they do not receive much medical treatment as a rule. The exception, of course, would be in cases where the suicide attempt caused critical injuries, in which case the NFSB patient would be admitted to a critical care unit and not the current ward. In the ward to which the NFSB patients are usually admitted, medical treatment is mostly limited to removal of toxins from the body, blood tests and the provision of intravenous fluids. It was therefore not surprising that some of the participants found that the doctors' involvement in their treatment was limited:

P10: Doctors? You know…doctors…they have seen me on Thursday only. They said that I'm okay, that's it.

While interaction with medical doctors was limited, some of the participants reported very positive views:

P9: The doctors were amazing. They treated me well. They stated everything that was going on.

Two participants, however, commented on feeling judged by their treating doctors:

P2: Okay. The first one…at first they called a nurse to try and insert it, but like it was so like…I tried to push it out like…okay… So when the doctor came, he was like "We're going to leave you and you're going to die here". So like…when he said that it was so painful! I felt it.

This passage illustrates that the participant was not cooperative with the treatment initially. She then relates a doctor's response in apparent reaction to her lack of compliance. She makes it very clear, though, that the comment was hurtful.

P4: Yes. And when the doctor came to check the x-ray, he said that he must help me last, because I don't deserve to be here. I deserve to be in the mortuary.

While this participant did not elaborate, there is a strong impression that she felt judged by the treating physician. Even though the contextual information here is limited, it does appear as if the doctor expressed disapproval of the self-induced emergency.

Nurses assist the doctors and they are also the ones who are in close proximity to the patient for the duration of their hospital stay. This participant shared her experience with one of the nurses:

P8: The nurse was nice. She told me to be strong, because she's trying to help me. And then I was strong and then she told me to stay calm, because it's all over now.

This extract illustrates not only competent medical assistance by the nurse, but also a comforting, supportive role to the participant. Such positive reports about nurses were, however, not confirmed by all participants:

P10: But the other nurse… I will ask them like questions about my health. Like health advice, like just ask them questions… Some of them will be like… I remember this other time I asked the nurse about taking my ARVs and she was like "Why didn't you bring yours?" And I was like "Well, I overdosed with them, so obviously they are finished." ... So she was like "Where do you expect us to get them from?" I'll be like "Oh, but Doctor prescribed them for me, so…". Some of them are nasty, some of them are very nice.

From this clipping it appears that the participant did not feel that the nurse was helpful or supportive, but she also ends her comment with a confirmation that some of the nurses were good to her.

Some of the participants expressed gratitude towards the doctors and nurses who cared for them, even acknowledging that they are alive because of the treatment that they received:

P5: Apparently, it's nice, because they try their best to make you like live a healthy life.

I: Do they help you live a healthy life? Okay, what do they do to help you live a healthy life?

P5: They…they can see what is your problem and they fix it.

I: Okay, who does that?

P5: The doctors. And the nurses.

I: Okay. And what did they do for you?

P5: Like… They saved my life!

After considering that the doctor's medical treatment to NFSB patients is often not indicated and the nurses take care of the patient's physical comfort and treatment, the other essential element of treatment to NFSB patients is the hospital's counselling services. Most of the participants found these services helpful.

I: Do think that coming here helped you?

P3: Yes, it did.

I: How did it help you?

P3: At least like I tried to talk to someone. Like before, I'd never talk to anyone.

This extract refers to the participant's possible isolation and keeping her psychological difficulties a secret prior to the suicide attempt. She also seems to understand that talking about her problems can benefit her.

P2: Yes. Because like…I feel better now, that like I can even smile right now, because liked I talked to you guys. And yes, it helps a lot, because it helps me, like, to not think about that thing. Like personally, it's out of my mind. Even though it's still there, but like…it's out. Yes, it helps a lot.

When the participant refers to "you guys", it is a general comment about the psychologist and social worker who treated her, and she clearly associates the researcher with the hospital staff. She communicates something of the relief of talking about her problems. Even though she acknowledges that the problems are still there, she found the counselling helpful.

I: So do you think that it was a good thing for you to come here? Is there anything good that came out of your admission to hospital?

P4: Yes.

I: What?

P4: When you talk to someone…you will not feel angry or sad. Because you take it out.

This participant shares the perception that talking about the problems brings relief. She refers to the therapeutic effect of expressing difficult emotions.

The counselling duty in the hospital officially falls on the shoulders of the psychologist and social worker.

P9: It was, because through seeing them, I realised what it is that brought me here. So, because I've seen them, it's easier for me to talk about it. And I'm beginning to accept what made me come here: the depression and everything else. So yeah, I feel like it was useful.

This participant discusses a higher level of insight into her own psychological journey and the professional assistance that she has been receiving for that. This passage also points towards an openness to psychotherapeutic interventions and suggests that she may really benefit from some kind of therapy at this stage. This is a significant point when one takes into consideration that the NFSB patients are generally kept in hospital for a very short time.

I: So you were only here for one night… Do you think it's long enough?
P2: [laughs] It's not long enough. It's just short, but I'm glad it is…

This participant confirms some kind of psychological preparation for leaving the hospital. Even though she acknowledges that staying longer could benefit her, she expresses relief that she is allowed to go home. The system's tendency to discharge NFSB patients as soon as possible comes as a welcome relief to the adolescent patient who does not want to be there in the first place.

When considering the holistic treatment protocol available in this context, the following participant reported a significant benefit:

P7: Talking to people that are kind to me. The psychologist and the doctor. That's the thing that I enjoyed most. And the thing that helped me, is seeing myself being okay in my mind and my body…

One participant commented on the positive experience, as opposed to her expectations that were negatively tinged by the media:

P9: Ward 36… The treatment was better than I expected, because I read a lot. So, I did not expect good treatment.

I: You read bad things about the hospital?

P9: About public hospitals. It was better than expected: I was treated well, I ate well, yeah. But this ward is extremely different. It is less nice, but I think it's because a lot more people are here, so the nurses have a lot more responsibility...

5.5 Conclusion

The first category of adolescent participant themes included intra-psychic, relational and contextual factors that shed light on how participants experienced their lives prior to the suicidal incident. Themes that were common among participants were included in this discussion, as well as individual reports that carry significant meaning within the context of inquiry.

Under the theme relating to the prior existence of symptoms indicative of depression, the following experiences were noted: a history of a low mood or prolonged sadness, reports of previous suicidal ideation, the tendency to isolate herself from others, and rumination. In addition, experiences of the loss of a loved one and the presence of a chronic illness were included, since these aspects impacted negatively on the meanings that participants assigned to their experiences.

Then the narrative account focused on aspects related to the developmental stage of adolescence. Explosive and uncontrollable emotional experiences with specific reference to anger came under the spotlight. The tendency to act impulsively was also a shared report among participants. In relation to these intense emotions and reactional styles, conflictual relationships were also considered.

The next theme focused on aspects related to the participants' socio-economic and socio-political realities prior to the suicide attempt. The focus then shifted to different forms of victimisation that the participants had been exposed to. The forms of victimisation included physical violence, verbal abuse, rejection and witnessing violence against loved ones.

When considering all these aspects related to the participants' intra-psychic, relational and contextual realities prior to the suicide attempt, it becomes clear that there are significant challenges these adolescents have been faced with daily. In some instances, these challenges were so profound that an act as desperate as a suicide attempt becomes almost understandable.

In the next section, the ensuing narrative account focused on some of the reasons participants flagged for their NFSB, which included conflict, a long history of challenges, a relationship break-up and stress.

When considering the theme of intent, there were indications of an intent to die, a need to escape and cries for help.

In terms of a history of suicide attempts, some of the participants reported previous attempts. In relation to a previous attempt, secrecy was noted, as well as a progression in terms of the seriousness of the next attempt.

The methods of suicide attempt were ingestion of different substances ranging from medicines to toxins. The discussion then focused on the consequences of the suicide attempt, indicating aspects such as material gain, safety being restored and receiving confirmation from loved ones. Experiences in which nothing was different after the NFSB were also reported.

The theme of feelings associated with the attempt comprised confusion, the absence of suicidal ideation following the attempt and a continued suicidality where reasons for the attempt remaining unchanged.

The last category explored the participants' experiences in hospital following their NFSB. It was noted that, because all the participants in this study had ingested toxic substances, they were either dizzy or unconscious upon arrival at hospital. This may have caused initial feelings of confusion.

The narrative account then focused on feelings of ambiguity about being in hospital: while all the participants agreed that they did not enjoy being in hospital, numerous advantages to being admitted were identified. Some participants felt physically safe in hospital, others felt safe from their daily pressures.

With regard to their placement in hospital, three critical concerns were evident: participants' feeling uncomfortable being placed with adults in a ward; distress due to exposure to critically ill people; and the threat of contracting chronic diseases.

When considering the participants' experiences of the hospital staff, attention was given to experiences with doctors and nurses. The counselling element of the treatment, which is

provided by the psychologists and social workers, was experienced as positive by most of the participants. The reality of a very short stay was also highlighted.

This chapter focused on findings from the adolescent interviews. Quotations and Atlas clippings were used to demonstrate how the themes resonate with the participants' reported experience.

The next chapter contains a narrative review of the health care providers' experiences.

Chapter 6 – Findings: Health Care Providers

6.1 Introduction

This chapter aims to provide a narrative account of the themes emerging form the health care provider transcripts. Quotations are noted to demonstrate a close adherence to the reported individual experiences.

6.2 Biographical details of participants

6.2.1 Gender of health care professional participants

All the focus groups and individual interviews included participants from both genders. Table 5 summarises the gender distribution of the participants.

Table 5

Gender of Focus Group and Individual Interviews Participants by Profession

Profession	Female	Male	Total
Clinical Psychologist	4	2	6
Medical Doctor	2	2	4
Nurse	4	1	5
Social Worker	3	3	6

6.2.2 Ages of health care professional participants.

Figure 2 specifies the ages of the health care providers who participated in the study.

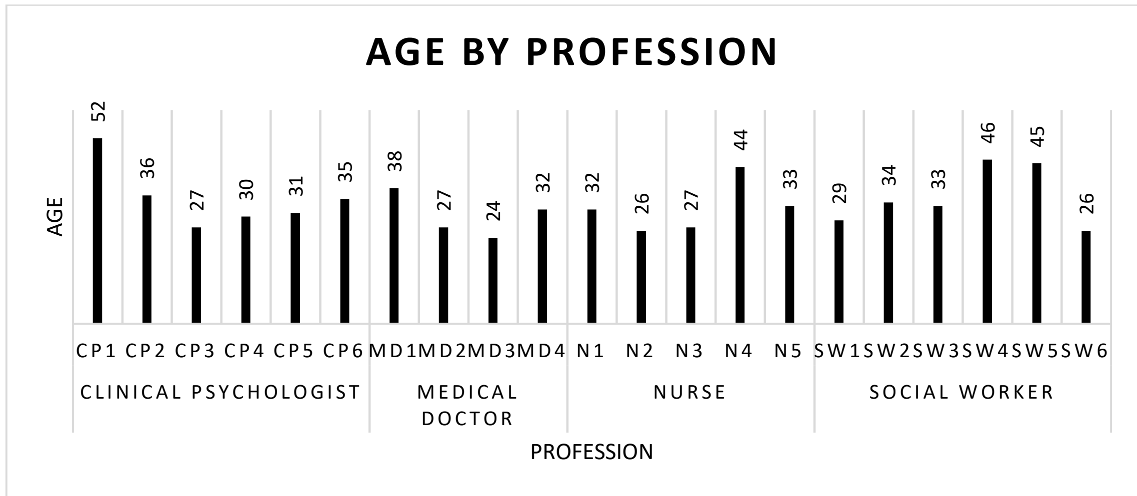

Figure 2. Age of Focus Group and Individual Interview Participants by Profession.

6.2.3 Number of years of experience in the profession.

The participants varied significantly in terms of their years of experience in the respective professions, as is indicated in Figure 3. In some of the focus groups the participants with more experience played a supervisory role in relation to the other group members, but this was not necessarily the case.

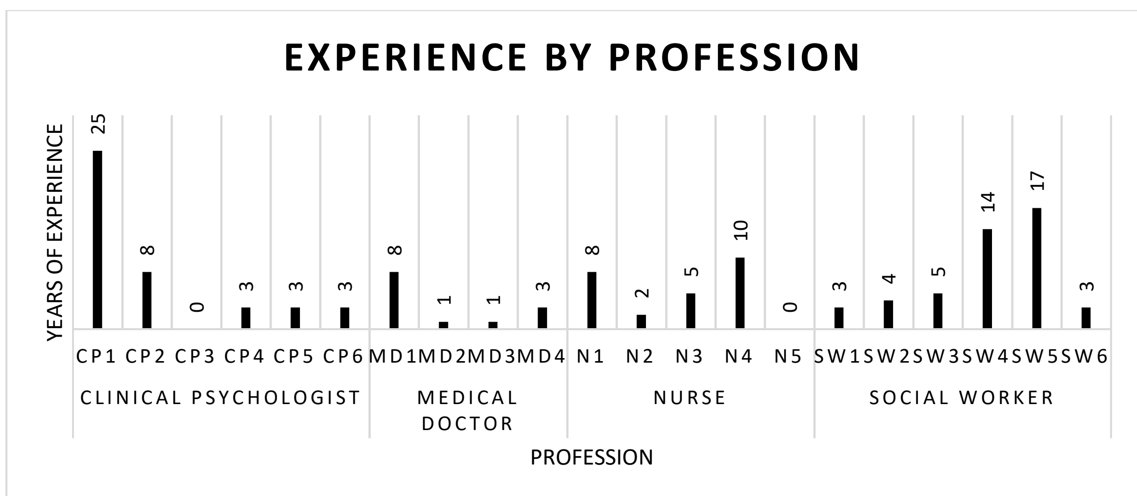

Figure 3. Years of Experience for Focus Group and Individual Interview Participants by Profession.

6.2.4 Participants' own children.

Part of the biographic data included whether the participants had children, which is illustrated in Table 6.

Table 6

Focus Group Participants Own Children by Profession

Profession	Own Children	No Own Children
Clinical Psychologist	5	1
Medical Doctor	2	2
Nurse	4	1
Social Worker	4	2

6.3 Analysis of transcripts

The analysis of the three focus group transcripts and four individual medical doctor interviews resulted in a total of 54 codes. For the purpose of ordering the results, these codes were divided into the following categories/superordinate themes:

- Themes related to the developmental stage of adolescence
- Themes that are centred around the health care professionals' experiences with NFSB patients
- Themes related to the hospital context
- Experiences unique to the different professional groups

Findings will be discussed under these four categories.

6.3.1 Themes related to the developmental stage of adolescence.

Many health care professionals referred to challenges associated with the adolescent developmental stage.

S3: Because with most of the adolescents, it's peer group problems as they are developing. So there's conflict between the parent and the child. Maybe the grooming, the discipline, that sort of thing. So with adolescents, most of the time, that's mainly the issue: they have behavioural problems as they are developing.

This social worker commented on the fact that relationship problems occur between adolescents and parents but stated that the behavioural problems are related to the developmental period: it is part of the process of developing. These behavioural problems can easily lead to power struggles.

N5: I think with adolescents it's number 1, the problem of peer pressure. Number 2, they don't like to be reprimanded. And number 3…it's a crucial stage – the stage of adolescence, because they see themselves as…they want to compete with the adults…

The nurse in this excerpt mentioned the challenges of peer pressure, but then focused on the ongoing power struggle: adolescents are no longer children, but they are not quite adults. They still have to adhere to parental discipline measures, but they want to enjoy the privileges of inceptive adulthood. Another social worker summarised the challenges of adolescence as follows:

S5: That's why we have to look at the developmental stage, because it's not only with the families that there is conflict. They are dating and all of that, so that peer group issue also comes in. Maybe at the same time, they are trying to find their self-identity. They are experiencing new things, now there is the peer pressure and the demands of adolescence… There are a lot of things. Now it might be difficult for them to express themselves and tell us what they need. Whatever they need, they need it now.

This quotation refers to the complexity of the challenges that an adolescent is exposed to, incorporating difficult developmental processes such as establishing an identity. She also commented that the adolescent might experience this complexity as confusing, which sheds some light on why it is difficult for adolescents to express their needs. She also introduced the concept of impulsivity, which was echoed in other focus group discussions:

C2: I think what I've found with adolescents, is that mostly if you look at the presenting complaint…and how it was done, the planning, you find that it was something that was very impulsive, in most of them. It's something that happens on the spot, almost like, you know, throwing a tantrum? Um… this is happening now, I'm not getting my way, you know? And in some of them, still being an impulsive act, it's related to something that happened at home, be it a fight with a parent, bullying at school, whatever, which is something that can really hurt them emotionally. However, it becomes very impulsive. It's like they don't think through what other options do I have? So what I find with most of them is also that they sort of like lack coping skills. They lack life skills as well: how to manage themselves, how to deal with problems, where to go. So they resort to this attempt. Let me… Either as a matter of I want to teach someone a lesson, I want to be heard… You know, yes, around that. Yes, without taking into consideration… If I take that rat poison, what might happen to me, you know. What could be the possible consequences, so it's on the spot, impulsive.

This clinical psychologist discussed the element of impulsivity in adolescent suicidal behaviour and compared it to a tantrum, an impulsive acting out. While the trigger for the suicide attempt might be something apparently trivial, she acknowledged that it may have been very hurtful in the adolescent's experience. With regard to the impulsivity, she referred to a disregard for the possibly lethal consequences of the acting-out behaviour, but also to a possible lack of coping skills on behalf of the adolescent. When considering the complex nature of the adolescent stage, in conjunction with what this health care worker experienced as a lack of a coping and life skills repertoire, the possibility of feeling overwhelmed becomes fathomable. In further exploration of the element of impulsivity, this social worker also commented on the unexpectedness of a suicide attempt, even in cases where behavioural and/or mood problems were evident:

S1: Yes, I was going to say… What I've come across: parents would say: this is teenage behaviour, and all of that. They will try the way they are trying. But in terms of – would they be able to detect the signs and say is this child now very unhappy…we can notice that they are very unhappy, there's a lot of sadness… It's almost like it happens. There is a difference, a fight or a conflict and the next thing, it happens just like that. There is not that gradual … to say okay, there was sadness… Yes, the build-up, it's not there. They snap. And then they try to attempt suicide. For the parents, it's like…out of the blue! Why, you know…

Again, an impulsive "snap". The discussion went on to explore the signs of suicidality and whether parents or significant others realised what was happening in the period building up to the suicide attempt. Even though the low mood might be evident, the suicidal act still comes with an element of unexpectedness. The following 45-year-old social worker referred to her personal experience of being the mother of an adolescent to bring the message across that the relationship difficulties and problematic mood periods are a natural part of the developmental stage of adolescence and not necessarily perceived as signals of suicidality:

S2: I understand what you are saying guys, but sometimes it's very difficult to see that your child is unhappy. Yes, you can see that my child's mood has been… But for me it doesn't mean this child might end up killing him- or herself. That's why we are saying that the actual act just happens like… because yes, I saw that this child has been unhappy. Locking himself in the room, you know, not wanting to sit with other people. But to say that this child may end up taking his or her life, really to be honest: as a parent, it doesn't come to your mind to say this child can go to this extreme. Maybe I'm talking from personal experience, that I have a teenager. Now and then we have to reprimand and sometimes he will be this happy, sometimes he will be this moody... And I mean, you won't say…because today or for the past few days, he's been like this. Even when you try to engage as much as possible to check with the child as to how are they feeling, why are they this sad… And you don't get the answers that you are looking for. It doesn't automatically tell you that this child might end up attempting suicide. Even if the child gets punished in a way, you don't think that they might end up taking his/her life.

This quotation reveals something about the unpredictability of a suicide attempt and how the warning signs may have been there but seem to be muffled under the everyday challenges that form a natural part of the adolescent stage. This social worker's congruent acknowledgement that her personal experience of being the mother of an adolescent may have altered her view of adolescent suicidality gives some insight into the complexity of working with the adolescent NFSB patient. It does not seem to be natural for a parent to consider possible suicidality when their adolescent children are struggling emotionally. As a health care worker who provides services to adolescent NFSB patients, personal experiences and views do have an impact on how the phenomenon is experienced, made sense of and managed.

6.3.2 Non-fatal suicidal behaviour (NFSB): experiences of health care providers.

There was consensus among the different professions that high numbers of NFSB admissions are continuously being recorded at this hospital.

S3: Para-suicide patients are admitted on a daily basis. And it's worse on Fridays and weekends and Mondays and holidays… Even if we were on stand-by, we can know that on Monday, we are going to find at least two… It's a bit overwhelming, you know. When I started, I used to worry a lot, because the number would keep increasing and increasing.

These were comments from a young social worker (26 years old) who acknowledged her initial anxiety in relation to the high numbers of NFSB patients that are seen at this hospital. In addition to the high numbers of 'para-suicides', different professionals also agreed that adolescent females in particular constitute a significant proportion of this patient group.

D3: When I get called to casualty for 'para-suicide', I mostly admit females around the ages of 15, 16, 17 to 19, that's the range mostly of the ones that I admit for this ward. You will find that they will take rat poison, others… and then we normally try to correct the imbalances as to…yeah, we just try to remove whatever is toxic in them.

This 27-year-old intern doctor was of the opinion that NFSB patients are mostly adolescent girls. He also referred to the recurrent suicide method of ingestion of toxic substances.

D2: We usually see a bit of… like 30 or so tablets taken by the patient. Usually the tablets are… what family members are taking, like blood pressure tablets or so. Panado. Usually it's tablets that are available in the household.

This excerpt made reference to the availability or practicality of the method of suicide that is selected. The method of suicide also appears to be linked to the reason for the attempt, as is referred to in the next passage:

D1: I think, just like…we learn at medical school and they always teach you that look, if they drink pills, it's not like a serious attempt. Or severe. It's usually about crying out for help and attention. And I see it in a lot of these adolescent females where they will tell you that they drank four Panados or five. It's not a lot. And you get the odd one that really tried to go all out. There's no suicide note, so they didn't actually plan the whole thing through, they were just trying to seek help and attention. Somebody, please listen to me. I still want to live, but I don't want to live under these circumstances. So to see how the situation can be resolved or at least get better.

This 32-year-old doctor commented that the reason for the attempt may not have been an intention to die, but rather to communicate a desperate need for help. He made this conclusion based on the negligible amount of medication taken in some instances, in relation to perceptions of overwhelming challenges. This quotation starts out with a potentially stigmatising and underestimating generalisation about the seriousness of overdosing on medication, but then provides an explanation of some of his experiences that culminated in an appreciation for the desperation prompting the suicide act. This impression of the attempt being a cry for help was reiterated in other focus groups:

S5: In some instances, especially with the adolescents… When you assess, you can find out that okay, this one doing this, it's another way to express how they are feeling, how they are coping at home in terms of experiences and how damaged things are at home. So it's sort of a shout for attention: I am here and I'm crying to you verbally, but you don't listen. I've been complaining about this for so long and you seem reluctant to listen to me, so this is what I'm doing. Just to say: wake up, look at me.

There is the implication that the adolescent may have tried to cope unsuccessfully in other ways but had not been able to get the help that he/she needed, thus necessitating something as serious as attempting suicide. There is also a reference to the seriousness of the difficulties that they might be facing, which introduces an important aspect that relates to intention. All the disciplines participating in this study commented at some point on the severity of challenges the adolescent is faced with – even if she tries to commit suicide for an apparently superficial reason.

The perception that suicide attempts were cries for help came up repeatedly in the focus group results.

The observation of apparently superficial triggers for suicidality was noted in different discussions.

C5: …in my experience, often most of the patients that I have seen, have been teenagers, for instance, around young adulthood or so. And often, every case that is presented…there's a superficial reason that comes up when you ask the person what they are presenting with. And it's easy to take that and say the reason is so superficial, like I don't understand why you'd kill yourself for this. But when you go deeper, you start realising some serious psychological issues that the person is presenting with and that…what they are presenting with is just what seems to be more acceptable or what seems to be a justification for that particular point. So what I've realised is that there is a build-up of serious psychological issues that are underlying and then they get to a point where there is something that comes as a trigger. Now they just need to do something and that is what they present with.

This clinical psychologist called the seemingly trivial reason for the attempt a trigger: the last straw after a long process of struggling to cope with excessive psychological challenges. The reasons for suicide attempts vary, but it was significant that socio-political/socio-economic challenges came up in a number of focus group discussions focusing on how the adolescent ended up in this situation.

D1: Yes, I think it's quite a difficult stage of your life. And sometimes there's no parents involved as well. You'll also find that there's also conflict at home with a lot of these adolescent individuals who take…neither of the parents… they don't have a good relationship with any one of them. So if you ask them about support, they say they don't have [any]. So, they don't cope with situations at school or social issues and then they can't talk to anyone. They are basically left alone to deal with these issues and some people can't do that. And they don't have the answers, like if you ask them why did you do it? It's just like I can't cope. And I have no-one to talk to.

The absence of parental guidance and support as a contributing factor to isolation and collapsing under pressure was clearly noted here. A lack of parental care resulting in neglect was reiterated in a different focus group session:

S4: She drank Rattex, because there was no food. The mother left them without anything to eat so the child decided to eat Rattex. It was a girl and she intentionally decided to kill herself. She said that she was doing it intentionally, because her mom always does this and that. She always leaves us behind… always at the bottle store or somewhere there, so she was…

In this quotation the utter despair and hopelessness of a young child having to fend for herself became clear. The following segment considers more challenges:

I: Okay, what is your impression…with adolescent para-suicide patients…what is normally in your opinion the reason why they try to commit suicide? Why do they do that?

N6: Okay, mostly it's peer pressure. But some, if you listen to their stories, some are really, really…like some are child-headed families, now it's too much for them and all that. Some, maybe, have medical conditions…some maybe may have been raped a long time ago, but they never really spoke and it's only coming back to them now.

This nurse made reference to the staggering pressures associated with being in charge of a child-headed household, suffering from a medical condition and having been exposed to a history of trauma that may form part of the socio-political challenges that adolescents in this population are faced with.

C6: On another level to that… What I found is that they find themselves in a situation whereby they are stuck. It feels like they cannot get out of this situation that they find themselves in…Because I find myself in these social or financial circumstances, therefore I cannot think outside this box, therefore I'm not going to amount to anything in life, therefore let me take my own life. You know, without forethought, of course. However, as you said, that when you look into it, you find out that there are layers of issues that need to be addressed as therapy progresses. So mostly, as I say that, it's more about that stuckness and the disadvantage of the bigger system that is failing them. And the other one was on the…child-headed households, you know… Everything is just too much for them. They can't deal with that. Then they don't

see their future. They cannot see a life where they can ever get out of this situation that they find themselves in and the best way to go about it is just to eliminate myself out of this.

This excerpt provided a reflection on the overwhelming implications of the socio-political reality that some of these adolescents find themselves in. What this psychologist also referred to was the lack of hope that things can change for the better and how this sense of hopelessness may have contributed to the suicidal ideation. In the health care professionals' transcripts, socio-political challenges or structural vulnerability surfaced consistently and in some cases the professionals also made reference to the limitations of the assistance that they can provide, considering the socio-political constraints of this context.

C1: …There is nothing that you don't see in this hospital. With it being a general hospital and a teaching hospital with all the different teaching departments, there isn't much that you don't see… Yeah, the bad is the…often a lot of the "health issues" that we end up dealing with, are not really health issues. They are more like economic, social and political issues that end up becoming health problems. And you feel quite powerless as a health professional, because you realise that you are a health professional who are dealing with the health outcomes of a much bigger structural problem that you have no control over.

This 52-year-old clinical psychologist reflected on structural determinants beyond the control of the health care system that have implications for patients' health. He also made congruent reference to his own sense of powerlessness when it comes to assisting patients who are victims of a dysfunctional context. He then continued to share some of his personal observations as a father of adolescents himself:

C1: …once you start delving deeper into the issues of what the person presents with, the para-suicide, you learn quite a lot about the things that go on in our society... And also, it gives you perspective into our society or information into how our society works. Because sometimes when I would see a child the same age as my child … and then I listen to this child's circumstances and I look at my child's circumstances. And then you realise the social distance. And the inequality that exists in society and then you become sensitised to a lot of social justice issues that occur in our society. Yeah, that's why I said earlier that this is social sciences unplugged. Social science that is not choreographed, but that happens in real life.

This honest reflection on the injustices and remaining inequalities provides some insight into the complexity of experience for the professionals who work in this context. Again, personal observations of adolescent NFSB patients may carry different meanings for the people responsible to take care of them.

Other reasons for suicide attempts that came up included relationship problems, depressed mood, a general lack of coping skills and problems unique to the adolescent developmental stage.

When considering the consequences of the attempt, different opinions were raised. The first was the possibility of being ostracised because of the NFSB.

C4: I found that it actually also affects other social relationships, which leads to alienation. Like for example with peers who know that this person attempted suicide… And then they distance themselves from that person. Or if it was a relationship thing… Like maybe somebody attempted suicide, because their boyfriend said something nasty, so this boyfriend now might end up pulling himself from that relationship, saying you are a bit crazy, I don't want to be in a relationship with you…

This fragment introduces the possibility that the suicidal behaviour may have contributed to existing problems and perhaps caused further isolation and even rejection. The reality of stigmatisation is clearly acknowledged. However, this was not always the case, and some observations were shared of family members coming together to support the patient.

C5: I also wanted to point out that it might be different like in cases whereby you have other cases like depression for instance. So it's depression that is presenting in adolescents and this kind of behaviour presents to the family that this is the problem and it's serious. And then it might help the family to realise and take it seriously. So then in those other cases, unless they know for instance that this child is presenting with depression… And then it eventually lands them here and the family is now becoming more concerned and they take the depression seriously, so we can refer and take treatment.

In this case, it seemed like the adolescent's cry for help was heard and taken seriously. What was also highlighted, was that in the presence of a psychiatric diagnosis, the suicide attempt may have led to the family taking notice and thus becoming able to support the depressed adolescent.

This clinical psychologist then went on to clarify that depressive disorders are not common among adolescent NFSB patients in his experience, which was reiterated by the other group members:

C5: …But with most of the cases that we see here, which are mostly not like depression cases or psychiatric illnesses…

M: Okay, so you would say that it is the minority of cases that really have a depressive element?

C5: Yes.

M: And everyone agrees with that?

All: [agreement]

This point may indicate that elements of the reported low moods in the possible presence of suicidal ideation may be related to common mood fluctuations or understandable reactions to difficult circumstances. It is possible, therefore, that psychiatric diagnosis does not necessarily dominate this presentation.

Whatever the reason for the attempt may have been, it became clear that health care professionals experience emotional reactions to this patient population.

D3: But normally you realise after some time… At admission, I don't judge, I just treat them. But when it comes to the ward where you start asking questions, you can see oh, this one is an attention-seeker. But then you just have to push for psychological support. Because maybe her healing is based on how we are going to treat her. And she will recover based on our support. Because I can't say I'll discharge her, because I can see that there is nothing real about this patient…

This doctor acknowledges the potential significance of the treatment that the NFSB patient receives, but also introduces an important aspect that came up repeatedly in relation to the NFSB adolescents: a possible annoyance with what may be perceived as manipulative behaviour. This also relates to stigmatisation and associated judgement. While it has been established that a suicide attempt is a sign that something in this adolescent's life is not right at a psychological level, the medical context into which they are admitted may at times lack empathy.

C1: Yeah, you see… Often as a silent message that goes out to them and that we also pick up, is that they are more of an irritation or a nuisance or an inconvenience to the hospital. Because sometimes when you walk into the ward and you introduce yourself, they will say oh, here's the guy for that one with the social problems… So now when they pick up such vibes that we are an irritation, we are a nuisance… And at the same time, there is a dysfunctional system at home. So the possibility of that person coming back for therapy is probably not there.

This clinical psychologist made reference to a possible attitude that social problems are not real enough to be taken seriously in the hospital context. He specified emotional reactions such as irritation and annoyance on the part of health care providers, which are inevitably noted by NFSB patients. And this has implications for the patient's openness and cooperation in receiving help. To take the possible existence of negative attitudes towards NFSB patients further, some of the social workers mentioned the outright judgment that these patients are at times exposed to:

S3: But if you look at what led to this behaviour, it's what she has said: the attitude of the staff.

S4: Because they get scolded. What's the reason for admission? I tried to commit suicide because of my boyfriend. And they will say… Boyfriend!? You are so stupid… You have a boyfriend? You're so young! And this starts in casualty. So people must come and see this stupid girl…

The forthright opinion and associated labelling that these social workers report on is related to the apparent superficiality of the reason for suicide. In this instance, the judgmental insults are reported to give way to collective ridicule, which obviously has significant implications for a patient who may already be experiencing varying levels of psychological distress, guilt and even shame.

However, as was established earlier in this discussion, some of the professionals do appreciate that the superficial reason for the attempt is often merely the trigger amidst long-standing crisis situations that have been building up.

C6: Yeah, I think, what I find frustrating is that I will go to the wards and then it's more that they are dealing with the problem on face value. They don't know the reason why…yes, the presenting complaint as such, but then the psychological meaning behind that is different

to what has been presented. So, they are working with what has been presented, therefore they would scold and shout at the patient. So that…it has a different dimension to it and the patient would internalise that and it would not yield positive results for therapy.

Despite the possibly hidden, deeper psychological roots of the suicidal behaviour, this psychologist participant also confirms the condemnation from staff members reacting to the superficial reason for the attempt. From the psychological perspective, she further reflects on the possibility that NFSB adolescents may assimilate such negative comments into the views they have of themselves, which is detrimental to the psychological healing that these therapists aspire to. However, not even clinical psychologists appear to be immune to feelings of irritation in relation to some of the superficial reasons for suicide attempts:

C1: Yes, and then you get to another extreme where I sometimes find myself getting extremely irritated, I don't know… Where there is a certain kind of counter-transference in me that I would think… What!? This person did such a harmful thing to themselves just because…the boyfriend or girlfriend said something. And then you realise that this person was even intoxicated when they were saying something like that…

Here the clinical psychologist confessed an honest sense of frustration, despite the awareness that there has probably been a build-up of stressors leading to the point of a suicide attempt. It is interesting to note that he shares some of the frustrations reported by the other professions, although his theoretical understanding and professional training add a reflective awareness that may have the potential to govern his overt reactions more circumspectly.

Health care workers' unique experiences of NFSB are coloured by a variety of contextual elements that they are faced with personally and professionally on a daily basis, but they do seem to share related frustrations. The related contextual elements will be considered further in the next section.

6.3.3 Patient- and hospital-related themes.

One such contextual reality that might be contributing to how health care workers view NFSB adolescent patients in their wards is the issue of placement in the hospital. The procedure in the hospital is that NFSB patients are admitted to an adult medical ward, which houses quite serious medical conditions.

N5: They are not correctly placed. This is a medical ward. Here are so many diseases. And then most of them…we don't know their status. And then the people will say keep them here, we still want to talk to the family etc. and the longer they stay here…they contract these diseases.

This nurse expressed her concern that the adolescent NFSB patients are placed in a medical ward, which is not optimal. They are exposed to diseases, while they may be completely healthy. Also, when adolescents are kept in the ward in order to receive counselling, their exposure to these diseases is prolonged. The following excerpt from a medical doctor reiterated this nurse's concern:

D1: I mean, they are next to patients who are actually very ill: TB…they are exposed to a lot of infectious diseases, first of all. And I think it's not a good environment, I mean… There is mentally a problem. Not physiologically. I mean, sometimes they end up here having a problem…maybe they had two paracetamol and the liver is deranged, yeah, we do understand that they are also very sick then. But most of them are physiologically fine the next day. Just about all of them are very stable and now they are lying next to patients who are fighting for their lives. It's also, I think, it's a bit nerve-wracking for them. Their emotional state is also down low: they are depressed and now we are even exposing them to a more depressing environment. How are you going to improve a depressed patient in a depressive environment? It isn't possible.

This doctor also picked up that being placed in a bed next to a patient who is fighting for his/her life may cause significant anxiety for the NFSB patient. He confirmed his experience that in most NFSB cases, the adolescent patient is physiologically stable the day following admission. He also made mention of the fact that their problems, in fact, are mental and that admission under these conditions may not be an optimal space for psychological recovery.

N6: I know that's why sometimes they want to go home. Especially if their neighbour…especially if someone dies. If the neighbour dies, they become very scared. Maybe they'll be telling the relatives…obviously they'll be influencing each other: that they can't stay here and all that. Although they are not coming to us, but we know that.

I: Okay. And does it happen often that patients die here…in this ward?

N6: Yes! Although we try not to put them with the very sick patients, but sometimes it's not possible, because when the ward is too full, we just put them in the next available bed.

This nurse also made reference to an important reality of being placed in a medical ward that houses critically ill patients: patients often die. This obviously causes further discomfort for the adolescent NFSB patient. The nurse also highlights aspects related to her own experience. The first is that NFSB adolescent patients do not always feel free to discuss their concerns with the nursing staff, which may reflect an inadequate system of communication with health care users. Another significant element is her reported feeling of protectiveness towards these adolescents, which may prove futile in the presence of an exceptionally high patient throughput. This confirms that, at an emotional level, the health care provider may react differently to the adolescent NFSB patient specifically.

The following quotation shed some light on one of the reasons why the adolescent NFSB patients are kept in this medical ward:

N5: ...but to our unit...it's full! Sometimes we are overcrowded and we even have to take other patients to other wards, because of the para-suicides that are taking up the beds.

I: Okay, and you need the beds?

N5: We need the beds for the sick people. And they can't take the para-suicides to another ward, because they can't control them. They don't know what is happening to them. So we need them next to us.

This nurse's frustration was clear. Here she makes reference to adolescent NFSB patient's tendency to abscond, which is considered a serious adverse event and as such places a lot of responsibility on the nurse's shoulders. The understanding is that the current ward provides more supervision to prevent adolescents from exiting the hospital without following procedure.

Nurses manage high numbers of critically ill patients daily, and having healthy 'para-suicides' taking up beds that could have been utilised for truly sick patients causes them frustration. From the previous nurse's statement that beds are needed for patients who are sick, the reference may be picked up that NFSB patients are not really sick, yet they require resources. The question of entitlement to care may surface here, introducing the question whether people who inflicted their own injuries have a right to use resources that are set aside to care for truly sick health care users. This subtle theme of entitlement to care was also

revealed in the clinical psychology discussion, with more of a focus on taking responsibility for actions:

C2: Yeah… Where you're sort of called into the ward, because they want to discharge the patient. You must quickly come and sort it out, which then does not give you enough time as a clinician to sit and assess this patient… So again, they are putting pressure on the system, they are putting pressure on you, because they want to go back home. Then you don't get to really work with them on the level that you are supposed to, which can be frustrating. On the other hand, you find yourself thinking: well, you brought yourself here. So give me time to work with you! [laughs]

While this clinical psychologist acknowledges the fact that the adolescent NFSB patient is admitted for a self-inflicted condition, she also shares her frustration at not being able to do her job properly due to pressure from the patients to go home.

The following response was from a doctor after being asked if he thinks that the current admission procedure is optimal:

D2: No. Not at all. Not healthy patients, no. We are all exposed to TB. I think that 50% or more of these patients have got TB. And most of the time it's newly diagnosed TB, so we are not sure if it's NDR TB or XTR TB. All these patients that are in the ward, even the medical staff in the ward, are exposed to these health issues. And it's not optimal.

He clarified his opinion that placement of NFSB patients in this ward is not optimal because of the severity of illnesses accommodated here, but he also made reference to the potential health risks for both patients and staff. Because of these identified risks, masks are made available to medical staff working in the wards, which are always visible when visiting the ward. The doctor in the following excerpt was wearing his mask throughout the interview which took place in an empty cubicle in the ward:

I: Okay, can I ask you about the mask? [he is still wearing his] You wear that obviously…

D1: Every day, yeah. Because there are a lot of TB patients in the ward, sometimes we are waiting for the TB results. So there's also a lot of... infectious diseases that can actually spread. Contagious diseases. Um…so you work here ten hours a day in the ward, so you're

exposed the whole day. So the N95-mask protects I think about 99.9% or something of all of those infections. It's just about protecting yourself.

M: Okay, but do they offer the para-suicide patients face masks?

D1: I must say, to be honest… No. And I don't know why. Because a lot of patients where you know actually they are TB positive and therefore should be isolated, which we most often do. But they should also wear masks. I mean, the patient that is infected must wear a mask to minimise the cross-contamination.

This is a complicated topic, but certainly an aspect deserving of further exploration. Isolation rooms are not always available to accommodate these patients. This topic of discussion also surfaced in the nurses' focus group.

N5: So the face mask is because this is a medical ward. It's supposed to protect the staff from airborne…it's meant to protect everybody. Even the visitors.

I: Hmm… But not the patients?

N5: The patients…they are supposed to wear the mask…especially those that are coughing…not everybody.

I: Oh, okay, but they don't?

N5: Yes, we do give them, but you'll find that they choose not to.

According to this nurse's statement, the ward policy is that patients who are coughing should be wearing masks at the very least. She reported that patients refuse to do so. While this matter is not the focus of the current study, implications for the study population has been noted.

During the focus group discussions, members of all the different professions were in absolute agreement that the placement of adolescent NFSB patients in an adult medical ward is not optimal. Several recommendations were recorded in the transcripts.

S1: Firstly, I think the ward – even if it's not a good ward, we need a dedicated ward. Because para-suicides…their recovery is a lot quicker than someone who is seriously ill. And if you have recovered, the drowsiness is gone, you are yourself again. And if you are in that environment, it will push you to want to go home as quickly as possible, because you are looking at all these seriously ill people around here… You are not ill! I'm not sick! So that environment… Let's have a proper ward where we can accommodate para-suicides.

This social worker participant reiterated the medical doctor's earlier statement that this is a mental problem, not a physical one. There should be a separate, accommodating space where they can be treated. The following doctor had similar thoughts:

D3: Once you make that diagnosis of para-suicide… If the patient is stable, my plan is to just like…this patient is normal, but they need psychological support. They are different from those that are ill. If it were up to me, those patients wouldn't have to come to the ward where they can contract other illnesses such as TB and stuff. They should be in a separate place. With some of them, we don't know their HIV status. Because of their immune suppression, they can contract infections from the ward. That's one of the things I don't know how we can deal with it, but they should be admitted in a place where there are less chances for them to contract infections. Because they are not really sick patients. If they are normal, they should be separated and await the psychologist for that support.

From this quotation, it is clear that even the medical doctors have given the problem of NFSB patients in the medical ward a lot of thought. The following doctor continued the recommendations:

D1: Yeah. I even spoke to one of my consultants about it. I thought it would be fantastic if these patients could be stable…okay, you saw them at casualty and make sure that physiologically they are fine. They don't need attention from a doctor, basically. They just need attention psychologically or from a social worker as well. If they can just go into like a small…one cubicle in one of the wards which is not exposed to like critically ill patients…

This doctor demonstrated insight into the psychological needs of a NFSB patient. The following excerpt from the psychologists' transcripts summarised many of these concerns and suggestions:

C2: And I think adding to the challenge as well, is where they are admitted is a problem as well. Because they are admitted in a medical ward. Hence, I guess, we experience these challenges. I find it…I struggle to get my head around para-suicides in the medical ward. Because in my experience in the past, para-suicides will be in psychiatry. So you find they are there, so I think even the level of seriousness, that this could possibly be a mental condition

and it should be treated as such, it's not. So it's basically not emphasised how the system works. Because if you think about the suicide watch… It's not there. You still find patients in the wards hiding pills in their bras, because who is monitoring them? And they'll be telling you when I leave here, I'm going to use them, you know! Because there isn't that seriousness around… We don't take para-suicide or attempted suicide very seriously in the hospital. So. I think that's another challenge. And because they are there and they can be pumped out, dripped and go home, they don't realise the seriousness of what they had done…

When considering the suicide risk and need for counselling, the suggestion arose that it might make more sense to group the NFSB patients under the psychiatric category. The understanding is that psychiatric ward staff members are better equipped to manage suicidality. This clinical psychologist pointed to the possibility that admission to a medical ward may give the impression that physical recovery from toxicity implies resolution of the problem, while the psychological origins remain.

These difficulties related to placement and procedure in the hospital make it clear that the medical professionals try to provide efficient, professional services under challenging conditions. While different professions have different experiences, all the focus groups agreed that placement in the hospital is a central limitation in the treatment of NFSB patients.

6.3.4 Experiences among the different groups of professionals.

6.3.4.1 Nurses.

During discussion with the nurses, a number of challenges related to their working context became evident.

N5: Since this thing of patients' rights and the help desk or whatever…people are very sensitive…and when a patient is admitted, the families expect 100% attention and they complain over every little thing…they start to blame the nurses, that we kill their family members…

This nurse reflected on the high expectations of patients and their families, which is supported by Department of Health initiatives to improve service provision, such as the Patient

Rights Charter, Batho Pele principles, etcetera. However, in practice the nurses report that the extremely high numbers of patients who require intensive individual nursing makes it very difficult to maintain such standards. She referred to what she perceived as unreasonable yet disturbing indications of blame. The nurses' focus group even reported regular harassment from health care users and their families.

N4: We are facing so many different people in this ward. Even the community… Sometimes they harass us and we can't say anything.

I: Also the family members who come to visit?

N4: Yes! And even the patients.

N3: They don't see us as human beings like them.

N1: Sometimes the patients… they are lying to their families, they complain about us, whereas others… It's not true. Just because we nurse them nicely and we understand them and we become patient for them, but they are not satisfied. I don't know how…because we try our best. Then the visitors came to us…others speak nice to us…others understand, others they don't understand.

This excerpt noted feelings of not being appreciated and what could even be perceived as dehumanising abuse. A 26-year-old auxiliary nurse also shared her perception of being voiceless in a work context where patient rights are prioritised over the needs of employees. It was also significant to note that the focus group members reported similar maltreatment from adolescent NFSB patients:

N1: Yes, because sometimes we admit them during the weekend on Friday, but then they have to wait here to be seen only on Monday… [by psychologist] [loud noises….inaudible] So then nothing is done until on Monday.

N2: and they become violent – they want to go home. You can't contain them…

I: The adolescents? They become violent?

[Many yesses.]

N2: Yes, especially them!

I: They fight with the nurses?

N2: Yes, sometimes they have done some things that they regret after. And then when they are here, their minds come back, now it's…what's going on?

N6: Maybe they feel ashamed…I don't know.

This transcript quotation reported on adolescent NFSB patients who feel frustrated when they realise where they are. The focus group members reported that they sometimes take out that frustration on the nursing staff, who are the health care providers that remain with them. The last line referred to an observation that the adolescent might feel ashamed of what they had done, which provides some insight into how this nursing professional tries to make sense of the dismissive way in which they are treated.

The following young nurse started a statement about adolescents behaving aggressively, but gave up:

N4: Yes… We try. We try to calm them down when they are aggressive and then we just…[silence]

Her sense of hopelessness is evident in her giving up on trying to explain. When linking this comment with her earlier observation of feeling voiceless in a work context that she perceives as abusive, an impression of this particular participant's significant unhappiness in the current work context starts to emerge. It should also be noted here that apart from voicing these feelings of hopelessness and disempowerment, she was mostly quiet during the discussion.

Through the discussion it became clear that the NFSB adolescent patients can be demanding in the wards, while the nurses are already exposed to a lot of pressure in terms of their work load.

N6: If they come and see you now and then everything has to be done, because maybe they are going somewhere to report you now. Because I think we tend to overlook the para-suicides. Like when they get here…oh, it's just a para-suicide. When they get here the para-suicides…eish, I'm going to refer her, because she's a para-suicide. You see now the para-suicide is there, the nurses have to give medication now you see the patient is crying there. You have to leave whatever you are doing and sit down with the patient and talk to that patient. That can even take an hour.

N5: And the patients are there waiting for you…we have the whole ward…

The first nurse referred to the difficulty of accommodating nursing duties in relation to NFSB patients in a ward that houses critically ill patients. She acknowledged that due to the severity of the medically ill patients' conditions, NFSB patients may at times be overlooked.

This topic was discussed earlier in these findings. She mentioned having to leave her nursing duties to sit down and listen to a NFSB patient who is in hospital for a mental problem – something she does not have time for. Another factor introduced here was the nurse's responsibility to assist with what is seen as a counselling task. This seems to happen because the nurses are the ones who are present with the patients at all times, and therefore pick up patients' struggles and concerns. The nurses' frustration at having to care for patients grappling with emotional turmoil and in the process neglecting their medical care duties was evident. However, despite all these challenges that the nurses face, their concern for adolescent NFSB patients still remained. The following fragment expresses congruent feelings of sadness in relation to NFSB adolescent patients in the ward:

I: My question was how is it different to work with adolescents who try to commit suicide, as opposed to adults?

N2: It's a sad situation, because these kids…they put their parents under tremendous stress. If they don't understand to maybe take a life, that it counts…it saddens me…I don't know what is happening, actually, in their minds.

I: It saddens you?

N2: yes, because the numbers are too high.

These were the words of a 50-year-old enrolled nurse who is also the father of an adolescent. From his reflection and sympathy for adolescent NFSB patients' parents, there is an indication that he identifies with these parents as opposed to an empathic awareness of what they are going through. In addition to these reported subjective experiences of sadness in relation to NFSB adolescent patients and the related high incidence, other forms of concern also entered the discussion:

N1: That's what I do: I feel pity for them, because they are too stressed and they can't share their difficulties with others. Sometimes I will ask him /her: Why do you do this? To see if they can share this, or sometimes they are afraid to share with their parents…it depends on the problem. So sometimes they can tell you, sometimes they can become more aggressive. So you explain to them: problems are all over. Even myself: I am nursing you, but I also have problems, but don't try to do that thing. Sometimes they understand. It depends the way you talk to that patients. Sometimes you see them smiling and agree yes, I will not do it any more.

Sometimes they just say you know very well…they are angry. You are just talking, talking, you don't know how I feel…

This is an extract from a 33-year-old auxiliary nurse's statement when asked about her feelings with regard to adolescent NFSB patients. Keeping in mind that she received significantly less training than some of the professionals interviewed in this study, it is noted that she refers to feeling "pity" for them – as opposed to empathy. However, she does communicate a real empathic understanding that the adolescents who end up in this situation in hospital are there because they have been struggling to cope with their lives. She goes on to explain that she attempts some form of lay counselling where she tries to explore their reasons for attempting suicide. She also urges them to not try attempting suicide again, in which instance she takes on quite a prescriptive style, even negating the trigger for the suicidal incident. The latter may be significantly counter-productive from a therapeutic point of view, an aspect that she is not aware of due to her limited training and knowledge. She does, however, communicate an understanding that she is not always effective in this approach, but what is evident from this quotation, is that she is affected by seeing adolescent NFSB patients and she wants to help.

While counselling may not be an official nurse's duty, it does seem to become the nurse's problem.

N6: We are also not getting enough support from the multi-lateral, because the doctors admit the patients and the patients are brought to the ward. Now it's the nurse's responsibility. So when you call the social worker or the psychologist…sometimes they take their time. There's no matter of urgency. So we are stuck with the patient. Sometimes then the nurses have to do the counselling themselves.

This quotation painted a clear picture of the nurse's predicament. They are always with the patient in the ward. If there are emergencies, they have to manage until the relevant professional makes his/her way to the ward. This does put nurses in the position where they sometimes have to resort to fulfilling duties that they are not trained or qualified to do, such as counselling patients. This additional requirement significantly adds to the pressure that nurses already experience.

The members of the nursing focus group were honest about their need for more training in relation to NFSB patient care:

I: ...Are you trained ... does it come into your training? Do you talk about suicidal behaviour in your training?

N1: We do psychology.

I: So you feel that you have enough knowledge?

All: No!!

The group was unanimous in their observation that they do not possess sufficient knowledge to nurse this unique patient group effectively.

When pressure from health care users and their families, extremely high patient throughput, duties that fall outside of the nursing scope of practice and other contextual implications are taken into consideration, it makes sense that nurses experience their work as stressful and possibly overwhelming. The next excerpt made further reference to the emotional toll of working in this medical ward:

N2: The support is not enough. It's not enough, the support.

N5: I can say…he says it's not enough…we don't have any support. We literally don't get any support. Because some of the patients become so… [difficult to hear: too much noise in the ward] ... and their families… sometimes the patients come here and you are off for a day and when you come back, the patient has demised and you ask yourself: what did I do wrong? I've been working here for a long time. Sometimes you give medication and you go to the next patient and when you come back you find that the patient is no longer, and you ask yourself: did I give the right medication? So, it's just…it's not nice…you ask yourself so many questions. So we don't get…somewhere we need debriefing.

This nurse expressed a need for support. Her reflection on patients passing away on her watch and related self-questioning implies feelings of guilt and responsibility in a situation beyond her control. What is significant is the emotional baggage that accompanies her work in this ward, which permeates her private life and has been building up over the years. She reveals an awareness of the psychological implications of her experiences and even expresses a need for debriefing – confirming her subjective experience of being traumatised.

When considering suggestions from the nursing professionals in terms of how adolescent NFSB patients may be treated more effectively, all the focus group members agreed that they need more training. More appropriate placement of NFSB adolescent patients was also mentioned repeatedly but will not be included here as it was discussed earlier.

6.3.4.2 Social workers.

Without going into too much technical detail about the social worker's role in the treatment of adolescent NFSB patients, it should be noted here that the social workers' main contribution (apart from counselling) centres around the inclusion of the family/support system in the management of NFSB.

S1: And most important, when it comes to para-suicides, especially adolescents, the involvement of the family is very important. Very, very important. With an adolescent, you are not done until you have involved the family, because they are playing a very critical support role to the patient. Even if the cause may not be directly from the family, but as a support system they are very important. Also, for parents, as well to say what happened? Why would they go to that extreme to take their lives? It becomes a problem for the parents as well. So to bring them in as well to leave with their own shock and their own emotions and experiences. That becomes very important. And then also bringing in: how did the situation get to that point for the teenager?

Not only is the support system seen as crucial to treatment of NFSB adolescents, but there is also concern for the family members and the availability of support to them.

The presence of an empathic understanding for the adolescent NFSB patient has been evident throughout the discussion of the findings. The following excerpt confirms a young social worker's feelings towards these young patients:

M: Do you feel differently about an adolescent suicide patient than you would about an adult?

S3: Okay, I don't want to get into trouble with my supervisor… [laughter] You know, for me with adolescents, mostly if it's a girl… It's like a younger sister, because I have a younger sister. So you'll be professional for 30-40 minutes, but when it really gets down, you feel like you have to be a good sister in a way. You also try to position yourself… It goes back

to when you were also an adolescent. I also try sometimes try to put myself in their shoes. So it's different than with an adult, because this is someone that can still be turned around. You can still empower them, give them skills… Sort of open their mind in a way. So for me it's totally different, I wouldn't lie.

This 26-year-old social worker comments that she hopes her supervisor will forgive her for acknowledging how close to her heart some of the female adolescent NFSB patients are. She identifies with them since she also recently experienced adolescence and the related challenges. And the fact that she has a younger sister may introduce a personal element of caring. She comments on the prognosis in stating that they are still young and can still be guided to a different path.

Other indications of social workers' empathic views and experiences of adolescent NFSB are scattered throughout this discussion.

The following quotations indicate some of the challenges that social workers face in the effective treatment of NFSB adolescents:

M: So when you think about the adolescents that are admitted here… What are the challenges that you face in terms of the treatment that you provide for them?

S1: For me the big one is time. Sometimes I feel that there are big issues that cannot be dealt with within the time that we have to deal with the suicide. And they should be in therapy for some time, so that they can work all these things through. Because sometimes I feel…yes, you will empower the person for that time. But for others, you need that time, so that you will be able to properly monitor and follow up and see what is happening. So time for me is the big one. And we don't have, unfortunately, enough resources in the community so that we can say okay, I can refer this person to this organisation and they would be able to get the on-going assistance that they need.

Here the issue of insufficient time to conduct proper counselling is introduced. He also mentions that the community resources are not always in place to allow the hospital social worker to refer the patient to counselling services when they get home. This issue of time came up repeatedly in the social worker transcripts:

S3: I think in addition to what she has just said… For me the biggest challenge, and every time it's a challenge with para-suicide patients and particularly adolescents as well… Is the

fact that…they are treating social workers as discharge agents. And it becomes a problem, because here you are as a professional. You want to provide a valuable service. Just like the doctor has done with the patient. Because you have to assess the patient, provide intervention and then also do a risk assessment. And before you discharge that patient, there are things that still have to unfold before that and you might need a day. But the patient will come to you, telling you that I'm going home… Yes. So it affects the atmosphere. Because when they come into your office, you were going to do an assessment, but before you even start… "Am I going home?" "I'm discharged. I've been told I'm going home." And they'll go to a point of saying that even in my file, it's written: discharge via social worker… But this problem…it won't end, because in future this person will come back as a re-admission, because in the first place… the issue was not resolved.

This social worker makes reference to the fact that she is put in an impossible position when the patient, who does not want to be in hospital in the first place, is sent to her with the message that she has to see the social worker in order to be discharged. Under these circumstances the social worker is hardly in a position to do a proper risk assessment and intervention, the patient is discharged before anything is resolved and this inevitably results in re-admission for the same reason at a later date. This issue was reiterated by the clinical psychologists.

6.3.4.3 Clinical psychologists.

When asked about the challenges that clinical psychologists face in working with NFSB adolescents in the hospital, this psychologist responded as follows:

C2: The first thing for me would be the "discharge therapy".

I: The discharge therapy?

C2: Yeah… Where you're sort of called into the ward, because they want to discharge the patient. You must quickly come and sort it out, which then does not give you enough time as a clinician to sit and assess this patient. And again, because they are adolescents…they do it for someone else and now they are here and they don't want to be here! So again, they are putting pressure on the system, they are putting pressure on you, because they want to go back home. Then you don't get to really work with them on the level that you are supposed to, which can be frustrating. On the other hand, you find yourself thinking: well, you brought yourself

here. So give me time to work with you! So it gets to that. You find that we are working against these two obstacles most of the time and once you become…firm regarding them staying so that you can do a proper assessment, then it impacts on your relationship with the patient as well. And then, on the other hand, the system wants the bed. So the sisters are frustrated because they want to see this person going and you want to see this person, so you find yourself caught in that…

She also makes reference to the pressure on the clinician to speed up the discharge process for the patient. She reflects on feeling frustrated when the situation does not allow her to use her clinical judgment and professional skills to assist the adolescent in the way that she feels is indicated. Then she goes on to mention that the adolescent NFSB patient made some attempt to end his/her life, that is why they find themselves in this hospital environment. Perhaps then they should also take responsibility and follow the necessary procedure. She does, however, consider the implications for rapport between the psychologist and her patient if the psychologist is the reason why the patient has to remain in hospital against her will. This is not conducive for therapy. She also discusses how the agendas of the different stakeholders in the hospital system are in conflict due to the place where these adolescent NFSB patients are kept: beds are needed for patients that are physically sick and keeping physiologically healthy adolescents against their will to enable psychotherapy causes frustration for the nurses. However, out-patient treatment also does not seem to be the solution:

C5: I think another challenge is for them to follow up. [Agreement] So, most of them don't come back for individual follow-up, because they don't consider it to be a primary health care issue, as compared to being in hospital…

This quotation links with the previous one. If the patient insists on being discharged for numerous good reasons, one solution would be to continue with individual psychotherapy on an out-patient basis, which is a service provided at this hospital. However, in practice the follow-up rates are disappointingly low. This psychologist was of the opinion that adolescents choose not to follow up with the psychologist, because their physical health is not under threat. As the focus group discussion on a lack of interest from patients to follow up on psychotherapy progressed, some focus group members seemed to experience NFSB adolescents as feeling that it is not necessary.

C6: …and again you find that we identify issues that need psychological attention. After bringing that insight, the ball is in their court to follow up. Some of them will follow up and some won't. Regardless of their financial state of affairs. For some, they just don't see the need to follow up and think that they will cope by themselves, whatever the case might be. But it's more that after we have imparted that insight in them, then they would have to decide if they follow up or not. And most of them don't if they feel that you know what…we will be fine…

Part of the discussion centred on whether financial constraints might be a reason why patients do not come back for follow-up, but the members of this focus group felt that if the patient acknowledged the need to be in therapy, they and/or their family members would find a way to access follow-up psychotherapy. It seems that NFSB patients often do not acknowledge the extent of the psychological turmoil that led to the suicide attempt in the first place. This is a topic that has surfaced earlier in this discussion: the apparently superficial reason for the attempt. The following psychologist refers to these hidden psychological matters that should form the focal area of the clinical psychological intervention:

C5: And for me…it's… always be on a position of I want to know… Like I'm trying to find out more. Especially if they present with what seems to be superficial. Like they are giving me surface layers and I find it hard to connect with them so that we can even go deeper. So that has been the challenge and I always find it interesting that until I can actually connect with them so that they can trust me to go to a deeper level, that in itself, the experience itself always makes it worthwhile.

He reflects on the challenge of finding a way to make that connection with another person, to establish the rapport that can enable the psychotherapeutic process to progress to a deeper level and considers how meaningful psychotherapy of this nature can be, even for the therapist.

When considering the clinical psychologist's modus operandi in the treatment of NFSB adolescent patients, reference was made during the focus group discussion to the possibility that the lay counselling attempts from nurses – as discussed in the previous section – may be detrimental to the clinical psychology treatment process:

C6: And in most cases you will find that they have some kind of a contact with the nurses, because they talk to them and they talk to the doctors and then they provide some sort of an

advice, you know… Sometimes they will yell at the patient or they will give some advice to the patient and sometimes that can be a deterring factor for the patient in terms of how serious does he/she view the condition. Regardless of the insight of therapy you provide for them.

This brings the discussion back to the lay counselling task that nurses attempt to perform. While the nurse may aim to normalise experiences and motivate adolescents to change their coping styles, clinical psychologists aim to explore and seek insight into the underlying psychological material that contributes to suicidality before considering management thereof. In this instance, conflicting professional goals may actually be detrimental to the treatment input that adolescents receive.

Despite their sophisticated level of insight into the psychological reality of NFSB adolescent patients, clinical psychologists are not immune to some of the irritations reported by other health care professionals who work with NFSB patients:

C6: Sometimes it's frustrating, sometimes it's exciting, sometimes it…it makes you wonder, and it leads [you] to introspect. Frustration in the sense that, you know, as the intent is not… You find them committing suicide is somewhat…not worthy of taking your own life. So in that case, it's more on… You know, why would you take your life over such a petty thing, you know? Then it's frustrating based on that. And exciting on the level that sometimes there are issues, you know maybe psycho-social or financial issues that are happening at home, that maybe the patient finds him/herself not having other ways of dealing with the situation. So therefore they resort…[to] taking one's life. Then you go through that process as well, of which leads to possible long-term therapy with the patient.

In addition to this reference to possible frustration with the apparently superficial reason for the suicide attempt, other psychologists reported other contextual factors that might be contributing to feelings of frustration with the high numbers of NFSB referrals:

C3: For me…I think that initially I was at the irritation and I was just tired of seeing para-suicides…

I: Can I just ask you: was this after doing it for a long time?

C3: Well, after internship and community service, I was okay. Well, I think after internship. But then I came to a different understanding in 'commserv', where I stopped looking at what they were giving me and I started digging into the under-things…

This quotation shed some light on the clinician's contextual challenges that may influence their empathy levels when it comes to NFSB. As intern clinical psychologists, clinicians deal with high numbers of NFSB patients during a time when they are still in training and they are personally under a lot of pressure. When this clinician reports that she started seeing the NFSB differently after completing her internship and starting to understand that she needs to look at the underlying symptomatology, there is an implication that professional experience may equip the clinician with a deeper understanding and possibly more empathy.

6.3.4.4 Medical doctors.

While the medical doctors' role is to manage any physiological problems, the nature of NFSB admissions nonetheless necessitates that they give consideration to the possible existence of psychological issues.

D2: ...but in family medicine we stabilise them in casualty. If there's any electrolyte abnormalities or any side-effects of the treatment that the patient overdosed on, you need to stabilise that and treat the side-effects of the medication or the substance they took. And also, I think, you need to establish the reason why they took what they took. The reason for the para-suicide. And definitely to refer to a social worker, a clinical psychologist and if needed a psychiatrist, if you expect any psychiatric diagnosis. And not to discharge them unless all the aspects have been addressed: the social issues, the psychological issues. And then to educate the patient on the para-suicide to prevent any more para-suicides.

This young intern doctor provided an accurate summary of the treatment protocol of medical professionals in the case of NFSB. While she did not have extensive experience in this area, it was clear that she has been briefed and understood what was required.

When keeping the medical doctors' work schedule in mind, working conditions may at times contribute to lower levels of patience.

D1: So it means if you're on call, you start the day normally and then at 16h30 you just continue to work until the next day at 12h00. Like today I am here until 12h00, because I was working through the night at casualty. And then on weekends, you start at 08h00 and then you work until the following day at 08h00.

M: But you seem very awake for someone who worked through the night…

D1: Yeah! You get used to that, yeah. So I do understand that some doctors get very frustrated with para-suicides who attempt suicide in the early hours of the night. But it's usually at night when they try, because they can't sleep. I mean, they are depressed, they can't sleep…

This doctor reflected on how empathy for NFSB patients may be limited at certain times of the night when on-call medical professionals may be tired. Again, this statement highlights the fact that personal experiences from the professional's point of view have an impact on the treatment of this patient population.

When considering how the medical doctors experience NFSB on a personal level, similar statements to the other professional groups were recorded.

D4: Okay, on a personal level… I'm not… Okay, you try to not judge the person, because you don't know their circumstance. But obviously, sometimes, you close your mind and why? Why would she do that, you know? But you try not to put any pressure on the person, because at the end of the day it's her choice, so… You can't really know what is happening in her life, why did she do that. So because you don't want to cause more trauma to the patient, it's better to stick to what you know best, which is the clinical. Maybe wanting to help with emotional stuff, you could cause more trauma. So for me personally, I want to stick to the clinical.

This doctor confirmed her point of view that one should not judge others if one does not know what they are struggling with, yet she acknowledged that is it only human to wonder about the occurrence of NFSB, to have questions about why people resort to that. Still, she goes back to her non-judgemental position, honouring the individual's right to make her own decisions about her life. It is also significant to note her insight that digging around in psychological matters without being trained to do so could cause more harm. Therefore, she sticks to her scope of practice.

The following clipping shed some light on a medical doctor's struggle to withhold judgment in the case of NFSB patients.

D1: I don't think it's our place to judge an individual for trying to commit suicide. But I must say, in some instances you feel a bit on the edge, almost on the brink of starting to judge

the individual. I mean, you see cases where the person tried to commit suicide over a minor thing. But they don't divulge the bigger picture until afterwards, so I think it's important for us not to judge, because there is usually a bigger picture behind that. It's like the iceberg effect: you only see the tip, but usually there is something huge going on… Crying out for help or something.

While he acknowledged that seemingly trivial reasons for a suicide attempt may cause frustration, the insight that the trivial reason is only the tip of an iceberg, is what enables him to contain his judgment and remain empathic. In addition to possible frustration in relation to the reason for the suicide attempt, it is also a fact that the medical doctors in this medical ward are under tremendous pressure to provide care to critically ill patients – their main focus of work. This might limit the time they have available to NFSB patients.

D2: I think we are dealing with all these sick patients in the ward and a lot of our attention goes to them and their treatment. And I think with the para-suicide, we tend to feel that it's another person's problem afterwards. Like you stabilise the patient, that's your primary function, but then we tend to shift social and psychological issues to the clinical psychologist and the social worker to sort that out. So the attention and the time that we put into the other sick patients…I don't think it's the same as the attention and time we give to the para-suicide patients. Which is not…fair to them.

This young doctor reflected on the fact that she spends less time on the NFSB patient due to her medical work requirements and expresses her opinion that this is not fair to the NFSB patient. This re-introduces the responsibility of medical management of patients, which leaves little time for emotional support, which is then referred – appropriately so. This excerpt implies the possibility that she may feel guilty for not providing more attention to her NFSB patients, which does not seem fair when considering the extent of her medical responsibilities. This highlights another subjective experience from a health care provider in the context of NFSB treatment, which is guilt for a perception of not providing what is needed.

While the matter of inappropriate placement will not be revisited here, it should be noted that all the doctors made recommendations around more accurate placement, more time for psychotherapy/counselling and a more focused intervention for NFSB patients.

D3: Yes. Especially if you were to have a team that is going to look at para-suicide. That's why I think it would make more sense on psychiatry's side, because on Medical you don't have time. It would really help if we had a certain team working with them and trying to minimise the recurrence. Because with some of these patients… You can treat them, but along the way they don't get enough or sufficient treatment…they try again and some will even be successful. So yes, if there were a team that would follow their rehabilitation all the way until you see that now the patient is fine…

Here psychiatric placement was considered to provide an optimal placement option. The doctor reiterates the importance of spending enough time to provide an efficient intervention that may reduce future suicidal behaviour.

6.4 Conclusion

This chapter started with tabled information detailing the compositions of the different focus groups. The results from the focus groups and individual medical doctor interviews were grouped under the headings of adolescence, NFSB-related experiences, patient and hospital-related aspects and experiences of the different professional groups.

Under Adolescence, the focus group members referred to different adolescent developmental period-related challenges, such as peer group pressure, parent-child conflict, behavioural problems, a search for identity and impulsivity – especially in relation to the suicide attempt. There was also mention of the fact that that adolescents may find it difficult to express their needs, which could culminate in a suicide attempt. Empathic reflections on the unexpectedness and unpredictable nature of adolescent NFSB were considered.

In terms of NFSB, the focus group members made reference to the high numbers, the fact that more female adolescents seem to be admitted for this reason and that the method is mainly ingestion of toxins or medication. The apparent superficial reasons for attempts came up repeatedly, as well as the health care providers' understandings that there is more to the suicide attempt than the impulsive trigger that they often present with. Opinions were raised that suicidal behaviour was perceived as a cry for help or a need to escape overwhelming circumstances. Socio-political implications in relation to suicidal behaviour were cited, as well

as a lack of support and other difficulties. The perception that depressive features are not always present in NFSB presentations was noted. Attention was given to the consequences of the attempt for the adolescent. Then the focus was moved to the health care sector and different experiences related to views that health care workers do not always take NFSB seriously and may stigmatise or judge this patient population. Awareness that such feelings of annoyance may impact adolescent health care users and their cooperation in their treatment was also acknowledged. However, empathy from health care workers was also evident, confirming that the existence of different truths.

Under patient and hospital-related matters, the issue of placement was the main concern. The discussion touched on the health risks related to placement in a medical ward, as well as the problematic use of face masks. The health care workers offered recommendations in this regard.

When considering information related to the specific specialist categories, the following themes were evident:

Nursing: Nurses experience a wide range of challenges in their work context, including perceptions of being blamed and harassed. Their feelings regarding NFSB among adolescents vary from empathy to sympathy and frustration. There was some reference to nurses finding themselves in positions where they had to do counselling, which they are not qualified to do. They concluded that they need training, emotional support and a more efficient treatment protocol for adolescent NFSB patients.

Social Workers: The point was made that their main contribution with NFSB adolescents is involvement of the family. Their empathy and/or sympathy for the patients were considered, as well as time pressures in the treatment of this patient population.

Clinical Psychologists: Again, the concern around premature discharge came up. Psychologists' challenges in establishing rapport were considered. While a clear understanding for the severity of some of the adolescent NFSB patients' difficulties was demonstrated, lingering feelings of annoyance were also acknowledged. The problem that adolescent NFSB patients rarely follow up for out-patient follow-up was considered.

Medical Doctors: It was clear that the medical doctors also acknowledge psychological challenges in NFSB patients and they revealed an empathic understanding for factors contributing to suicidality. Feelings of frustration in relation to NFSB adolescents were also acknowledged, as well as work pressure and other challenges.

From these results it was evident that while there are elements related to the treatment of adolescent NFSB patients that the different health care providers have in common, every health

care practitioner has his/her own context in which they experience this phenomenon, which ultimately has implications for their interventions.

In the next chapter the findings from these data sets will be incorporated in a final discussion.

Chapter 7 – Discussion and Conclusions

7.1 Introduction

This section will aim to draw together all the different sources of data in the hermeneutic circle. This will be achieved by combining the participants' personal information and stories, the researcher's observations and existing literature.

This study resulted in a wealth of information and themes, which were clustered in order to allow the identification of convergence among the different data sets, but also specific significant idiosyncrasies. The following section is a discussion of themes that were significant to the focus of the study, but also carry a rich evidentiary base from the data sets.

7.2 Themes

The themes that will be focused on are

1. Placement
2. Impulsivity
3. Intent
4. Judgment
5. Nursing and NFSB adolescents

7.2.1 Placement: 'Just send me home…' 'I feel like I'm in the wrong place at the wrong time'

Table 7

Codes and sub-codes relevant to the discussion of Placement

Code	Sub-Code	Count
CP	NFSB challenges	13
Hospital	Face mask	5
Hospital	Placement	16
Hospital	Psychiatry	1
Observation	Entitled to care	1
Observation	Not depression	1
Observation	Not taken seriously	4
Observation	Patient open to assistance	3
Observation	Patient wants to go home	4
Health care experience	Counselling helpful	10
Health care experience	Doctors	9
Health care experience	Feels judged	2
Health care experience	Medical treatment	11
Health care experience	Nurses' attitudes	9
Health care experience	Psychologist	5
Health care experience	Recommendation to talk to them	1
Health care experience	Social worker	4
Health care experience	Suffering in silence	1
Health care experience	Very short hospital stay	3
Placement	Face masks	5
Placement	Hospital helped	7
Placement	No interaction	3
Placement	Patients here are sick	8
Placement	Relief to leave hospital	3
Placement	Hospital space is unpleasant	9

7.2.1.1 Placement with adult patients.

In the hospital where this study was conducted, NFSB patients who are not critically injured are admitted to an adult medical ward, regardless of their age. One thirteen-year-old adolescent participant reflected on feeling out of place, as well as her related need to leave the hospital context. A fifteen-year-old participant had a similar experience and mentioned her feelings of loneliness in the absence of peer interaction, or at least someone to talk to. She also expressed the related need to go home. It is widely noted that developmental differences unique to the adolescent population are not always considered in the provision of health care to adolescents (Sawyer et al., 2014). One such need, for example, is an adolescent's wish for contact with their peer group (Crossen, 2017).

Adolescent patients seem to be falling through the cracks of the current hospital system. On one hand, findings from this study indicate that placement among adults may not be optimal to create a comfortable healing space. Although placement of adolescents in adult wards is not uncommon, no existing South African publications reporting on NFSB adolescents' experience of admission to an adult medical ward were found at the time of compiling this report. When considering paediatric placement, on the other hand, concerns of inappropriate placement are also raised. In lieu of South African accounts, the option of paediatric placement could only be assessed through European literature. In the United Kingdom, for example, the treatment protocol for self-harm patients under the age of 16 years is to be admitted to a paediatric ward where the patient can safely be assessed the next day (National Institute for Clinical Excellence, 2004). While this is the prescribed guideline, the inappropriateness of placing NFSB patients in a paediatric ward is documented in relation to the reasons that paediatric staff are not trained in mental health, the ward is too busy and the work load too demanding to provide meaningful interventions to this patient population (Fischer & Foster, 2016). It has also been recorded that paediatric treatment contexts are not equipped to contain self-harm behaviour, and other vulnerable children in the ward may be placed at risk (Royal College of Psychiatrists, 2015). In addition, the process of transfer from a paediatric to an adult treatment context due to chronological age introduced different problems, as was noted in a Swedish study (Idenfors et al., 2015). Here the movement of patients resulted in refusal of treatment due to a feeling that their needs were considered less important than administrative processes.

Recent years have seen an increasing awareness in health care literature that the adolescent health care user has been neglected (Patton, Sawyer, Ross, et al., 2016), and even at times subjected to extremely unfavourable experiences in in-patient health care contexts

(Royal College of Psychiatrists, 2015). This neglect has been evident in more modest monetary investments in adolescent health programs and a more limited focus on adolescent needs in the training of health care providers, which has resulted in an insufficient understanding of adolescent health care needs and the related inadequate provision of resources (Patton, Sawyer, Santelli, et al., 2016). In reaction to the identified neglect of adolescent health care needs, the World Health Organization (WHO) identified global standards aimed at the improvement of adolescent health care (Nair et al., 2015). However, to date the international progress on improvement of health care services to adolescents remains insufficient (Coles & Greenberg, 2017; Patton & Borschmann, 2017; Patton, Sawyer, Santelli, et al., 2016). When considering the very limited literature on adolescent health care in the South African context, reports are focused largely on the Department of Health's identified risk areas, such as maternal health and HIV/AIDS in the community health setting (Geary, Webb, Clarke & Norris, 2015). A South African study focusing on young clinic health care users concluded that the throughput numbers of adolescent NFSB patient are too low, and the space and facilities too limited, to justify their own confidential youth-friendly space (Geary et al., 2015).

When these challenges are considered, it does not appear that the WHO's global standard for improvement of adolescent health care number 5 (Nair et al., 2015), which requires adolescent-friendly facility characteristics, has been sufficiently executed. While attempts at improvement have been initiated, they have not been widely implemented, and the adolescent patient's displacement within the current study context, as well as the wider health system, remains clear.

7.2.1.2 Placement with critically ill patients.

Adolescent participants in this study made reference to the seriousness of some of the physical conditions they witnessed in the medical ward where they were admitted following NFSB and expressed their discomfort and helplessness at having to observe intense physical suffering. One participant recalled people dying, being unable to walk and coughing up blood. This was reiterated by a nurse participant who confirmed that people demise in the ward under discussion and that the nursing staff are not always in a position to protect adolescent patients from witnessing such disconcerting events. This nurse's protectiveness towards the adolescent patient indicated an empathic awareness that the context is not beneficial, yet she seemed unable to do anything about it owing to the physical realities of her working environment. A doctor participant made reference to the fact that NFSB adolescents are grappling with their

own mental health emergencies, yet they are put in a position where they have to witness others fighting for their lives, and he shared his insight that this cannot be conducive to their psychological healing.

The realities of placement in a medical ward and the potentially negative impact thereof on the adolescent patient have been recorded with a focus on chronic physical diseases (Barling, Stevens & Davies, 2014). While the practice of admitting NFSB patients to a medical ward is reflected in other institutions across the globe (Carroll et al., 2016; Steeg et al., 2018), literature on how such placement is experienced by patients is hard to come by. What has been established is that the impact of NFSB admission to medical wards requires further investigation, especially in absence of confirmation that such admission reduces the risk of repeated self-harm behaviour (Carroll et al., 2016). The latter may be partly explained by the fact that medical treatment contexts may successfully treat the physical injury, but the suicidal behaviour itself is not directly attended to (Tynan, 2013). Of course, this manifestation seems applicable to the medical treatment context.

Some of the clinical psychology focus group participants were of the opinion that NFSB patients should be admitted to a psychiatric ward, where the focus of intervention would be their mental health, regardless of the presence of a psychiatric disorder. However, this does not seem to be an ideal solution, and health care providers' views of NFSB patient treatment in addition to the diagnostic debate are addressed elsewhere in this document. From the patient's point of view, placement of NFSB patients in a psychiatric setting may be experienced as stigmatising and detrimental to their mental health (Bantjies et al., 2016). This negative experience of a psychiatric in-patient context was confirmed in other studies, with specific concerns related to potential contagion of suicidality that has been identified in adolescent patients (Carroll et al., 2016; Shilubane et al., 2014).

7.2.1.3 Danger of contracting contagious diseases.

A significant aspect which relates to the discussion of this specific medical ward is the danger of contracting contagious diseases. The medical ward where the adolescent NFSB patients are kept is an adult medical ward where a range of contagious diseases such as tuberculosis are treated. One doctor participant estimated that at any given time about half of the patients in the ward are presenting with tuberculosis at various stages, stressing the health risks for patients and staff who enter the ward. He noted that such patients should be isolated, but physical logistical constraints often make this impossible. Owing to the highly contagious

nature of such diseases, staff members working in the ward wear face masks to protect themselves. While one nurse participant indicated that patients who are coughing are offered masks and reportedly refuse to wear them, no other data sets confirmed this protocol. It should be noted here that the researcher has never seen patients in the ward wearing masks. This health risk for NFSB in-patients has not been recorded in existing literature.

From the adolescent interviews, the participants' awareness and concerns over this health risk was clear. One seventeen-year-old participant shared her perception that she is the "…only one in the ward who is not coughing". She worked out for herself that there must be contagious diseases such as tuberculosis in the ward, posing physical danger. Her suspicions were, however, not discussed with health care staff, nor did she receive related information from them. She expressed her concern that her immune system is already compromised and disclosed to her health care providers, leaving her with the perception that staff members in the ward do not really care about her well-being. One of the doctor participants noted at a general level that compromised immune systems are in even more danger in this ward, suggesting an awareness and empathic concern. However, these concerns are not openly expressed, and a wide range of resource restrictions and health care policy deficits may contribute to his silence. Another 17-year-old participant expressed her suspicion that she may have to be tested for tuberculosis, even though this was not suggested by a medical professional. Two central elements are clear from these responses. One, these adolescents are informed and intelligent enough to come to their own understanding of the implications of what is happening around them, even though the health care workers do not discuss risks or provide protective solutions. This is an issue that is addressed in global attempts to make health care more youth-friendly: adolescents' abilities and rights to receive information about their health care and to give input into what their needs are, resulting in a voice for adolescent health care users (Nair et al., 2015; Patton et al., 2016). This report clearly illustrates the adolescents' ability to understand and advise a health care system that is currently failing them. The second element is the threat that the NFSB adolescent patient may now have an added health concern to deal with in addition to the lingering crisis that brought her to hospital in the first place.

7.2.1.4 A short hospital stay and the implications thereof.

In a situation where patients feel out of place, where staff members are perceived to not care about their health and they may be in danger of contracting physical diseases, it makes sense that they would want to leave the hospital context as quickly as possible. Apart from

adolescent participants clearly communicating the need to leave the hospital during the individual interviews, the possibility of downplaying psychological difficulties, which leads to premature discharge, is also a strong possibility. It is therefore debatable whether the number of adolescent participants' reports of a sudden significant improvement of mood and related absence of suicidality were truthful or manipulating health care workers in an attempt to accelerate discharge. This phenomenon was echoed in a Swedish study considering young people's experiences of professional care after self-harming incidents, where participants disclosed their pretence that they are doing well in order to ensure earlier discharge (Idenfors et al., 2015).

From the health care worker's perspective, doctors and nurses are also in favour of adolescent NFSB patients leaving as quickly as possible. On a practical level, they need beds to admit enormous numbers of seriously ill health care users who are waiting to receive care. However, on a more empathic and possibly disempowered level, they are aware of the physical dangers of adolescents staying in the ward for longer than they need to be there.

This procedure of a short hospital stay, mostly one or two nights in hospital, is typical to adolescent NFSB patients admitted to this hospital. The incidence of short hospitalisations mainly to stabilise especially young NFSB patients is reported to be on the increase in other organisations as well, although possibly for different reasons (Hughes & Asarnow, 2013). It has been noted that when patients express remorse in relation to the suicide attempt and undertake not to repeat the behaviour, they qualify for discharge (Tynan, 2013). Such short stabilising hospitalisations are extremely expensive in terms of various resources and yet not proven effective in terms reducing further suicidality (Carroll et al., 2016; Hughes & Asarnow, 2013; Tynan, 2013).

Short hospitalisations have implications for the mental health element of the treatment. Different adolescent participants commented on the relief of being able to verbalise their difficulties, with specific reference to the value of receiving professional counselling from social workers and clinical psychologists during their hospital stay. Indeed, existing literature documents the possible openness to interventions at the point where an adolescent is admitted to hospital for NFSB, due to a more realistic appreciation of risk and other forms of insight that are related to the suicidal incident (O'Connor et al., 2015). In addition to an adolescent's possible receptiveness to therapeutic engagement, focus group members also mentioned that the shock of the suicide attempt has the potential to bring family members together with a willingness to address relationship problems. The family's openness to therapeutic intervention is also recorded elsewhere (Patton & Borschmann, 2017).

From both the social work and clinical psychology focus groups, the clear message was communicated that proper therapeutic engagement is not possible due to the quick discharge procedure that takes place. From the previous discussion, it is understandable that both NFSB adolescent patients and their physical health care providers agree that as soon as the physical concerns are resolved, the patient should leave the system. However, later in this discussion the focus will be on the probable depth or extent of social and/or psychological problems that may lead an adolescent to the point of attempting suicide. This aspect requires significant input from clinical psychologists and social workers: something that is not enabled by the current system.

This is of great concern when considering the extremely low out-patient follow-up rates as discussed in the clinical psychology focus group session. Whatever the reasons might be for the lack of adherence to out-patient follow-up treatment, this notorious tendency is widely recorded (Costemale-Lacoste et al., 2017; Patton & Borschmann, 2017; Pillay, Wassenaar & Kramers, 2004). The risk of future suicide attempts and other psychosocial difficulties ultimately remains unresolved (Beckman et al., 2018; Borschmann et al., 2017; James et al., 2017; World Health Organization, 2018c).

7.2.1.5 Conclusion.

Under the theme of placement, difficulties in relation to placement among adult patients who are critically ill, as well as exposure to contagious diseases, were considered. The resultant short stay in hospital was also discussed, as well as the implications of an accelerated discharge process.

What emerged from this discussion was that the current placement procedure for adolescent NFSB patients in this hospital is not optimal for any of the stakeholders. Doctors and nurses are under pressure to discharge, while clinical psychologists and social workers are not allowed time to conduct an efficient intervention. NFSB adolescent patients ultimately leave the system without addressing the cause of suicidality, which may imply continued risk of suicide.

7.2.2 Impulsivity: 'So I felt like the only solution was to find a way out and at that time, it made sense to just die.'

Table 8

Codes and sub-codes relevant to the discussion of Impulsivity

Code	Sub-Code	Count
Adolescence	Impulsivity	28

Note: the sub-ordinate themes included under this section were all clustered under impulsivity or adolescence, therefore there was no variation of different themes.

7.2.2.1 Lack of planning.

The apparently impulsive nature of what is perceived to be the case in most of the adolescent suicide attempts that are seen in the hospital came up repeatedly in different health care provider discussions. Close readings of the adolescent transcripts also provided evidence of impulsive elements to the suicidal acts. Some of the adolescent participants were not able to report what kind of medication or how many they had taken, illustrating the intense, rushed and uncalculated nature of the suicidal act. For example, one participant reported a sudden, intrusive thought that her family does not care, prompting her to take the first tablets she could find. Upon inquiry, she could not identify what she had taken. Later on when the interviewer inquired about the presence of prior suicidal ideation, she made it clear that this was her first thought of attempting to end her life. Another participant relayed her story of a conflict situation where she felt overwhelmed and suddenly decided to drink paraffin. On further investigation she clearly stated that the option of suicide had not entered her thoughts before this day, although the abuse and conflict that triggered it had been present for a while. In both these instances the adolescents had been grappling with challenges for a while, leading to an episode of overwhelming emotions that triggered impulsive decisions to attempt suicide.

One South African study on youth risk behaviour reported that there seems to be an increase in impulsive self-harm acts, arguing for a unique subcategory of adolescent self-harm behaviour that nonetheless still had the potential to progress to lethal suicidal attempts (Shilubane et al., 2013). In these cases, it was noted that the adolescent does not report suicidal ideation or even planning of the suicidal act beforehand, which was also evident in the current

study. The connection between self-harm behaviour and impulsivity has been noted in relation to a short space of time between initial thoughts of suicide and actually going through with it (Stanford et al., 2017).

In relation to comments on the often impulsive nature of the suicidal acts, health care participants also observed a paucity in considering alternative, more constructive ways to manage the current crisis. Additionally, a lack of consideration of the possible dangers of ingesting toxins or unknown medication also came up in focus group discussions. Indeed, some authors argue that the presence of impulsivity may even facilitate the self-harm process, because less attention is given to possibly harmful consequences or consideration of more constructive coping mechanisms (Stanford, Jones & Hudson, 2017).

7.2.2.2 Neurological explanation for adolescent impulsivity.

Different neurological explanations for adolescent impulsivity exist and these theories are constantly evolving. One clarification makes reference to an imbalance caused by an immature cognitive command system coupled with vehement desires to experience new things, which ultimately leads to increased risk-taking behaviours in the adolescent phase (Steinberg & Chein, 2015). While the adolescent may be programmed to seek excitement, the ability to inhibit inappropriate desires continues to develop well into adulthood (Borschmann et al., 2017). Possibly in relation to this, it is also recorded that the adolescent may rely more on emotions than on reason when making decisions – especially when the accompanying emotions are experienced as intense (Patton, Sawyer, Santelli, et al., 2016). It has also been confirmed that impulsivity associated with a reduced appreciation of the possible consequences appears to be typical to adolescence in general (Romer et al., 2017). The latter explanations are evident in the participant examples above.

While the current study focused on the psychological variables associated with adolescent suicidal behaviour, acknowledgement of relevant existing neurological literature is important due to its possible implications for treatment.

7.2.2.3 Unexpected by significant others.

On a related note, the suicide attempt may be experienced as unexpected by the adolescent's significant others. Although parents were not interviewed in the current study, it was significant to note this observation from the health care provider focus groups. One male

social worker, who is also a father, shared his experience of how a suicide attempt may seem unanticipated in an adolescent who has mood swings and often appears unhappy. Fluctuating moods are after all a common element in the adolescent developmental stage. This was reiterated by another social worker who has an adolescent child herself. She commented on the typical adolescent behaviour of spending time in their room by themselves and pointed out that no parent would equate that to signs of suicidal ideation. Two central elements are clear from these remarks. The first is that the turbulent emotional nature of the adolescent developmental period makes it very hard to identify signs of suicidality, possibly dangerous impulsivity or mental health concerns, which is confirmed in publications elsewhere (Paruk & Karim, 2016). The second is that health care providers are people and parents too, which may have significant implications for their professional experience of an adolescent NFSB patient.

7.2.2.4 Conclusion.

The theme of impulsivity is evident in suicide attempts that are not planned. The neurological implications associated with the adolescent development period were considered, as well as the unexpectedness of suicidality to significant others.

What crystallises from this discussion is that the nature of the adolescent developmental stage may complicate the process of picking up warning signs for suicidality, which has implications for adolescent suicide risk and the management thereof. The understanding that health care providers' personal views and experiences have implications for working with adolescent NFSB patients also emerged.

7.2.3. Intent: "I thought of dying. There is nothing to live for in this world. I thought maybe it was a mistake that I was born…"

Table 9

Codes and sub-codes relevant to the discussion of Intent

Code	Sub-Code	Count
Adolescence	Avoidance	3
Adolescence	Caregiver abusing substances	1
Adolescence	Health	2

Adolescence	Hoping the problem will go away	2
Adolescence	Impulsivity	11
Adolescence	Lack of support	4
Adolescence	Left school	2
Adolescence	Long-standing relationship problems	10
Adolescence	Peer pressure	3
Adolescence	Self-blame	2
Adolescence	Socio-political	9
Adolescence	Substances	2
Consequences	Access to material needs	1
Consequences	Family concerned	4
Consequences	Family confused	2
Consequences	Family gives confirmation	2
Consequences	Family showing support	4
Consequences	Guilt	1
Consequences	Safety restored	2
Depressive symptoms	Burden	1
Depressive symptoms	History of low mood	7
Depressive symptoms	Isolates self	8
Depressive symptoms	Loss	3
Depressive symptoms	Previous suicidal ideation	8
Depressive symptoms	Rumination	6
Depressive symptoms	Sadness	9
Feelings re attempt	Still suicidal	3
History of attempts	Attempt was a secret	3
History of attempts	First attempt	7
History of attempts	Second attempt	6
Intention	Asking for help	4
Intention	Longing to be dead at point of ingestion	15

Intention	Looking for attention	1
Intention	Need to escape	3
Method of attempt	Ingestion of toxin	3
Method of attempt	Overdose	15
Observation	Consequences	8
Observation	Not depression	1
Observation	Reason for attempt	17
Response	Cry for help	21
Victimization	Physical abuse	7
Victimization	Sexual abuse	1
Victimization	Verbal abuse	8

7.2.3.1 Definition.

Current suicide-related nomenclature can cause confusion, as discussed in Chapter 2. *Self-harm* is considered an umbrella term that includes non-suicidal self-injury (NSSI) and suicidal self-injury (SSI), which are two completely different phenomena, requiring different health care interventions (Iemmi et al., 2016). The current study, therefore, used non-fatal suicidal behaviour (NFSB) as the working definition to indicate suicidal self-injury with or without an intent to die (Ougrin et al., 2015; Schlebusch, 2005). The extent of this intent poses significant implications for the adolescent who attempted suicide, as well as the treatment context, and as such deserves closer attention.

7.2.3.2 Aetiology of suicidality.

When considering intent to die, the aetiology of the suicidal behaviour becomes important. Participants in the current study reported long-standing relationship problems, emotional isolation, academic pressure, hard work/unreasonable chores at home and financial problems in relation to their intent to bring an end to their suffering. A number of factors that are perceived to contribute to suicidality also surfaced in the health worker focus groups. One nurse participant commented on the intensity of some of the problems that adolescent NFSB

patients present with, with specific mention of child-headed families, medical conditions, sexual assault and other past traumas. Other contributing risk factors mentioned by the focus group members include low self-esteem, anxiety, problematic family dynamics and other relationship problems. Doctors mentioned academic pressures, social isolation and absent parents. Literature confirms these multifactorial aetiological factors that may be related to structural vulnerability, problematic interactions and poor coping mechanisms among others (Bruwer et al., 2014; Cluver, Orkin, Boyes & Sherr, 2015; Schlebusch, 2012). For the purpose of this discussion, the emerging aetiological themes of socio-political vulnerability, exposure to violence or abuse and the question around the presence of a mental disorder will be considered more closely.

a) Socio-political challenges/structural vulnerability. Overwhelming socio-political constraints that contributed to suicidal ideation were certainly present in the current study. One young male social worker shared the story of a young girl who drank rat poison, because her mother had abandoned them and they had no food. While the theme of structural vulnerability is discussed in more detail in Chapter 2, it should be reiterated here that racial and material imbalances in post-apartheid South Africa can be complex and challenging for adolescent mental health, with Black youth often bearing the brunt of these social injustices (Das-Munshi et al., 2016).

One 21-year-old participant in this study (P4) reflected on how her domestic responsibilities, the task of looking after younger children and financial problems in her home led to her leaving school prematurely. She was unemployed and perceived her situation as completely disempowered, hopeless and helpless. Her mood was quite low during the interview and while this was her first suicide attempt, suicidal ideation had been a reality for a long time. In the post-apartheid system which focuses on correcting the injustices of the past, access to education is one of the main mechanisms of empowerment. While it is recorded that secondary education retains significant mental and cognitive health benefits for girls especially, poverty, social marginalisation and a lack of social support remain realities for some (Patton, Sawyer, Santelli, et al., 2016). In addition to these disadvantages, she also shared the loss of her mother: another childhood adversity documented as highly correlated with suicidal behaviour (Bruwer et al., 2014). When considering the level of intent, this participant made her intention to die clear, although underneath that she communicated a deep need to escape the emotional pain. It is possible that the need to escape emotional agony and a wish to be dead become indistinguishable at some stage, which has implications for her treatment.

One psychologist shared his opinion that the 'health issues' seen in hospital are most often of economic, social or political origins, leaving him as a professional powerless to intervene. Another psychologist elaborated on how the political and social systems resulted in people who have no alternative but to consider suicide, stressing associated feelings of powerlessness and desperation. A 52-year-old male psychologist also shared his experience that his own son is an adolescent and he has realised – on a deeply personal level – that social injustices and imbalances are still evident in our communities. These external social and economic determinants of health still impose barriers to the health of South Africans, including the adolescent developmental group (Mayosi & Benatar, 2014). From these findings it can be deducted that such barriers may also have implications for the health care providers themselves, possibly giving rise to feeling helpless or demoralized.

b) Violence/abuse. It is significant to note that half of the adolescent participants in the current study recalled some form of intimate or relational physical violence or abuse at some stage of their lives. These violent recollections varied from so-called discipline measures to serious assaults. One participant shared her experience of being the victim of sexual abuse. Four participants had been exposed to verbal abuse.

This high prevalence of exposure to violence is consistent with existing South African literature. One study investigating exposure to violence and possibly associated symptoms of trauma, anxiety or depression, for example, found that 84% of the adolescents participating had been exposed to some form of community violence (Stansfield et al., 2017). Indeed, violence is noted as an adverse childhood experience that is linked to suicidal behaviour in Sub-Saharan Africa, mainly due to the negative effect thereof on coping mechanisms (Cluver et al., 2015). More specifically, physical abuse is one of two most prevalent childhood adversities linked to suicidal behaviour in South Africa (Bruwer et al., 2014). The connection between physical/sexual abuse and suicidality is also recorded elsewhere (Bruffaerts et al., 2010).

c) Depression. A number of depressive symptoms were identified from the participant transcripts (P1, P2, P6, P8, P9 & P10), including a persistent low mood, social isolation, suicidal ideation and rumination. Literature widely echoes the correlation between the presence of a psychiatric condition and suicidal behaviour, with specific reference to mood disorders and depression (Isometsa, 2017; Schlebusch, 2012). In fact, some authors even go so far as to call existing psychopathology a precondition for suicidality (Isometsa, 2017). This

view is confirmed in the Diagnostic and Statistical Manual of Mental Disorders, which notes the presence of suicidal ideation and behaviour as a symptom suggestive of the presence of a depressive disorder (American Psychiatric Association, 2013). When considering the previous discussion of overwhelming problems and a related inability to cope that may contribute to the suicidal act, the lack of problem-solving abilities and focus on negative emotions that are associated with a depressive disorder can understandably play an important role in suicidal ideation (Horwitz, Hill & King, 2011).

While clinical indications of depression were picked up in some of the participant conversations, it is significant to note that most of the participants reported a complete absence of suicidal ideation or intent to die at the time of the interview. This reported absence after admission to hospital was commonly associated with regret about hurting themselves, elevated energy levels and optimistic expectations related to a second chance on life. In addition, it has been noted earlier in this discussion that some of the participants reported an absence of suicidal ideation prior to the attempt, explaining the attempt as an impulsive, uncalculated and possibly unexpected event. It can be argued that the latter aspect, together with a significant, rapid improvement of mood, is not consistent with a depressive disorder diagnosis. This introduces the question whether depression necessarily plays a central role in the majority of suicidal behaviour cases. This was confirmed by a clinical psychologist participant who commented on his experience that very few NFSB presentations that end up in hospital are actually cases of clinical depression.

A number of publications challenge this idea of a causal relation between prior psychopathology and suicidal behaviour (Bruwer et al., 2014; Curtis, 2017; Nock et al., 2009). While it is known that the presence of depression can predict suicidal ideation, knowledge is limited with regard to how mental disorders contribute to other aspects of suicidal behaviour such as planning and attempting (Sveticic & De Leo, 2012). Bantjes and Kagee (2013) take this argument further, stressing that a psychiatric diagnosis is not necessarily the cause of suicidal behaviour, as many people with psychiatric disorders do not attempt to kill themselves. A recent Australian study reported a key result that a group who was psychologically 'normal', i.e. not presenting with depression, anxiety, low self-esteem or poor coping, presented with significantly higher rates of self-harm behaviour (Stanford et al., 2017). These cases were identified as isolated NFSB incidents, while people with psychopathology engaged in more frequent self-harm. This may re-introduce the element of impulsivity and desperate intent to be heard, which could be associated with a crisis that has simply reached proportions beyond the scope of an individual's coping repertoire (World Health Organization, 2018a). This idea

was confirmed in a recent study where young people reported suicidal behaviour in reaction to overwhelming pressure, agony and a lack of support as a 'normal' response – as opposed to cases where psychopathology my also account for suicidal behaviour (Stubbing & Gibson, 2018). A recent South African study with NFSB adolescent participants noted that most of the participants did not have a prior psychiatric diagnosis (Ani et al., 2017). In fact, impulsive suicidal acts with no intent to die may not be as rare as some theorists proclaim, but rather comprise a subtype of suicidal behaviour among adolescents that is on the increase – also in South Africa (Shilubane et al., 2013).

7.2 3.3 Low or no intent to die/cry for help.

The suicide attempt may therefore merely be a desperate cry for help – a perception that surfaced repeatedly in different focus group discussions. One social worker participant in the current study viewed the NFSB as a desperate communication that their lives are falling apart, and that no-one seems to notice. A doctor participant mentioned being taught at medical school that overdoses are generally 'not serious'. On a related note he did, however, refer to the probable intensity of underlying problems, where the reason for the attempt might seem trivial, but underneath there is a long history of uncontrollable suffering and sadness. This is consistent with Schlebusch's (2012) opinion that the young person's problem-solving attempts may have failed, which was reiterated in the health care worker focus groups of the current study. A clinical psychologist participant made reference to what she perceived as a lack of constructive coping skills to efficiently manage relationship problems and intense emotions. She also viewed the impulsive NFSB act which does not consider possible consequences as a desperate need to be heard.

This combination of an inability to cope with challenges that seem to have reached a crisis stage and the subsequent cry for help may be evident in suicidal acts that consist of the ingestion of possibly harmless substances: a method of suicide that was prominent in the current adolescent participant group. In the current study population, three adolescent participants acknowledged that their suicide act was a cry for help. It is also important to note that in most of the adolescent interviews, participants reported that significant others had responded to the cry for help, providing relief for the adolescent patient. This may in part explain why most of the adolescent participants described regret for their suicidal behaviour and that the suicidality was completely resolved. This observation may also be linked to an impulsive element to the suicide act and was confirmed by adolescent participants in another

South African study, who saw their peers' suicidal behaviours as an attempt to acquire the attention of a parent or other significant other, with no intention to actually die (Shilubane et al., 2014). When considering the lower end on a spectrum of intent in NFSB, Schlebusch (2005) confirms that the suicide act may be an attempt to escape what the adolescent perceives to be intolerable mental agony, without any consideration of actual death. This is confirmed in a different publication, citing that a yearning for death may be present at the moment of overdose, yet ending one's life may not be the primary aim in most NFSB cases (Kraemer, 2010). Instead, a wish to escape an overwhelming situation is considered to be more accurate. Suicidal behaviour with the aim of accessing help was also confirmed in a recent South African study (Ani et al, 2017).

From the adolescent participant transcripts in this study, different participants made reference to overwhelming problems that they were experiencing and that had led to the suicide attempt. In addition to the aetiological factors considered above, some of their conversations tell stories about overwhelming academic pressure and ongoing interpersonal conflict that led to a point of desperately needing to escape. In these cases, however, the low suicidal intent was clear in actions such as replacing the knife with tablets and only taking two pills. This act of using the suicide attempt to escape stressful circumstances was confirmed by other qualitative investigations with adolescents, which also reported academic and other problems adding to the overwhelming pressure (Maphula & Mudhovozi, 2012; Stubbing & Gibson, 2018).

A number of adolescent participants also mentioned their decisions to keep secret their concerns about overwhelming pressure and even previous attempts of suicide. This decision may have kept them from accessing the help that they needed, thus contributing to feeling overwhelmed to a point of attempting suicide. While it is a normative development task of the adolescent developmental stage to limit personal disclosure in an attempt to reach autonomy, this may have negative implications for their ability to acquire assistance when necessary (Herrera et al., 2017). In addition, keeping personal challenges secret even from members of the peer group has been recorded as typical of this developmental period (Corsano, Musetti, Caricati & Magnani, 2017) and certainly surfaced in the current study, possibly maintaining problems associated with isolation.

The probability of using the suicide attempt to gain attention from significant others surfaced repeatedly in all the participant focus group sessions. Some health care participants also commented on how the NFSB incident may have been effective in achieving that when the family comes together after admission to the hospital. While this was evident in some of

the adolescent participants' experiences, not all reported subsequent support from significant others. In fact, some participants were not trying to attract attention to their emotional suffering but were attempting to die.

7.2.3.4 High intent to die.

In the current study, one participant (P7) made it very clear that her triggering stressors remained and that the risk of suicide was still present at the time of the interview. Upon engaging with her, the extent of her longing to be dead in relation to the perceived intolerable situation became clear. The suicidal ideation had been present for years, and from our discussion it appeared that her suicidal pursuit has not ended. While she did limit the lethality of the present suicide attempt, the continued danger is evident in this experience and as such, requires a different mode of treatment from the health care sector she finds herself in.

7.2.3.5. Conclusion.

This section commenced with thoughts on definitional confusion in suicide nomenclature. The aetiology of suicidality was considered with specific mention of structural vulnerability, exposure to abuse and the debate around the presence of psychiatric diagnoses.

This study found that most adolescent suicide attempts may happen impulsively in moments where adolescents' coping repertoires were found to be ineffective and a trigger situation drove them over the edge. It seems important to differentiate between the suicide attempt as a cry for help as opposed to self-harm behaviour associated with psychiatric disorders. Using the suicide attempt as a method for accessing assistance or escaping overwhelming situations appears to match with some of the unique complexities of the adolescent stage. Pathologising such behaviour unnecessarily may be detrimental. However, suicidality can lay maladaptive functional foundations for adulthood and as such deserves a focused and tailored health care intervention.

The existence of intent to die and related intensified suicide risk is nonetheless not excluded. These critical cases require a different form of intervention from the health care providers trained to assist.

7.2.4 Judgment: ‘He said…I deserve to be in the mortuary.’

Table 10

Codes and sub-codes relevant to the discussion of Judgement

Code	Sub-Code	Count
Observation	Consequences	8
Observation	Entitled to care	1
Observation	Not depression	1
Observation	Not taken seriously	4
Observation	Patient complains	2
Observation	Patient distrusting	3
Observation	Patient open to assistance	3
Observation	Patient wants to go home	4
Observation	Reason for attempt	17
Response	Can't understand	2
Response	Concern	2
Response	Crisis	1
Response	Cry for help	21
Response	Empathy	16
Response	Frustration	10
Response	Judgment	6
Response	Saddened	1
Feelings re attempt	Apologetic	1
Feelings re attempt	Confused	2
Feelings re attempt	External locus of control	3
Feelings re attempt	Focus on positive	7
Feelings re attempt	Future	2
Feelings re attempt	New plans	3
Feelings re attempt	No longer suicidal	15
Feelings re attempt	Questioned about attempt	3

Feelings re attempt	Regrets attempt	4
Feelings re attempt	Second chance on life	1
Feelings re attempt	Shame	1
Feelings re attempt	Still suicidal	3
Feelings re attempt	Talk about feelings	3
Health care experience	Counselling helpful	10
Health care experience	Doctors	9
Health care experience	Feels judged	2
Health care experience	Medical treatment	11
Health care experience	Nurses' attitudes	9
Health care experience	Psychologist	5
Health care experience	Recommendation to talk to them	1
Health care experience	Social worker	4
Health care experience	Suffering in silence	1
Health care experience	Very short hospital stay	3

7.2.4.1 Lack of empathy.

The contextual reality of the medical hospital ward in which the current study was conducted was portrayed earlier in this discussion, with particular reference to high patient numbers, severely advanced medical conditions and limited resources. These challenges cause pressure on health care professionals in the ward, which may have implications for their empathy levels when young patients admitted for self-inflicted conditions enter this space. The tendency of health care providers to have negative attitudes towards NFSB patients is confirmed by international studies (Norheim et al., 2013; 5; Patton & Borschmann, 2017; Saunders et al., 2012; Smith et al., 2015). The necessity of exploring South African health care workers' attitudes, beliefs and levels of knowledge in the treatment of suicidal cases was previously recorded in relation to the paucity of literature (Bantjes & Kagee, 2013).

All the professional categories who took part in the study acknowledged feelings of frustration or annoyance, mainly in relation to the apparent superficiality of some of the reasons for the suicide attempts. This response may be understandable in instances where a patient reports that they tried to kill themselves because the boyfriend said something, or they didn't

have money for airtime. However, the previous discussions indicated that there may have been a range of contributing factors with the trivial incident being the trigger. Nonetheless, related negatively tainted views from some of the health care participants in this study were noted.

7.2.4.2 Contributing factors.

One contributing reason for negative reactions to NFSB from health care staff may be the increasing numbers of suicidal admissions that the hospital is faced with, causing more overcrowding in an already tight space. The South African health care context, its challenges and resultant possibly negative impact on health care workers' morale and attitudes were discussed in Chapter 3. The rising number of NFSB admissions also adds to the challenges experienced by other general hospitals locally and across the world, requiring more human resources and ultimately imposing an economic burden (Carroll et al., 2016; Idenfors et al., 2015; Saunders et al., 2012; Shilubane et al., 2014).

One nurse shared her perception that NFSB patients take up hospital beds that are required for "sick people". While some judgement of this self-imposed condition may have been implied here, it is a fact that these staff members constantly try to make space available for patients with physical, and at times terminal, diseases. The theme of entitlement (or lack thereof) to medical assistance also surfaced in the clinical psychology group, where one psychologist mentioned that the adolescent NFSB patient brought herself into the hospital space: they should cooperate with the treatment process and not put pressure on staff for discharge. It should also be noted here that doctors and nurses are trained to provide medical treatment for physiological conditions, whereas NFSB patients may require mostly psychological care. This cause of frustration in relation to scope of practice is confirmed elsewhere (Conlon & O'Tuathail, 2012; Timson et al., 2012). It makes sense then that NFSB patients may have a low priority in this context, which is also recorded in other studies (Norheim et al., 2013).

In addition, nurses in the current study described incidents in which they felt disrespected by NFSB adolescent in-patients, or unable to communicate meaningfully with them. Indeed, NFSB youth specifically have been noted by nursing staff in other countries to be experienced as demanding, aggressive, disruptive and at times difficult to understand (Fisher & Foster, 2016).

Another reason for problematic reactions from health care professionals may be the NFSB adolescent in-patient's perceived need for attention, as one doctor explained. Although

she understood the necessity of referral to psychology and that the way the patient is treated may have implications for her psychological recovery, she nonetheless reflected on the "lack of realness" in the patient. Such perceived lack of congruence would naturally pose challenges to the health care provider's perception of corporation from the patient (Mendlovic et al., 2018). While details on the level of rapport between caregiver and patient are beyond the scope of this discussion, it should be noted that perceived incongruence may have implications for empathy.

In addition to the above, another aspect that may be contributing to negative perceptions of NFSB patients is the question around their entitlement to receive care for a self-inflicted injury or condition. It is from this point of view that two of the participants in the current study relayed stories about doctors sharing their opinions that they should be left to die, that they did not deserve to be in hospital. At this point the health care worker's reaction takes on a strong judgmental attitude as opposed to a mild annoyance. Questions from health care workers related to a NFSB patient's entitlement to medical treatment are documented in other studies (Smith et al., 2015). This strong judgemental response was echoed by a social worker who overheard staff members calling a young patient "stupid" for hurting herself because of a boyfriend.

7 2.4.3 Adolescent patients' experiences of stigmatisation.

While publications focusing on adolescent experiences of health care following a suicide attempt are limited, one study confirmed adolescent patients' fear of being labelled *attention-seekers* (Fortune, Sinclair & Hawton, 2008). Here adolescents expressed concerns that their self-harm may not be taken seriously by health care personnel, who suspect that they are 'acting out'. There can be no doubt that the adolescent NFSB patient picks up these evident attitudes.

In a different discussion, a clinical psychologist participant also referred to staff members scolding patients after attempting suicide for apparently trivial reasons. In this context, the clinical psychologist ascribed the judgmental behaviour to taking the presenting problem at face value: the "superficial" reason. Here the question arises if the health care professional is sufficiently trained to deal with a NFSB adolescent patient: to understand the underlying implications for the emergency act and to provide a holding environment where she can recover from that emergency. This incident in which a health care provider may tend to label NFSB patients as attention-seekers or time-wasters may be due to an inability to appreciate the underlying psychological processes of the suicide act (Owens et al., 2016). Such inability to understand may be related to a lack of insight and/or knowledge. Indeed, research confirms

that increased knowledge and professional skills contribute to the more positive and effective treatment of NFSB patients within a health care setting (Saunders et al., 2012; Timson, Priest & Clark-Carter, 2012).

7.2.4.4 The role of training to counteract judgement perceptions.

When considering training in relation to NFSB patient treatment, the nursing focus group experienced their knowledge as insufficient and reiterated a need for more input on the aetiology and treatment of NFSB, especially in adolescents. The medical doctors, on the other hand, were surprisingly well-informed in relation to NFSB, which may also have contributed to higher levels of empathy and efficacy with this patient group (Saunders et al., 2012; Timson et al., 2012). Health care workers in this study agreed that clinical psychologists and social workers play a more important role in the treatment of NFSB. This is confirmed by publications, although literature on how these professional groups experience NFSB patients is non-existent (Norheim, et al., 2013). This is an important contribution by the current study, because NFSB poses unique challenges on psychological and social levels. Indeed, the exploration of the psychological complexity of the suicide attempt appears to form the essence of the medical management of NFSB (Awenat et al., 2017).

7.2.4.5 The question of a NFSB myth.

When considering the expertise of the treatment team, it seems important to bring the hermeneutic circle back to the topic of annoyance. A clinical psychologist shared her experience that she appreciates and understands the complex psychological phenomenon of a suicide attempt, yet at times she could not shake the extreme irritation at self-harm behaviour for an apparently insignificant reason. This acknowledgement was echoed in other focus group discussions. This introduces the possibility that a myth exists among the health care team that NFSB patients or *parasuicides* are a source of frustration, or that their presentations are not serious enough to justify mental health intervention. Another clinical psychologist referred to this possible myth as "…a silent message that goes out to them and that we also pick up, is that they are more of an irritation or a nuisance or an inconvenience to the hospital." If such a myth does indeed exist, it may not be unique to the current study context (Patton & Borschmann, 2017). In fact, it has been recorded that mental health qualification does not exempt a professional from stigmatising a patient (Kraemer, 2010).

7.2.4.6 Implications of being judged.

The negative perceptions and stigmatising thoughts related to NFSB adolescents that are held by health care providers may have significant implications for this patient population. Indeed, some of the adolescent participants in the study reflected on their embarrassment and guilt in relation to the suicide attempt, as well as lingering feelings of worthlessness and not being wanted, which may have been associated with their prior attempt to die. Judgemental or impatient treatment by hospital staff members could intensify existing feelings of shame and worthlessness that may have preceded the suicide attempt (Owens et al., 2016).

When considering the impact of judgmental attitudes on the adolescent health care user, it should also be noted that the judgment is not limited to members of the health care team. One participant referred to her father's observation in response to her suicide attempt, reporting that he "…no longer has space for me in his heart". This participant's feelings of guilt at her suicidal act was shared by others. Literature confirms that not having a confidant to talk to, a belief that one should be able to cope by oneself and reluctance to burden loved ones with problems are typical adolescent experiences that can contribute to suicidal behaviour and reluctance to seek help (Fortune et al., 2008; McAndrew & Warne, 2014). Judgement of NFSB by different role-players may therefore reinforce existing intra-psychic concerns and, instead of providing containment, may isolate the adolescent even more. Literature notes adolescent health care users' fears of being judged, embarrassed or ashamed (Patton, Sawyer, Santelli, et al., 2016).

A clinical psychologist participant shared her thoughts on the implications of negative health care provider responses for the patient's willingness to engage with therapeutic interventions or even out-patient care, which is confirmed in other health care contexts (Lindgren et al., 2018; Norheim et al., 2013). What is of great concern is that negative treatment by health care staff may cause the adolescent to avoid accessing health services in future, while the suicidal incidence increases her chances of developing mental and even physical problems well into adulthood – not to mention fatal suicide (Idenfors et al., 2015; Owens et al., 2016).

South African literature on health care workers' and adolescent patients' experiences are (while still scarce) mostly limited to studies that are related to focus areas of the National Department of Health's strategic plan aims, such as HIV/AIDS, maternal and child health. This discussion is therefore mostly based mostly on international studies and confirms the importance of reporting these results.

7.2.4.7 Conclusion.

This theme was discussed through the consideration of a possible lack of empathy from health care providers for NFSB patients, as well as an exploration of health care workers' experiences and views that may lead to the reduction of levels of empathy. Adolescent NFSB patients' experiences of stigma were considered. The importance of training in enabling a better understanding and appreciation for adolescent NFSB presentation was also noted.

The existence of a myth that NFSB adolescent patients are a source of frustration and may not qualify as a serious case justifying mental health intervention was hypothesised, and the implications of judgemental health care provider attitudes for adolescent NFSB patients were considered. This applies to their current openness to engage in treatment, but also has implications for future health-seeking behaviour.

The value of considering the phenomenon of adolescent NFSB from these different perspectives lies in the attainment of a deeper understanding of what the parties involved are dealing with. Challenges are evident from both the adolescent patient and the health care worker's perspectives. Such challenges exist in a national health care context that is already fraught with obstacles beyond the control of these stakeholders.

This study confirmed that training and supervision of mental health care professionals does not make them immune to thoughts of stigma. It is important to reflect on this, especially in lieu of literature on how these professionals experience and perceive NFSB patient care.

The negative implications of a lack of empathy for NFSB adolescent patients were also considered. Perhaps the only solution would be for health care professionals who may tend to perceive the NFSB patient as a nuisance who wastes time and money to strive to see a vulnerable young person who may significantly benefit from efficient health care assistance.

7.2.5 Nursing group: "Sometimes the patients come here and you are off for a day and when you come back, the patient has demised and you ask yourself: what did I do wrong?"

Table 11

Codes and sub-codes relevant to the discussion of Nursing Group

Code	Sub-Code	Count
CP	Other professions disenable therapy	2
Hospital	Placement	16
Intervention	Training	6
Intervention	Try to help	3
Nurses	Feelings	3
Nurses	Harassment	5
Nurses	Intervention	2
Nurses	NFSB challenges	21
Nurses	Overwhelmed	6
Observation	Entitled to care	1
Observation	Not taken seriously	4
Observation	Patient complains	2
Observation	Patient distrusting	3
Observation	Patient wants to go home	4
Response	Can't understand	2
Response	Judgment	6
Response	Saddened	1
Health care experience	Nurses' attitudes	9
Placement	Hospital helped	7

7.2.5.1 Rationale for the individual consideration of the nursing group.

The clinical psychologists and social workers who took part in the current study had access to both clinical training and supervision: they were trained on the psychological and social implications of suicidal behaviour, and in both categories at least the novice clinicians have access to supervision. While some of their personal challenges became evident during focus group discussions, they are probably better equipped to work with suicidal patients, because of their knowledge base and the availability of supervisory support in accordance with their scopes of practice. When considering possible ways to improve health care services to NFSB patients, studies that recommend more training on suicidality and mental health (Lindgren et al., 2018), as well as access to clinical supervision (Awenat et al., 2017) were discussed in Chapter 3.

The doctors in the study reported that they were acquainted with the psychological aspects of suicidal behaviour during training or other work-related information sessions. While they also voiced some of their challenges, their main procedure is to contain physiological complications and refer any psychological concerns to the relevant multi-disciplinary team members. From their transcripts, it was evident that they mostly avoid engaging patients on an emotional level, thus sticking to the medical scope of practice as their job descriptions require.

The nursing group, however, reported multiple challenges on different levels, which was also observed during the research process as discussed in Chapter 4. As such, these participants' experiences deserve further consideration.

7.2.5.2 Trained to provide medical treatment.

One nursing participant stated that they tend to "overlook the para-suicides" (N6). This comment was made in relation to the responsibility to nurse seriously ill patients, while NFSB patients in the ward are in need of psychological/emotional support. The perception that NFSB admissions carry a low priority in a medical setting is recorded elsewhere (Norheim et al., 2013). Nurses are trained to provide medical treatment, as opposed to the psychological intervention that might be indicated in the case of NFSB admissions (Conlon & O'Tuathail, 2012; Timson et al., 2012). In fact, when considering patients who end up in hospital due to psycho-social problems, the question arises if they should even be admitted in the absence of physical concerns (Smith et al., 2015).

In addition to nursing being a medically-oriented profession, the setting where these NFSB patients are admitted is also a medical ward, as explained previously. The hospital's vast catchment area and the resultant overwhelming need for admissions referred to in Chapter 4 manifest in a constant need for beds in the ward. The nurses are hence under immense pressure to manage a high throughput of patients, provide medical treatment to severely ill and physically weak patients and even cope with occasional deaths in the ward. Within this context, one nursing participant shared her experience that she did not have time to spend with a tearful adolescent NFSB patient in need of attention. This perception that the ward environment was not optimal and that their time was too limited to care appropriately for NFSB patients were also noted in a UK study on nurses caring for adolescents in a paediatric ward (Fischer & Foster, 2016).

7.2.5.3 NFSB adolescents can be challenging to nurse.

Another challenge that the nursing focus group reflected on was that adolescent NFSB patients are often demanding or difficult to manage. One of the younger nurses shared her experience with trying to calm a NFSB adolescent down, but then giving up when the aggression overwhelmed her. Possibly in relation to this observation, the nursing focus group reiterated perceived violence or aggression from adolescent NFSB patients who insist on being discharged. Discharge instruction is a function that is not fulfilled by nurses, yet they have to enforce directives for patients to remain in the ward until they are assessed to be ready for discharge. The placement challenges were discussed earlier, possibly adding to nurses feeling intimidated and blamed for keeping patients in the ward against their will. NFSB adolescents in other contexts have also been labelled as unpopular patients, because they tend to be difficult to communicate with, they may be unpredictable and their behaviour at times may impact staff and other patients on the ward (Fischer & Foster, 2016).

In relation to a desire to go home, the matter of adolescent NFSB patients absconding also entered the discussion. The nursing focus group participants explained this as understandable in relation to a healthy individual stuck among sick people: they want to leave. However, absconding is considered a serious adverse event and can have punitive implications for the ward staff who are responsible for looking after patients. It should also be noted here that adolescent in-patients who are able to walk are allowed to visit the tuck shop and other destinations on the hospital premises, making it difficult for nursing staff focused on nursing their patients to supervise the whereabouts of others. This perception that South African nurses

are put in an impossible situation yet held accountable if problems arise is reflected elsewhere (Rispel et al., 2016).

7.2.5.4 Empathy.

While these negative perceptions of NFSB adolescents were very real in the discussions, one nursing participant also expressed sadness on a personal level in relation to suicidal behaviour in a young person. Numerous psycho-social stressors that contribute to suicidal behaviour from the nurses' point of view were voiced, indicating the existence of empathic awareness. One of the nurses also reflected on her futile attempts to protect adolescent patients from the harsh reality of morbidity in this medical ward space.

7.2.5.5 Adolescent participants' perceptions of nursing.

When considering how the participants in the current study experienced the quality of nursing care they received, opinions varied. Some nurses were reported to be supportive and helpful, others were experienced as unhelpful and rude.

7.2.5.6 Experiences of abuse.

In addition to providing services to in-patients on their wards, nurses also have to accommodate loved ones who visit patients. This may add another level of expectations on already thinly stretched health care workers. Nursing respondents in this study reported feeling harassed and dehumanised by community members who blame them for family members' suffering in the ward. The public perception that South African nurses do not provide optimal health care in line with nursing ethics has been acknowledged (Rispel & Barron, 2012). Nursing focus group members also referred to complaints procedures that are in place to ensure that patients' rights are upheld, leaving them with a sense of powerlessness. This is confirmed in other publications where nurses reported feeling voiceless in a context where the political agenda is focussed on redeeming patient rights (Eyles et al., 2015; White, Phakoe & Rispel, 2015). This matter understandably impacts the morale of nurses, as will be elaborated on later.

7.2.5.7 Responsibility for NFSB patient care.

The nursing participants commented on their perceptions that the NFSB adolescents are ultimately their responsibility. They explained that doctors admit these patients, do a physical examination and leave. Social workers and psychologists consult on a referral basis, depending on their time-tables and availability.

Since the nursing staff are with the patients 24 hours a day, they often find themselves in positions where they feel responsible to provide 'counselling' for NFSB adolescents, a matter that does not seem to be acknowledged in existing literature. This topic came up more than once in the nursing focus group and was also referred to earlier under the intensity of work pressure and the related lack of time to spend talking to patients. A 33-year-old enrolled nurse indicated that she feels pity for NFSB adolescent patients and often tries to explain to them that she also has problems but does not try to take her own life. While this form of lay counselling is well-intended, subtle judgments and other non-therapeutic implications such as sympathy may be present here. Indeed, one of the clinical psychologist participants commented on nurses providing advice or downplaying psycho-social problems, which can contradict the clinical psychologist intervention aimed at facilitating insight into the psychological depth of what a person is dealing with. Provision of counselling is not in the enrolled nurse's scope of practice: she is neither trained nor supervised to provide this intervention. The nursing predicament here is clear: as a front-line health care provider who oversees patients at all hours of the day and night, with a humane understanding of someone in need of emotional containment, she feels compelled to assist. However, she is not academically or clinically equipped to do so.

Despite a lack of knowledge and clinical support, the possible value of these authentic yet lay interventions cannot be ignored. One adolescent participant shared her gratitude towards doctors and nurses for saving her life.

7.2.5.8 Low morale.

The nursing focus group experience in the current study seemed dominated by low morale, which was a noteworthy departure from other focus group sessions. Different reasons may have contributed to this sense of morale. The focus group had to be held in the ward where contagious diseases are being managed, and people had to wear face masks for protection, which restricted clear communication. Because the nurses could not leave the patients alone, the group was held among patients, porters, cleaners and even patients and their

family members. There was no confidentiality and constant interruptions. At times the noise was so overwhelming that the recording of the focus group session was inaudible. Focus group members left from to time to assist with patient and other queries, excluding them from the discussion context. Some of the nursing participants used the focus group forum to voice complaints about the multi-disciplinary team letting them down, patients and their families harassing them, how the system fails them, etc. One young nursing participant barely spoke during the focus group session, except for two comments centring around feelings of disempowerment and victimisation. Concerns such as health system deficiencies and human resource challenges are recorded as negatively impacting the morale of the South African nursing profession (Munyewende & Rispel, 2015). This ward context was not conducive to the focus group dynamic. It does not seem to be conducive to nursing NFSB adolescents either.

7.2.5.9 Need for training and support.

It should also be noted that the nurses in the focus group clearly expressed their need for more training and knowledge in order to understand NFSB patients, as well as some form of supervision. One nurse participant also requested "debriefing", providing some insight to her experience of being traumatised in her place of work. Of note, possible feelings of guilt in relation to patients dying in situations beyond nurses' control surfaced in the focus group discussion. Nurses may tend to question their own competence when the demands of the ward context overwhelm them.

Literature holds the view that increased knowledge and supervised skills can facilitate a deeper empathy for NFSB, as well as more confidence in caring for them (O'Connor & Glover, 2017). However, the current group may need additional support in terms of acknowledgement of their rights and more supportive working conditions.

7.2.5.10 Conclusion.

This discussion started out with the rationale for focusing on this profession specifically. Nurses' experiences were considered in terms of their being medically trained, as well as challenges that they experience in relation to NFSB adolescents in the ward. Nurses' subjective experience of adolescent suicidality was considered, as well as an indication of how the current study participants viewed them.

The theme of feeling abused by their patient population came up, as well as their extensive responsibilities and a related low morale. The nursing group expressed a need for training, supervision and support.

It is important to note these challenges, because the nurses play a central role in accommodating the adolescent NFSB patient in the hospital setting. It is possible that this group of professionals require urgent intervention in terms of training and support in order to conduct their duties efficiently. Nurses may have the potential to contribute in unique ways to making the in-patient setting more adolescent-friendly. This potential deserves further exploration.

7.3 Chapter Conclusion

When considering the main themes emerging from the current study, namely placement, impulsivity, intent, judgment and the nursing team, the complexity of adolescent NFSB in the health care system becomes clearer. Different role-players in the system experience different needs and concerns, but these impact each other when everyone enters the hospital space.

While a variety of costly resources are dedicated to assisting NFSB adolescent in-patients, it cannot be confirmed that their needs from the health care context are met. This may have implications for future suicidal behaviour. From health care workers' point of view, challenges and concerns may also influence their experiences and restrict their related ability to provide quality health care services.

This investigation provided valuable insight into the unique yet complex experiences of role-players in this South African health care setting.

Chapter 8 – Limitations and Recommendations

8.1 Introduction

This final section will be devoted to a critical consideration of the limitations of the current study, as well as recommendations for future research endeavours.

8.2 Limitations

8.2.1 Language and culture

The researcher conducted the semi-structured interviews in English, while English is not the home language of any of the adolescent participants. Relaying their stories in a second or third language may have had implications for how the adolescents' stories were told, as well as the researcher's understanding thereof.

In Chapter 4 the researcher reflected on this problem of language and contended that language difficulties could be overcome in a situation where both the researcher and the participant attached significant meaning to the topic of discussion. In addition, it was an inclusion criterion for adolescents to be able to communicate in English, which was possible in the current population of adolescents who had been exposed to secondary education.

It is noted, though, that a conversation in the participants' home languages might have been more comfortable for them, possibly resulting in a more detailed expression of their experiences. On a related note, the researcher's different cultural background may have had implications for the process of exploration and understanding.

8.2.2 The researcher as a clinical psychologist

This dual role may have had positive and negative implications for the research process, as was reflected on in Chapter 4. In terms of strengths, clinical psychology skills assisted the

researcher to establish rapport, pick up on hidden meanings that participants might have found difficult to express, understand when to follow up on relevant cues, note non-verbal messages and so on.

The challenge was the responsibility to maintain a constant awareness of not engaging at a therapeutic level. Even when participants were emotional, the researcher had to refrain from crossing the boundaries into a therapeutic space and redirect such content to the treating clinical psychologist.

It is also not clear whether being a psychologist was a positive element in getting participants involved in the research process, or whether it imposed a sense of obligation to participate.

It can therefore not be concluded that being a clinical psychologist was a limitation, especially since the initial research idea originated from the clinical psychologist's role in the hospital.

8.2.3 Semi-structured interview

In the current study this interview style was selected because it provided guidance to ensure some kind of consistency among interviews, as well as a focus on the research questions. In addition, it also allowed space for individuality and unique exploration.

It may be argued, however, that the semi-structured interview is too prescriptive or directive. The argument can also be made that this is a western method of data collection and as such cannot be applied to participants of African descent. In this regard there are other methods, such as story-telling, that may also be useful in accessing this form of idiographic, phenomenological information.

8.2.4 Application of the IPA research design

The IPA research design was developed by researchers in the United Kingdom. Even though literature provides suggestions for adaptation to different contexts, this South African state hospital contest is unique.

The researcher therefore worked creatively and carefully to adapt the design to the current study context. It may be possible, however, that there are research designs that are more suitable to this context.

On a related note, the IPA research design, as discussed in Chapter 4, was developed for the in-depth exploration of individual voices. The current study, however, involved a significant number of participants in order to accommodate the different views in this context. It is possible that the population was too big for a true IPA focus and that all the individual voices may not have been explored optimally in this document.

8.2.5 The use of focus groups

The social worker and clinical psychologist focus groups worked extremely well in the sense that there was rapport, people were comfortable to voice their personal thoughts and interesting discussions ensued.

The nursing focus group, however, never reached a stage of comfortable, confidential rapport where people felt safe to voice their congruent opinions. Although their voices were heard, it is not clear if this method of data collection failed this particular group.

It should also be acknowledged here that the focus group members were colleagues, which may have had implications for their willingness to be completely honest about their experiences and perceptions of the topic under investigation.

8.2.6 Sample size

This research is based on a small sample of adolescent NFSB patients in one particular hospital. Even though the data recorded are applicable to this study population, the findings may not have relevance in other populations.

8.3 Recommendations

Based on these possible limitations, the following recommendations are made:

A quantitative investigation on this study population that considers numbers of NFSB adolescent admissions, socio-demographic factors and other details that could enable generalisation or comparison.

Repetition of the current study on similar populations at a national level.

Further qualitative investigation of NFSB among adolescents in a language of their choice.

A similar qualitative investigation of the experiences, perceptions and responses of health care professionals, utilizing the method of individual qualitative interviews may provide a more in-depth understanding.

Implementing a different research method that allows a larger sample of adolescent participants to enable the identification of more factors contributing to suicidal behavior.

Qualitative investigation of adolescents' health care needs and experiences through the use of a less structured, more culturally appropriate research method, such as story-telling.

It may be useful to conduct similar studies at hospitals elsewhere to foster awareness of the unique needs of different adolescent health care user populations. This information can be used to inform suicide prevention work in the current community and perhaps in other areas of South Africa.

Disseminating these findings may be instrumental in creating an awareness in health professionals of their potential impact and the importance of utilising that responsibly.

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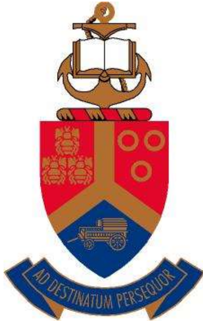
APPENDIX A: COVER LETTER AND CONSENT FORM: Adolescent in-patient participants – 18 years and older



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YUNIBESITHI YA PRETORIA

Department of Psychology
Private bag X20
Hatfield
Pretoria
0028
DATE

INFORMATION ABOUT THE RESEARCH STUDY

Dear Potential Participant

I am conducting research into suicide attempts by adolescents at Dr. George Mukhari Academic Hospital. The title of the study is "Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences".

You have been identified as a patient in the Hospital who may be able to assist us in this study. If you are willing to participate, you will be interviewed by myself, Ms. Mia Kritzinger, a clinical psychologist. I will ask you about your experiences before and after you were admitted to hospital.

If you feel any distress during the interview, you will be referred to your assigned clinical psychologist for therapeutic assistance.

Participation is entirely voluntary. You may withdraw from the study at any time with no negative consequences for your in-hospital or out-patient treatment.

All information will be treated with confidentiality and anonymity: interviews will be conducted in a private room and codes will be used during the analysis of the data.

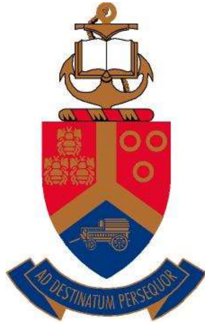
The information gathered may be used for further research in the future.

Should you have any questions or concerns at any time, please contact either the researcher (myself), Mia Kritzinger, or my supervisor at the University, Dr. Linda Blokland.

Ms. Mia Kritzinger:
Dr. Linda Blokland:

Please read and sign the consent form below if you are willing to take part in the study.

Thank you for your time!



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Department of Psychology
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Hatfield
Pretoria
0028
DATE

CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY

1. I volunteer to participate in a research study conducted by Ms Mia Kritzinger of the University of Pretoria.
2. I understand that the study is intended to collect information about adolescent suicidal behaviour.
3. I understand that I will not be paid for my participation.
4. I may withdraw or discontinue participation at any time without punishment.
5. I have the right to decline to answer any question.
6. Participation involves being interviewed by the researcher.
7. I understand that the researcher will not identify me by my name in any reports using information collected in this research. My confidentiality as a participant in this research will remain protected.
8. I understand that notes will be written during the collection of the information.
9. An audio tape will be used to collect information. The recording will be transcribed for the purpose of analysis.

10. I understand that the information gathered will be stored securely and safely.
11. I understand that this study has been reviewed and approved by the University of Pretoria Ethics Committee.
12. I understand that this study has been reviewed and approved by Dr. George Mukhari Academic Hospital management.
13. I have read and was told about the objectives of the research study.
14. I understand the explanations given to me.
15. I have had all my questions answered to my satisfaction.
16. I voluntarily agree to participate in this study.
17. I have access to a copy of this consent form.

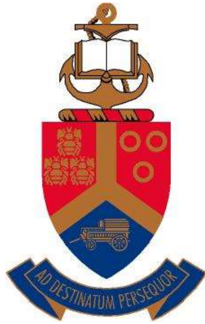
Participant's signature Date

_________________________ _____________________

Signature of the Researcher

____

APPENDIX B: COVER LETTER AND ASSENT FORM: Adolescent in-patient participants younger than 18 years



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INFORMATION ABOUT THE RESEARCH STUDY

Dear Potential Participant

I am conducting research into suicide attempts by adolescents at Dr. George Mukhari Academic Hospital. The title of the study is "Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences".

You have been identified as a patient in the Hospital who may be able to assist us in this study. If you are willing to participate, you will be interviewed by myself, Ms. Mia Kritzinger, a clinical psychologist. I will ask you about your experiences before and after you were admitted to hospital.

If you feel any distress during the interview, you will be referred to your assigned clinical psychologist for therapeutic assistance.

Participation is entirely voluntary. You may withdraw from the study at any time with no negative consequences for your in-hospital or out-patient treatment.

You are under the age of 18 years, therefore your parent/caregiver will also have to sign consent for you to participate. All information will be treated with confidentiality and no information that you provide in the research process will be shared with your parent/caregiver.

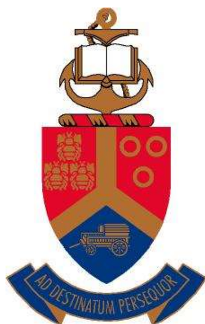
Information gathered during this study may be used for further research in the future.

Should you have any questions or concerns at any time, please contact either the researcher (myself), Mia Kritzinger, or my supervisor at the University, Dr. Linda Blokland.

Ms. Mia Kritzinger:
Dr. Linda Blokland:

Please read and sign the consent form below if you are willing to take part in the study.

Thank you for your time!



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1. I volunteer to participate in a research study conducted by Ms Mia Kritzinger of the University of Pretoria.
2. I understand that the study is intended to collect information about adolescent suicidal behaviour.
3. I understand that I will not be paid for my participation.
4. I may withdraw or discontinue participation at any time without punishment.
5. I have the right to decline to answer any question.
6. Participation involves being interviewed by the researcher.
7. I understand that the researcher will not identify me by my name in any reports using information collected in this research. My confidentiality as a participant in this research will remain protected.
8. I understand that notes will be written during the collection of the information.
9. An audio tape will be used to collect information. The recording will be transcribed for the purpose of analysis
10. I understand that the information gathered will be stored securely and safely.
11. I understand that this study has been reviewed and approved by the University of Pretoria Ethics Committee.
12. I understand that this study has been reviewed and approved by Dr. George Mukhari Academic Hospital management.
13. I have read and was told about the objectives of the research study.
14. I understand the explanations given to me.

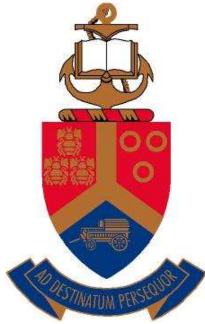
15. I have had all my questions answered to my satisfaction.
16. I voluntarily agree to participate in this study.
17. I have access to a copy of this consent form.
18. I understand that my parent/caregiver also has to provide consent for me to participate.

Participant's signature ________________________

Date ____________________

Signature of the Researcher ________________________

APPENDIX C: COVER LETTER AND PROXY CONSENT FORM: Adolescent in-patient participant's parent/legal guardian if the participant is younger than 18 years



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YUNIBESITHI YA PRETORIA

Department of Psychology
Private bag X20
Hatfield
Pretoria
0028
DATE

INFORMATION ABOUT THE RESEARCH STUDY

Dear Parent/Caregiver

I am conducting research into suicide attempts by adolescents at Dr. George Mukhari Academic Hospital. The title of the study is "Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences".

Your adolescent child has been identified as a patient in the Hospital who may be able to assist us in the study. Because your child is under the age of 18 years, we need your permission for him/her to participate in the study. Your child will be informed about the study and asked to sign an assent form if he/she agrees to participate. If you are willing for your child to participate, he/she will be interviewed by myself, Ms.

Mia Kritzinger, a clinical psychologist. I will ask your child about his/her experiences before and after he/she was admitted to Hospital.

If your child feels any distress during the interview, he/she will be referred to his/her assigned clinical psychologist for therapeutic assistance.

Participation is entirely voluntary. Your child may withdraw from the study at any time with no negative consequences for his/her in-hospital or out-patient treatment.

All information will be treated with confidentiality and anonymity: interviews will be conducted in a private room and codes will be used during the analysis of the data.

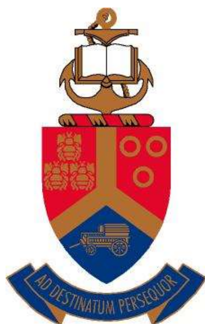
The information gathered may be used for further research in the future.

Should you have any questions or concerns at any time, please contact either the researcher (myself), Mia Kritzinger, or my supervisor at the University, Dr. Linda Blokland.

Ms. Mia Kritzinger:
Dr. Linda Blokland:

Please read and sign the consent form below if you will allow your child to take part in the study.

Thank you for your time!



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PROXY CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY

1. I give consent to my child to participate in a research study conducted by Ms Mia Kritzinger from the University of Pretoria.
2. I understand that the study is intended to collect information about adolescent suicidal behaviour.
3. My child will be one of the participants of this research study.
4. I understand that my child will not be paid for participation in the research study.
5. My child may withdraw or discontinue participation at any time without punishment.
6. My child has the right to decline to answer any question.
7. Participation involves being interviewed by the researcher.
8. I understand that the researcher will not identify my child by name in any reports using information collected in this research. My child's confidentiality as a participant in this research will remain protected.
9. My child and I understand that notes will be written during the collection of the information.
10. An audio tape will be used to collect information. The recording will be transcribed for the purpose of analysis.
11. I understand that this study has been reviewed and approved by the University of Pretoria Ethics Committee.

12. I understand that this study has been reviewed and approved by Dr. George Mukhari Academic Hospital management.
13. I have read about the objectives of the research study.
14. I understand the explanations given to me.
15. I have contact details of the researcher should I have questions regarding the study.
16. I voluntarily agree that my child participates in this study.
17. I have access to a copy of this consent form.

Signature of participant's parent/guardian Date

_________________________ _____________________

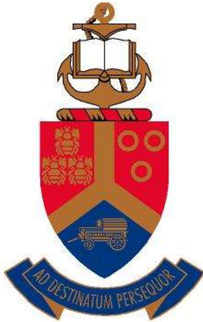
Printed name of parent/guardian Printed name of participant

_________________________ _____________________

Signature of the Researcher

____

APPENDIX D: COVER LETTER, CONSENT AND DEMOGRAPHIC FORM: Health care providers



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INFORMATION ABOUT THE RESEARCH STUDY

Dear Potential Participant

I am conducting research into suicide attempts by adolescents at Dr. George Mukhari Academic Hospital. The title of the study is "Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences".

As a health care provider at the Hospital who has been identified as being involved in the treatment of adolescents admitted following a non-fatal suicide attempt, you are invited to participate in the study.

Your participation will require you to take part in a focus group discussion with some of your health care provider peers at the Hospital. I, Ms. Mia Kritzinger, will facilitate the focus group. I am a clinical psychologist. You will be asked to participate in a discussion around your experiences as a health care provider treating such patients.

Participation is voluntary. You may withdraw from the study at any time with no negative consequences.

All information will be treated with confidentiality:: focus group discussions will be conducted in a private room and codes will be used during the analysis of the data.

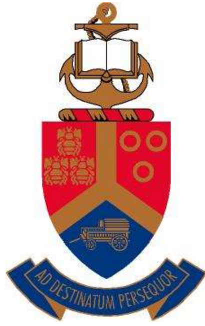
The information gathered may be used for further research in the future.

Should you have any questions or concerns at any time, please contact either the researcher (myself), Mia Kritzinger, or my supervisor at the University, Dr. Linda Blokland.

Ms. Mia Kritzinger:
Dr. Linda Blokland:

Please read and sign the consent form below if you are willing to take part in the study.

Thank you for your time!



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CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY

1. I volunteer to participate in a research study conducted by Ms Mia Kritzinger of the University of Pretoria.
2. I understand that the study is intended to collect information about adolescent suicidal behaviour and the related experiences of hospital professionals providing health care services to patients admitted for non-fatal suicidal behaviour.
3. I understand that I will not be paid for my participation.
4. I may withdraw or discontinue participation at any time without any negative consequences.
5. I have the right to decline to answer any question.
6. Participation involves attending a focus group session facilitated by the researcher.
7. The focus group session will be recorded and later transcribed for the purpose of analysis.

8. I understand that the researcher will not identify me by my name in any reports using information collected in this research: my participation is strictly anonymous. My confidentiality as a participant in this research will remain protected.
9. I understand that this study has been reviewed and approved by the University of Pretoria Ethics Committee.
10. I understand that this study has been reviewed and approved by Dr. George Mukhari Academic Hospital / Research management.
11. I have read and was told about the objectives of the research study.
12. I understand what I have read.
13. I voluntarily agree to participate in this study.
14. I am aware that I can request referral to EAP for counselling if I feel that I need that after the focus group discussion.
15. I have access to a copy of this consent form.

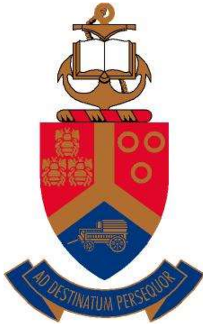
Participant's signature　　　　　　　　Date

__________________________　　　　______________________

Signature of the Researcher

____

Demographic information



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Please note that no identifying information is required when completing this form.

1. What is your profession? ____________________________________
2. How old are you? ____________________
3. Are you male or female? ___________________
4. What language do you speak at home? _________________________
5. What is your marital status? __________________________
6. Do you have children? If yes, how many and what are their ages? ____ ____
7. Where do you live? ____
8. Where were you trained? _____________________________________
9. What year did you qualify? ____________________________________
10. When did you start working at Dr. George Mukhari Academic Hospital? ___________________________
11. Where in the Hospital are you based? __________________________

Thank you for your time!

APPENDIX E: Ethical Approval to Conduct Research

8/30/2016 FullSizeRender.jpg

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Faculty of Humanities
Research Ethics Committee

20 May 2016

Dear Prof Maree

Project:	**Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences**
Researcher:	**AM Kritzinger**
Supervisor:	**Dr L Blokland**
Department:	**Psychology**
Reference number:	**11357542 (GW20160412HS)**

Thank you for the response to the Committee's correspondence of 9 May 2016.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 20 May 2016. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof. MME Schoeman
Deputy Dean: Postgraduate Studies and Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Dr L Blokland; Dr R Fasselt; Ms KT Govinder; Dr E Johnson; Dr C Panebianco; Dr C Puttergill; Dr D Reyburn; Prof GM Spies; Prof E Taljard; Ms B Tsebe; Dr E van der Klashorst; Mr V Sithole

https://mail.google.com/mail/u/0#search/linda+blokland/154f24cad97782b5?projector=1 1/1

APPENDIX F: Permission to Conduct Research

Dr. George Mukhari Academic Hospital

Office of the Director Clinical Services
Enquiries : Dr. PMT. Mabusela
Tel : (012) 529 3880
Fax : (012) 560 0099
Email: philly.mabusela@gauteng.gov.za
kedibone.matsimela@gauteng.gov.za

To: Ms. Anna M. Kritzinger
: Department of Clinical Psychology
: University of Pretoria
: Private Bag X 20
: Hatfield, Pretoria
: 0028

Date : 03rd October 2016

PERMISSION TO CONDUCT RESEARCH

The Dr. George Mukhari Academic Hospital hereby grants you permission to conduct research on "An investigation into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: patient and staff experiences at Dr. George Mukhari Academic Hospital."

The hospital is aware that you have already obtained Clearance from the University of Pretoria

This permission is granted subject to the following conditions:

- [x] That you obtain Ethical Clearance from the Human Research Ethics Committee of the relevant University
- [x] That the Hospital incurs no cost in the course of your research
- [x] That access to the staff and patients at the Dr. George Mukhari Academic Hospital will not interrupt the daily provision of services.
- [x] That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

DR. PMT. MABUSELA
DIRECTOR CLINICAL SERVICES

APPENDIX G: Turnitin Originality Certificate

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Mia Kritzinger
Assignment title:	Multiple Chapters
Submission title:	Investigations into Adolescent Non..
File name:	at_a_Gauteng_Public_Hospital_Pa...
File size:	2.49M
Page count:	246
Word count:	68,686
Character count:	404,837
Submission date:	29-Oct-2018 10:21AM (UTC+0200)
Submission ID:	1028787768

Investigations into Adolescent Non-Fatal Suicidal Behaviour at a Gauteng Public Hospital: Patient and Staff Experiences

ORIGINALITY REPORT

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APPENDIX H: Declaration by Language Editor

M S B Lane

555 32nd Avenue
Villieria, Tshwane 0186
(072) 614 6010
msblane@kbraunweb.com
www.kbraunweb.com/msblane

Certificate of Language and Style Editing

29 October 2018

To whom it may concern

This is to certify that the dissertation with the title *Investigations into Adolescent Non-Fatal Suicidal Behaviour at a Gauteng Public Hospital: Patient and Staff Experiences*, to be submitted by Anna Maria Kritzinger as part of the requirements for an PhD in Clinical Psychology, has been edited for English language, grammar, and punctuation and overall style as well as adherence to the APA 6th edition style guidelines by Dr M. S. B. Lane. Please note, however, that the author can accept or reject the editor's suggestions and changes. In addition, the document was edited subsequently in terms of adherence to the APA 6th edition style guidelines by a different editor. A copy of the edited document is available from the editor. Neither the research content nor the author's intentions were altered in any way during the editing process.

MSBLane

Dr MSB Lane
Editor

I, **Glenda Holcroft, (ID 5103060026082)**, a professional language practitioner, declare that I conducted the language, technical and APA reference editing of this dissertation, *Investigations into adolescent non-fatal suicidal behaviour at a Gauteng public hospital: Patient and staff experiences*, submitted by Anna Maria Kritzinger (Student number: 11357542).