

CAUSES OF ATTEMPTED SUICIDE IN OHANGWENA REGION:

A SOCIAL WORK EXPLORATION

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
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ABSTRACT

Suicide has become a major public concern in Namibia, particularly in Ohangwena region. This study investigated the causes of suicide in the Ohangwena region by exploring the causes of attempted suicide in the region. A qualitative approach was utilized. Data were gathered through semi-structured self-developed interviews and analysed using thematic content analysis. The sample of twenty (20) participants who were all suicide attempters, were purposively selected from the three districts of Ohangwena region, namely Eenhana, Engela and Okongo districts. Due to the sensitive nature of the study, pre- and post-counselling was provided to each research participant.

As participants are unique individuals, they as well presented the causes of their suicide attempts differently. The results were organized into four categories: reasons given for suicide attempts, impacts of suicide attempts on attempters, experiences and feelings of an attempter, and support system for suicide attempters. Several themes and sub-themes emerged from each category. Themes which emerged from the reasons given for suicide attempts included: interpersonal relationship problems which include relationship problems with family and relationship problems with community as sub-themes, financial problems, mental health related problems (which included two sub-themes namely hallucinations and impulsivity), previous suicide attempts and negative emotions towards the self (which included one sub-theme which is the feeling of hopelessness).

It is recommended that the Ministry of Health and Social Services strengthens its technical support and provides special training to the social workers in the regions on how to deal with suicidal clients. Additionally, participants of the present study have emphasized a concern with education - they advocated for the community to be educated on the prevention of suicide and this was based on the reason that many people may attempt suicide because of a lack of information. Furthermore, participants also recommended the Ministry of Health and Social Services to increase the number of social workers in Ohangwena region so that suicide attempts can be reduced and prevented. The study recommends that research with large samples and in other regions can possibly be undertaken.

Key words: attempted suicide, effects of attempted suicide, experiences of attempted suicide, Ohangwena region.

DECLARATIONS

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DEDICATION

This work is dedicated with love to my late father in-law, Michele Talia. His huge contribution before he left paved a way to the completion of this study.

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CHAPTER ONE

INTRODUCTION

1.2. Orientation of the study

The phenomenon of suicide has become a major public concern in Namibia, particularly in Ohangwena Region. According to Afunde (2008), suicide is the leading cause of death and it is increasing at an alarming rate. Afunde (2008) regards suicide as a post-independence phenomenon since a number of suicides in the country, especially in the North-Central regions (Ohangwena, Oshikoto, Oshana and Omusati) have increased without doubt after independence. Afunde (2008) further mentions that regional police reports documented a number of 45 people who committed suicide in 1994. In addition, Afunde (2008) explains that some 100 cases of suicide were recorded in 1995 and this number escalated to 191 in the year 2000. Suicide cases have mostly been occurring in the northern regions, and thus the current suicide phenomenon has become alarming (Caseloads of Social Workers, 2011).

According to Smith (2011), police statistics have shown that the suicide rate in Namibia is significantly higher than the world average of 16 suicide cases per 100,000 people. The latest Namibian statistics from 2009 indicate 23 suicide cases per 100,000 (Smith, 2011). According to Jason (2012), looking at the small size of the Namibian population, this statistic is very shocking and threatening. The Namibia Statistics Agency (2013) indicated a total number of 2,113,077 as the Namibian population. In addition, Kisting (2012) explains that the suicide statistics for the year 2011 in Namibia represent an increase of 12% compared to the year 2010. According to Kisting (2012) 489 people

committed suicide in 2011, while 432 people took their lives in 2010. Suicide is not only a grave concern in Namibia, but it is a challenge also worldwide. The World Health Organization (WHO, 2013) estimated that approximately one million people worldwide die from suicide every year. On average, this means that one death occurs every 40 seconds and there is one suicide attempt every 3 seconds.

The increasing rate of suicide is worrisome and it leaves families and entire communities in mourning. Shaanika (2011) points out that most suicide victims do not leave suicide notes behind and this makes it difficult to determine the reasons behind the ever increasing rates.

Based on this background, the rationale of this study was to find out what the causes of attempted suicide are in Ohangwena region.

The present chapter further defines the two concepts: attempted suicide and suicide, in order to delineate an overview of the suicidal situation in Ohangwena region. A brief description of the study area is given, including the population density of the area. The statement of the problem is also explained in this chapter. Moreover, suicide statistics are included to illustrate the magnitude of the problem of suicide and attempted suicide.

1.3. Definitions of the concepts

Even though attempted suicide and suicide are two different concepts, they are related in a way. On the contrary, Chopin, Kerkhof and Arensman (2004) state that “psychoanalytic theories usually did not distinguish suicide and attempted suicide as separate phenomena” (p. 42). However, in order to understand the causes of attempted suicide, the

two terms - attempted suicide and suicide need to be understood, therefore they are herewith defined.

1.3.1. Attempted suicide

According to Chopin, Kerkhof and Arensman (2004), attempted suicide is the failure to commit suicide after the suicide attempter tried to kill him/herself and survived. Furthermore, Chopin, Kerkhof and Arensman (2004) argue that in most cases suicide attempts represent a kind of spurious morbidity, their actors having no intention to die at all, but just wanting to manipulate their environment. Moreover, according to Maris (as cited in Chopin, Kerkhof & Arensman, 2004, p. 43), in the cases of the majority of people who attempted suicide without an intention to die, their first attempts seemed to be manipulative as they only wanted to change something in their lives. Therefore the “further development of suicidal behaviour depends on the reaction of significant others” (Maris, as cited in Chopin, Kerkhof & Arensman, 2004, p. 43).

In addition, Soreff (2003) outlines the following concepts: suicide gesture, suicide gamble, suicide equivalent and parasuicide as part of attempted suicide. A *suicide gesture* is when a person undertakes an unusual, but not fatal behaviour as a cry for help or to get attention. A *suicide gamble* is when the people risk their lives in the hope that they will be found in time and that the discoverer will save them but this can also end in fatality. For example, “an individual ingests a fatal amount of drugs with the belief that family members will be home before death occurs” (Soreff, 2003, p. 2). *Suicide equivalent* involves a situation in which the person does not attempt suicide. Instead, he or she uses behaviour to get some of the reactions that suicide would have caused. For

example we can have a person running around with a rope wanting to see how her/his relatives will react. Soreff (2003) regards this action as an indirect cry for help.

The World Health Organization (WHO) (as cited in De Leo, Burgis, Bertolote, Kerkhof & Bille-Brahe, 2004, p. 26) defines the word *parasuicide* as an act with a non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm.

1.3.2. Suicide

De Leo, Bille-Brahe, Kerkhof and Schmidtke (2004) and Ikealumba and Couper (2006) concur that the word suicide was derived from the Latin words *sui* which means *oneself* and *caedere* which means *to kill*. According to Soreff (2003), suicide is an act of killing oneself. The act constitutes a person willingly or perhaps ambivalently, taking his/her own life.

WHO (as cited in De Leo et al., 2004, p. 25), defines suicide as an act of killing oneself, deliberately initiated and performed by the person concerned in full knowledge and expectation of its fatal outcome. However these definitions are not comprehensive as they do not cater for the people who kill themselves accidentally.

Figure 1 illustrates a more comprehensive explanation of the process of non-fatal suicidal behaviour (**attempted suicide**) and fatal suicidal behaviour (**suicide.**)

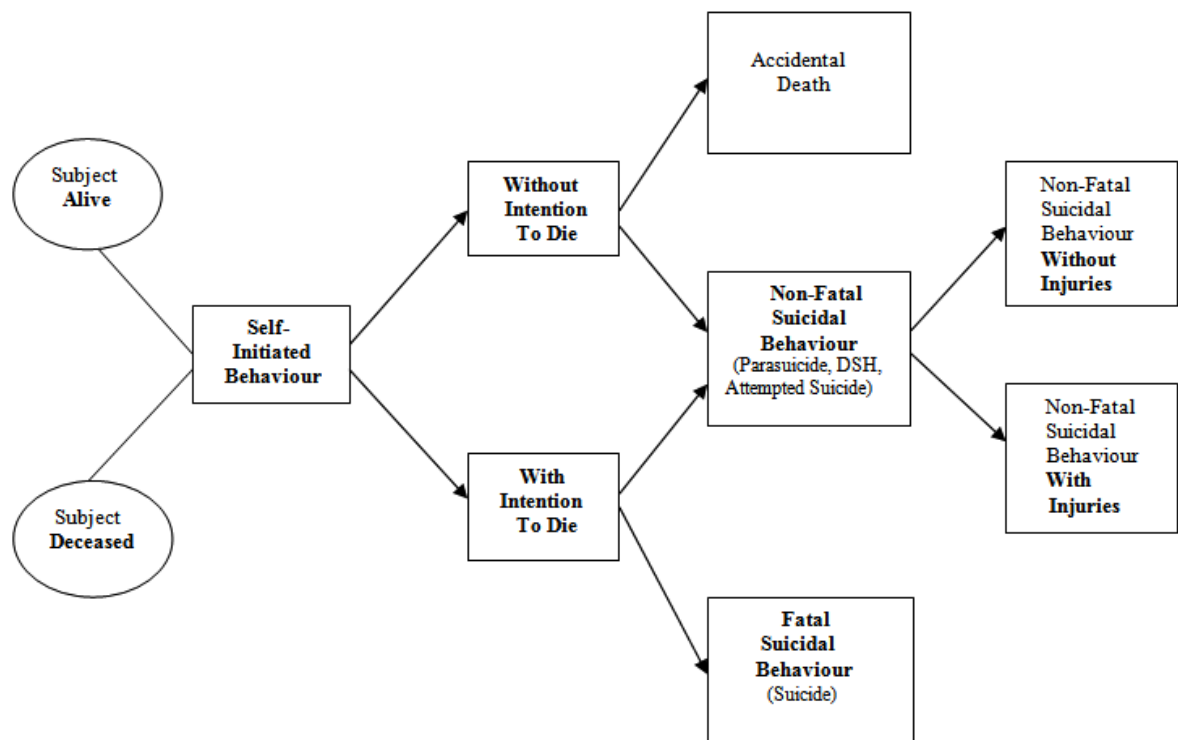


Figure 1: Fatal and non-fatal suicidal behaviour: Flow chart (De Leo et al., 2004)

In **Figure 1**, De Leo et al. (2004) explain the **subject alive or subject deceased** as the most logical starting point, that is observing the main outcome whether the person is alive or dead. At the **self-initiated behaviour** point/stage, De Leo et al. (2004) explain that whether the subject is alive or dead, we need to know that the behaviour was self-initiated, and, finally, the intention to die or stop living is introduced to complete the set of terms.

When a person displays a suicidal behaviour it is not always that s/he has **any intention to die**. De Leo et al. (2004) say that there are probably many more cases that are manipulative or an attempt to seek attention. For example, seven grade 12 students from Windhoek schools were reported to have threatened to commit suicide if the Ministry of Education published their examination results (Halwoodi, 2011).

Furthermore, Schlebusch (2012) states that suicidal behaviour can range from being lethal, with a high **intention to die** (fatal suicidal behaviour; **suicide**) to non-lethal attempts (non-fatal suicidal behaviour; **attempted suicide**) **without the intention to die**. Du Toit, Kruger, Swiegers, Van der Merwe, Calitz, Philane and Joubert (2008) and Ikealumba and Couper (2006) hold harmonized views that in general females have higher rates of suicidal ideation and non-fatal suicidal behaviour than males. However, Du Toit et al. (2008) further explain that the non-fatal suicide attempts by males might be under-reported because of the stigma that is associated with such behaviour. Therefore, men are more likely to use overtly violent or lethal methods, while women prefer less violent means such as self-poisoning by drug overdose.

Moreover, there are some suicides cases that occurred as **accidental death**, for example people with mental illness may commit suicide by accident because they are not conscious / aware of what they are doing.

Another example of an accidental death is that of a case reported by Hartman (2009) which happened in Swakopmund when a 13 year old schoolgirl accidentally hanged herself in an attempt to demonstrate to her 11 year old brother how an acquaintance of hers committed suicide. Hartman (2009) further reported that this schoolgirl took a kitchen cloth and went to the bathroom where she allegedly tied the cloth to the shower outlet and the other end round her neck. Hartman (2009) says that the death of this schoolgirl was considered as a very tragic accident because she did not intend to kill herself.

With regards to the accidental suicide cases, “many suicides go unreported, as it can be difficult to identify indirect suicide attempts as suicide” (Young, Iglewicz, Glorioso,

Lanouette, Seay, Ilapakurti & Zisook, 2012, p. 178). In this case, Young et al. (2012) gave an example of accidental drug overdoses or vehicular impact attempts as some of the passive methods that are difficult to determine whether an event was an attempt or accident.

Moreover, **non-fatal suicidal behavior (parasuicide, Deliberate Self-Harm (DSH), attempted suicide)** is the point/stage where a subject/person attempted suicide and survived, regardless of whether s/he had the intention to die or had no intention to die.

Even though parasuicide and attempted suicide are said to be used interchangeably, De Leo et al. (2004) point out the differences as follows: parasuicide comprises the cases with low suicidal intent. According to Du Toit et al. (2008) these are the people who make impulsive suicidal gestures or deliberately harm themselves, either as a punitive gesture or to draw attention to themselves or to their plight. Attempted suicide refers to the cases with a strong intention to die. du Toit et al. (2008) regard those cases as not failing deliberately, but those who intend to take their own lives and wish to die. As a consequence of the non-fatal suicide (**parasuicide, (DSH), and parasuicide**), the suicide attempter/person or subject who has attempted suicide may survive **the non-fatal suicidal behaviour without injuries or with injuries**.

Kisting (2012) mentions that hanging is the most prevalent suicide method in Namibia, but Namibians have also commonly died after shooting, drowning, poisoning themselves, slitting throats, overdosing and drinking battery acid.

1.4. Study area

Ohangwena region is situated in the North-Western part of Namibia and shares northern borders with the neighbouring country, Angola. It covers an area of 10 582 km². Ohangwena region is the second most highly populated region in the country with a population catchment of 303 888 inhabitants (Ministry of Health and Social Services, Annual Report 2012/2013). The region has 11 political constituencies, which are grouped into three districts (Engela, Eenhana and Okongo), and each has a district hospital. There are two health facilities or centres, twenty nine clinics and 136 fixed outreach points (i.e. points in the villages that are visited by nurses/health workers from the district hospitals in the Ohangwena region to deliver health services). Ohangwena region is categorized as one of the poorest regions, with the least urbanized areas in the country (Namibia Statistics Agency, 2013).

1.5. Statement of the problem

“Namibia is experiencing an epidemic of suicides, with over 800 people attempting suicide between 2010 and 2011” (Jason, 2012, p. 2). The Caseloads of Social Workers (2013) indicates an increase in suicide attempts from 2010 to 2012 in Ohangwena Region. In 2010, thirty two people attempted suicide, while in 2011 sixty people attempted suicide. A total number of ninety-six people attempted suicide in Ohangwena Region in 2012. Out of that number, forty-four cases were reported in Eenhana district, forty in Engela district and twelve in Okongo district.

According to Kisting (2012), Ohangwena Region reported the highest number of suicide cases in Namibia for the second time in 2011, when ninety people died due to suicide.

Out of that number, seventy-nine people who committed suicide were from Okongo district in Ohangwena region. According to Shaanika (2011) during 2007 to 2009, one-hundred and eighteen people committed suicide, while eighty-four people attempted suicide. Owing to the fact that suicide is increasing and has become a major concern of Ohangwena region, this study investigates the causes of attempted suicide in Ohangwena region. Social workers have been dealing with cases of attempted suicide for a long time; however the number of suicide cases continues to increase. This may be an indication that social workers do not have the necessary knowledge about the causes of suicide. However, to the knowledge of the researcher, there are no studies that have investigated the causes of attempted suicide and/or suicide in Ohangwena region

Therefore, the study selected Ohangwena region based on the following factors: Ohangwena region is among the most populated regions in Namibia. It's a region with the highest social problems such as Poverty, unemployment, low access to health care, and social welfare services and low access to information centres for those wishing to know more about attempted suicides or seeking advice. It is also a region with the highest rates of suicide and attempted suicide. In addition, this researcher has been a social worker in the region, under the Ministry of Health and Social Services, whereby she worked with those who attempted suicide and their families. This enabled the researcher to establish relationships with community members and thus enabling her to have access to the target population, in this case those who attempted suicide.

1.6. Aim of the study

The aim of this study is to contribute to closing the knowledge gap that exists concerning the causes of attempted suicide in the Namibian context, especially in Ohangwena Region.

1.7. Research questions

The research is guided by the following questions:

- What are the causes of attempted suicide in Ohangwena Region?
- What are the effects of attempted suicide on the suicide attempters?
- What are the experiences and feelings of the suicide attempters after attempting suicide?

1.8. Summary of the introduction

The focus of this chapter was on the introduction of the study, therefore the orientation to study was outlined. Definitions of the concepts were discussed for enabling a better understanding of the concepts attempted suicide and suicide. The magnitude of the problem of attempted suicide and suicide in Eenhana district, Engela district and Okongo district in Ohangwena region was presented through the statement of the problem. The importance of this study in the Namibian context was discussed and the study aim was also outlined. The research questions that guide the present study were also presented in this chapter.

1.9. Chapters outline

This study consists of five chapters as outlined below:

Chapter one includes the introduction and background information of the study. Definitions of the concepts, the statement of problem and the aim of the study are also covered in this chapter.

Chapter two consists of detailed information on the study such as the review of the literature, causes of attempted suicide and suicide and the study's theoretical framework.

The study methodology is presented in Chapter three, while Chapter four presents the results and a discussion of the research results. Conclusions, limitations and recommendations for practical implications and future studies are included in chapter five.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter gives an overview of the causes of suicide attempts and of suicide from different perspectives. The researcher used a systematic review to study the previous literatures with regards to the causes of attempted suicide and suicide. The researcher searched for several sources; however, only relevant sources were used in this chapter. Sources reviewed for this literature include EBSCOHOST database, SAGE publications, text books, newspapers and social media such as Facebook. The researcher reviewed previous literature focussing on topics such as the causes, effects and experiences of attempted suicide and suicide. Even though the present study aimed at investigating the causes of attempted suicide, the researcher could not have left out suicide since the causes of the two (attempted suicide and suicide) are similar. Moreover it is also highly possible that many people who die by suicide have had previous suicide attempts. Lastly, the research reviewed the theoretical framework on which this study was grounded.

2.2. Prevalence of suicide

The prevalence of suicidal behaviour is a major public health problem worldwide and in Africa. The International Association for Suicide Prevention (IASP, 2012) regards suicidal behaviour as a multifaceted incident that occurs in a progressive way from suicidal thoughts, to planning, to attempting suicide, and eventually death.

The World Health Organization (WHO, 2013), states that suicide is among the three leading causes of premature death among those aged 15 - 44 years in some countries and the second leading cause of death in the 10 - 24 years age group in some countries as well. Additionally, in their study, Joe, Stein, Seedat, Herman and Williams (2008) indicate that the high risk of attempted suicide is in the age group of 18 - 34 years.

The WHO (2009) estimates that one million people die by suicide every year, which translates to one death every minute, 3000 deaths every day and one suicide attempt in every three seconds. According to the WHO (2013), the suicide phenomenon was estimated to represent one point eight percent of the total worldwide burden of disease in 1998, and it might reach two point four percent in countries with market and former socialist economies by the year 2020.

IASP (2013) contends that the number of lives lost each year through suicide is higher than the number of deaths due to homicide and war combined. Furthermore, according to Sun and Long (2013), many nations set targets to reduce the high incidence of suicide with the aim to prevent people from committing suicide and providing adequate caring services to those who have attempted suicide. In addition, IASP (2012) explains that suicide rates are higher in Eastern European countries such as Lithuania and the Russian Federation. According to Schlebusch (2012), the suicide mortality has decreased in Western and Eastern Europe and it is increasing in Asia. Furthermore, Schlebusch (2012) mentions China and India as the main contributors to the whole number of suicides in the world.

According to IASP (2012), suicide statistics can be inaccurate because many suicides are hidden among other causes of death such as single car/single driver road traffic accidents,

unwitnessed drowning and other undetermined deaths. Some aspects of the life situations such as stigma, religious concerns and social attitudes contribute to the under-reporting of suicides and attempted suicides. In addition, Schlebusch (2012), states that the under-reporting is also affected by a diversity of other factors ranging from cultural and socio-economic variables and research limitations.

Schlebusch (2012), notes that the full extent of suicide and attempted suicide has not been well understood in the past years in Africa. Even though the attempted suicides and suicides phenomenon in Africa is disquieting, Schlebusch (2012) explains that there is a lack of reliable data in Africa on these two phenomena. However, in South Africa, Schlebusch (2012) indicates that suicide rates range from 11.5 per 100 000 to 25 per 100 000 depending on the sampling procedures and research methods. In a study conducted by Ikealumba and Couper (2006), it was established that there are no research reports on suicides and attempted suicides in Namibia. Moreover, Ikealumba and Couper (2006) also reported that the Namibian public has recognized suicidal behaviour as a problem.

Like the global situation, suicide incidences in South Africa are estimated to be higher in males than among females, while attempted suicide tends to be higher in females compared to males. According to Joiner (2005), men are more lethal regarding suicide and they have a higher ability to do lethal self-injury. “They have more exposure to guns, to physical fights, to violent sports like boxing and football, and to self-injecting drug use” (Joiner, 2005, p. 156)”. Furthermore Joiner (2005) noted that women might die less through suicide because they are less likely to abandon their relational values that form part of their identities. On the contrary, Schlebusch (2012) indicates that China is one of the counties with high rates of suicide among females than males. Schlebusch

(2012) explains that the ratio of males to females with regards to suicide is 5:1, whereas the ratio of females to males regarding non-fatal attempts is 3:1.

In Namibia, suicide is viewed as a “huge crisis as it is amongst the highest in the world” (Kisting, 2012, p. 3). According to Smith (2011), the Namibian statistics indicate 23 suicide cases per 100 000. As in South Africa, suicide is higher among men compared to women, and suicide attempts are higher in women compared to men. According to Kisting (2012), statistics in Namibia indicate that 408 males and 81 females committed suicide. Kisting (2012) further says that in 2010, 357 men and 75 women lost their lives by suicide.

Ohangwena is one of the regions that reported the highest cases of suicides in Namibia. According to Kisting (2012), 90 people committed suicide in 2011 in the Ohangwena region. Kisting (2014) states that Namibia has one of the highest suicide rates in the world. Reporting on the suicide statistics of 2013 in Namibia, Kisting (2014) indicates a total number of 473 people who died by suicide in 2013. Out of that number, Kisting (2014) reported that the highest percentage (14%) was recorded in the Ohangwena region, followed by Omusati and Khomas regions both with 13%. According to the report from *New Era Newspaper*, (2015, October 16), the statistics by the Ministry of Health and Social Services indicates that fifty eight people died by suicide in Ohangwena region, forty one in Zambezi region and thirty three in Kunene region in 2015. Hence suicide is viewed as becoming an everyday occurrence in the Ohangwena region and the age range of people who died by suicide in the Ohangwena region ranged from 11 to 93 years old (Shinana, 2011). This is supported by ISAP (2012) as it is noted that suicidal behaviour can occur at any age. ISAP (2012) further reported that the frequency of

suicidal behaviour occurrences escalates rapidly from childhood through middle to the late adolescence and into adulthood.

According to sources such as Kisting (2012) and Schlebusch (2012), some of the most commonly used methods of suicide and suicide attempts include hanging, shooting, poisoning/overdosing, gassing, and burning. However, methods used are different from country to country. Apart from that, Schlebusch (2012) notes that youth suicidal cases vary from other people due to the seasonal situations. Schlebusch (2012) explains that some of the seasonal variations have been noted often with the peaks of suicidal cases being around end of the year, which is mostly caused either by examination stress and concerns around entering university or the open labour market.

2.3 The causes of suicide

The incidences of suicide tend to be caused by various factors. As individuals are unique, they also experience different life events that lead them to suicidal behaviours. According to the WHO (2000), the majority of suicidal people often communicate their suicidal thoughts and intentions by sending signals or making statements about wanting to die or feeling useless. However, the WHO (2000) regards all of this as pleas for help which should not be ignored. Maris, Berman and Silverman (2000) have commented that individuals who are at the highest risk of suicide are those who have one or more of the following underlying psychiatric and behavioural disorders: depression, anxiety, panic, impulsivity, aggressive dyscontrol, alcohol or other drugs abuse or dependency, bipolar illness and schizophrenia. In addition, below are some of the known causes of suicide:

2.3.1. Physical illness

Several studies such as Garand, Mitchell, Dietrick, Hijjawi and Pan (2006) and Heikkinen and Lönnqvist (as cited in Harwood & Jacoby, 2000, p. 286), concur that there is a correlation between physical illness and suicide. In their study titled *Suicide in older adults*, Garand et al. (2006) confirm that physical illness plays a big role in the suicidal behaviour of older adults.

In addition, Stenager and Stenager (2000) explained that when a person is being bothered by an illness, it is associated with many problems in physical, psychological and social terms. Some of the problems linked to physical illness as explained by Stenager and Stenager (2000) are cancer diagnosis, spinal cord lesions, epilepsy, brain tumours, stroke and others. These are some of the most frequent life events that are contributing to the daily unpleasant experiences, resulting in depression that eventually ends in suicide. Similarly, Garand et al. (2006) also stated physical illness and depression as often co-occurring and ending in suicidal behaviours.

According to Shilubane, Ruiter, Bos, van den Borne, James and Reddy (2012), when serious illnesses such as HIV infection is experienced in a family, it can lead people who are infected to suicide or suicide attempts. The WHO (2000) argues that the risk of suicide in HIV infected people is being increased by the stigma, poor prognosis and nature of illness. Therefore, post-test counselling is important. According to the WHO (2000), if the person does not go for post-test counselling at the time of the HIV diagnosis, then there is a high risk of suicide.

In their study, Shilubane et al. (2012) found that “affected and infected individuals feel hopeless following the diagnosis, and this feeling may lead to a suicide attempt mostly because they cannot share it with anyone” (p. 182).

Even though it seems to be not easy to estimate an exact number of suicides by HIV and AIDS, Meel (2013) confirmed an increase of suicide among HIV positive individuals. In their study of *Suicide and HIV/AIDS in Transkei, South Africa*, Meel (2013) pointed out that the most important immediate risk factor of HIV/AIDS to suicide mostly occurred soon after an individual got to know his/her HIV status, then he/she tends to commit suicide. This might have happened because of the inadequate provision of counselling services. Thus, Meel (2013) reveals that many of the primary care physicians are not trained well enough in the area of the psychosocial aspects of health care and therefore, they do not provide the necessary risk reduction counselling during their physician-patient encounters.

In a study conducted by Obida, Clark and Govender (2013), it was reported of a participant who attempted suicide because she failed to disclose her HIV/AIDS status to her partner. Thus, Meel (2013) urged for an increase of the training and education of primary care physicians on the prevention of AIDS-related suicide.

2.3.2. Unemployment and inadequate financial resources

Long periods of unemployment may lead to suicide. Several studies (Maris, Berman & Silverman, 2000; Moosa, Jeenah & Vorster, 2005; Yur'yev, Varnik, Varnik, Sisask & Leppik, 2010) harmonized the correlation between suicide mortality, unemployment, inadequate financial resources and financial problems. According to Yur'yev et al.

(2010) the unemployment situation is a factor that leads to inadequate financial resources which negatively affects the living standards of unemployed people.

Platt, Stack and Haas (as cited in Maris et al., 2000, p. 197,) explained that the risk of suicide by unemployed people is associated with the decrease of income, reduction of self-esteem, increase in anxiety, increase in a sense of hopelessness, marital pressure and an increase in alcohol consumption. Other factors that have been reported as caused by limited resources and inadequate financial situations are such as “conflict, family dysfunction and lack of support which may lead to suicidal behaviour among family members” (Obida, Clark & Govender, 2013, p. 224).

According to Shilubane et al. (2012), unemployment and insufficient income can possibly create feelings of hopelessness, which also contributes to the feelings of ending lives with the aim of parting with difficult conditions.

Essentially, losing a job is one of the factors that have an impact on suicidal behaviour. Yur'yev et al. (2010) critiqued the frustration of becoming unemployed and the lack of a job as factors that affect human levels of aggression and auto aggression, and provoke emotional states that may contribute to suicidal behaviour and / or even lead to a higher suicide mortality. This is because people may not easily cope with the dramatic change that losing a job has on their daily lives.

Nevertheless, it is not only the factors of losing a job or unemployment which are associated with suicidal behaviours, but financial problems too lead to suicidal behaviours. Some studies such as by Kalischuk (2010) explain how employed people with inadequate financial resources or financial problems tried other means of increasing

financial resources through gambling. Gambling is not only an attempt to increase financial resources but it also affects the family of the gamblers. Similarly, Kalischuk (2010) argued that when people engage themselves in gambling, it does not only affect themselves individually but their families too as they tend to also lose lots of things such as money, family units, relationships and communication with their family members.

Apart from that, Yur'yev et al. (2010)'s study went into detail to identify the gender that is mostly led to suicidal behaviour by unemployment, job loss and financial problems. In their study, Yur'yev et al. (2010) found that the males' suicidal behaviour is much more strongly related than females to attitudes associated with their employment status because males have greater concerns about their socioeconomic contributions. According to Joiner (2005), the traditional gender role of men being the providers of others creates burdensomeness in men more than in women. Furthermore, Maris et al. (2000) explain that men are more affected by unemployment because of the greater pressure placed on them of being breadwinners. For this reason, being unemployed for men has a greater social stigma on them compared to women.

2.3.3. Poverty

“Persons in lower classes including the poor tend to have a relatively high suicide rate” (Maris, Berman & Silverman, 2000, p. 194). This implies that poverty also plays a role in relation to suicide risks. Lester and Stack (as cited in Maris et al., 2000, p. 194,) say that through the relationship to suicidogenic conditions such as family instability, mental troubles (such as depression), financial stress and physical illness, alienation from work, alcoholism and crime victimization cause poverty to increase the suicide risk. Additionally, Rao (as cited in Harwood & Jacoby, 2000, p. 287,) explained poverty as

one of the most important contributory factors to suicide, especially in the elderly who have experienced depression and physical illness.

2.3.4. Depression

Depression is one of the main causes of suicide. Lönnqvist (2000) and Fenwick, Vassilas, Cater and Haque (2004) concur that many of the depressed suicide attempters are said to have gone through psychiatric treatment or mental health services. This is because, according to Cheah, Schmitt and Pridmore (2008), suicide is a major public health concern that is often associated with mental disorders. In their study, Cheah et al. (2008) stated that the literature on the suicide of people who do not have a mental disorder is scarce.

Lönnqvist (2000) states that suicide might be the ultimate outcome of depression because only few people receive adequate depression therapy. Owing to that reason, people often remain untreated or undertreated because the diagnosis of depression is often missed. Additionally, Randall, Walld, Finlayson, Sareen, Martens and Bolton (2014)'s study found out that suicide and suicide attempt is high on the first year of diagnosis of a mental disorder, and particularly the first three months.

Even though depression plays a major role in suicide or suicide attempts, some of the studies hold various views towards the association between depression and suicide. In their study, Yaldizli, Kuhl, Graf, Wiesbeck and Wurst (2009) revealed that not all of the depressive symptoms are associated with suicidal attempts, for example being irritated or having depressive symptoms mostly in the mornings is not related to suicide ideation. Yaldizli et al. (2009) point out several depressive symptoms that can be predicted as

signs of suicide attempts such as crying a lot, loss of interest, weight changes, sleep disturbances, restlessness, feelings of low energy, sense of worthlessness or guilt, loss of concentration, hopelessness, suicide ideations and delusions or hallucinations.

2.3.5. Family history of suicide

A family with a history of suicide is one of the contributing factors to suicide attempts or suicidal behaviours. The association between the family history of suicide and suicidal behaviour is supported by various studies such as Lekka, Argyriou and Beratis (2006) and Shilubane, Ruiter, Bos, van den Borne, James and Reddy (2012). In their study titled *Suicide ideation in prisoners*, Lekka, et al. (2006) indicate some evidence on the link between the family history of suicide and the suicidal behaviour as being confirmed by many of the previous clinical and community based studies.

Roy, Nielson, Rylander and Sarchiapone (2000), state that a family history of suicide has been noted in women who have experienced depression due to violent suicides of a loved one, while depressed men who have a history of family suicides tend to commit violent suicides.

According to Schlebusch (2012), people who attempt suicide often have a higher rate of suicidal behaviour which is related to psychopathology such as mood disorders and substance abuse in their families.

On the contrary, Joiner (2005) argues that the contribution of a family history of suicide to an increase in suicidal behaviour can be a little more if there are multiple close relatives who have died through suicide, and it can be little less if there are relatively few and distant relatives.

Additionally, Joiner (2005) further explains that in any event, a child whose father has died by suicide has a risk that is around 2 out of 10,000 or .0002, not higher than 5 out of 10,000, or .0005. Being a surviving child of a father who died by suicide, Joiner (2005) argued that the thought adds credibility and reassurance to this case of family history of suicide.

2.3.6. Bereavement

IASP (2012) explained bereavement as one of life's most stressful events that increase risks of suicide and suicide attempts in vulnerable people, especially if the death is by suicide. According to Harwood and Jacoby (2000), bereavement appears to be a driving force for suicidal ideations, especially in the elderly who have been found to have high symptomatic levels of depression, hopelessness, complicated grief, anxiety and lower levels of social support. Nonetheless, in their study, Pompili, Shrivastava, Serafini, Innamorati, Milelli, Erbuto, Ricci, Lamis, Scocco, Amore, Lester and Girardi (2013) argued that suicide rates are high in young widowed persons than in older widowed persons. According to Bunch (as cited in Harwood & Jacoby, 2000), "the risk of suicide risk is greater in the widowed, especially during the first year after bereavement in men" (p. 286).

2.3.7. Previous suicide attempt

Previous suicide attempt is one of the major risk factors of suicide, whereby the suicide attempters are regarded as at high risk of repeatedly attempting to commit suicide. De Leo, Bille-Brahe, Kerkhof and Schmidtke (2004) say that 10 to 15% of suicide attempters may eventually die because of suicide. On the same line, Obida, Clark and

Govender (2013) also argue that the risk of suicide attempt can be increased by 100 times following episodes of parasuicide repetition.

Kerkhof (2000) explained that people who are likely to repeat attempting suicide are characterized by a higher level of depression, hopelessness, powerlessness, substance abuse, personality disorders, unstable living conditions, criminal records, psychiatric treatment and a history of traumatic life events, including broken homes and family violence. Similarly, Moosa, Jeena and Vorster (2005) also identified several factors associated with previous suicide attempts such as a history of a previous medically serious attempt and a known psychiatric illness.

Educational and socioeconomic factors, high unemployment rates and unmet expectations are other factors contributing to the repetition of suicide attempts in young persons as explained by Moosa et al. (2005). In their study, Moosa et al. (2005) indicated factors such as failing to solve problems and mental illnesses as other major reasons given for committing suicide or attempted suicide repeatedly. Apart from that, the study by Shilubane et al. (2012) revealed that reminding suicide attempters about their previous attempts may also cause the repetition of suicide attempts because they often feel uncomfortable when their previous attempts are brought back.

According to the WHO (2009), the rate of suicide for people who have previously attempted suicide is reported to be very high especially in the first years following their attempt. Therefore, the WHO (2009) recognizes the previous suicide attempt as one of the strong predictors of future suicide.

Additionally, Wang, Chou, Yeh, Chen and Tzeng (2013) note that almost one-third of participants are likely to reattempt while they are under suicidal follow up care due to poorer psychological health and social relationships than those who did not attempt suicide during the previous three months of follow up care.

Correspondingly, Holtman, Shelmerdine, London, and Flisher (2011) in their study pointed out that suicide attempters who had received counselling after suicide attempts described the hospital's social worker as unpleasant and disrespectful towards them as they were threatened with incarceration.

2.3.8. Substance abuse

Several sources confirm the link between substance abuse and suicidal behaviours. IASP (2012) regards substance abuse as a significant risk factor of unplanned suicide attempts among those with suicidal thoughts. "It is estimated that between 25% and 50% of all suicides are committed by alcoholics and drug addicts" (Berglund & Ojehagen, as cited in Keeley, Corcoran & Bille-Brahe, 2004, p. 165,) and "that 40% have presented with alcohol or drug misuse" (Lejoyeux et al., as cited in Keeley, Corcoran & Bille-Brahe, 2004, p. 165). Substance abusers might be at high risk of suicidal behaviour because of social disintegration, personal losses and depression.

According to the WHO (2000), about one-third of the suicide cases are said to be alcohol dependent, therefore at the suicide sites, many are found to have been under the influence of alcohol. The WHO (2000) further indicates that five to ten percentages of people who commit suicide are alcohol dependent. Additionally, Maris et al. (2006) assessed that alcohol intoxication plays a role in suicidal behaviour because it makes it easier for the

suicidal person to carry out her/his suicidal plan and to increase the lethality of the method of suicide. On the same line, in their study, Vatne and Naden (2011) discovered that five participants had consumed alcohol in advance of, or while taking the pills to attempt suicide.

2.3.9. Relationship problems

According to the WHO (2000), people who are divorced, widowed and single are at a high risk of suicide than married people, while those who are living alone or separated are more vulnerable. The WHO (2009) indicates that “people who are divorced and separated are 2 - 3 times more likely to have suicidal ideas than those who are married, and 3 - 5 times more likely to make a suicide attempt” (p. 8). Even though suicide is noted as over-represented among the divorced, widowed and separated people, several studies such as Joiner (2005) explain the matter of having many children as a protective factor against suicide. Additionally, Joiner (2005) further states that suicide rates among divorced people might be high because it affects both feelings of effectiveness and feelings of connectedness; such as one may feel failure as a spouse or feel to have lost social contacts not only with a spouse, but also with the spouse’s family, with children, and with friends that one has been shared with the spouse.

Apart from that, Löhr and Schmidtke (2004) identified dominating themes among the relationships of female suicide attempters such as smothering love, infidelity, battering and denial of affection. Despite the low rate of suicide among married people, Maris et al. (2006) explained that the threat of marital conflict and separation often leads to suicide attempts among the married women. In a study conducted by Afghah, Aghahasani, Noori-Khajavi and Tavakoli (2014), married people, especially women

tended to commit suicide in order to free themselves from life's hardships due to the socio-cultural burdens they are experiencing, for example forced marriages in young teenage females.

Relationship problems are experienced in various ways by individuals. According to Löhr and Schmidtke (2004), problems with a partner, problems with loneliness, mental illness or psychiatric symptoms are among some of the most frequently reported reasons contributing to suicide attempts among suicide attempters living in stable relationships. In addition, Löhr and Schmidtke (2004) pointed out some of the problems with the partners that were identified during their study such as: serious relationships problems, sexual problems, rows with partner, mentally mistreated by partner and financial problems with the partner.

In his study, Suto (2007) identified various factors associated with relationships problems such as lack of contacts, break up of intimate relationships, conflicts, poor communication, misunderstandings between parents and children or vice versa, problematic relationships with employees and attempters. Similarly, the WHO (2000) indicates some of life's stress events associated with relationship problems that are noticed to be experienced by suicidal people three months before suicide. Among life's stressful events are: interpersonal problems (such as quarrel with spouses, family, friends and lovers), rejection (such as separation from family and friends), work and financial problems (such as job loss, retirement and financial difficulties) as mentioned earlier.

2.3.10. Family problems

According to Maris et al. (2006) a family that tends to be disorganized, unstable, rigid, inflexible and conflict infested tends to show an increase in suicidal behaviour. In the same way, Obida, Clark and Govender (2013), concur with the previous studies that “being raised in a family prone to conflict is a risk factor for suicide attempts” (p. 224). However, Maris et al. (2006) view suicidality among children in the context of family as a sign of the inability to change the disturbing, chaotic, and stressful family environment.

Apart from that, Shilubane et al. (2012) indicate that false accusations and feelings of rejection in the disturbed relationship of the family and community members are some of the potential causes of suicide attempts especially in young people. Therefore, in their study, Shilubane et al. (2012) explained that most of the participants had suffered emotional stress because they had no family members or any trusted people to share their problems with or to rely on. Apart from that, Shilubane et al. (2012) further indicated that some of the participants were not even aware of the services within the community where they could have found professional help. Moreover, McGlothlin (2006) states that “the counsellor needs to ensure that each family member knows that there is help available and that if any of the family members think of suicide, there is help” (p. 133).

In addition, previous sources such as Rutter and Estrada (2006) regard the family as the main protective factor of suicide.

2.3.11. Aggression and violence

According to Obida et al. (2013) many people who come from dysfunctional families are being characterized by intimate partner violence, and a lack of trust and rejection which

leads them to suicidal behaviours. Furthermore, among factors that are associated with suicide are anger and frustration which precedes aggression.

According to Nock and Marzuk (as cited in Schlebusch, 2012, 186) murder-suicide is one of the most extreme examples of the link between aggression, violence and suicidal behaviour. Murder-suicide is a “dramatic phenomenon in which an individual kills one or more persons, and shortly thereafter kills himself” (Nock & Mazuk, 2000). Similarly, Schlebusch (2012) describes murder-suicide as an act which firstly occurs as an act of murder and then secondly suicide.

Joiner (2005) states that seventy-five percent of the murder suicide initiators are depressed and ninety-five percent are men. In the same line, Maris et al. (2006) note that “In a majority of murder-suicide, men kill women they are romantically involved with or estranged from and then kill themselves (sometimes they also kill their dependent children or their ex-wife’s or lover’s new lover or spouse” (p. 225) which is referred to as passion killing in Namibia. Furthermore, according to Schlebusch (2012), perpetrators commit suicide shortly after murder in order to avoid facing the legal consequences of the murder(s).

Maris et al. (2006) explain that men react with jealousy and anger whenever their spouses or partners threaten to end the relationships. In a study conducted by Holtman, Shelmerdine, London and Flisher (2011), it indicated that both alcohol and physical beatings lead to suicide attempts.

In spite of that, murder-suicide also occurs in family blood relations such as between the biological parents and children. Iileka (2013) explained a particular incidence that took

place at Eefadoukadona village in Oshana region, when a forty six year old man killed his sixty five year old mother and then hanged himself.

Furthermore, Vatne and Naden (2011) reported that suicidal vulnerability is increasing because of an untreated anxiety.

Murder-suicide contributes highly to suicide rates and it is common in Namibia. Mouton (2013) states that that one woman is killed each or every second week in Namibia at the hands of either a boyfriend or husband who kills himself afterwards. According to Mouton (2013), the Namibian Police statistics indicate the percentages of ninety five women who are killed as those involving boyfriends and girlfriends, while five percent are married women. According to Salkeus (2012), murder-suicides are not based on men loving their partners but rather on power, a situation that Salkeus (2012) describes as unhealthy and undemocratic.

Gender-based-violence and murder-suicide has gained a lot of media attention in Namibia and there has been a lot of dialogue around it and protests by activists. However, according to Sun (2012), close to ninety percentages (90%) of the thirty two (32) murder suicides in Namibia have taken place in northern regions or were committed elsewhere by people from the north. Sun (2012) further explained that the *Villager newspaper*, (dated December 2, 2012) reported an interview which was conducted with various people on why most of the Oshiwambo-speaking men resorted to killing their girlfriends and later killed themselves.

Sun (2012) described the interview findings and they read as follows: The first interviewee's point of view was that most of these young boys from the rural places come to the urban towns and get involved with girls for materialistic reasons.

The second interviewee said that the Oshiwambo-speaking men were raised with a belief that they are always right. In contrast, the third and fourth interviewees argued that it might appear as the Oshiwambo-speaking people are killing each other most but it is because of the fact that they are the majority in Namibia. The fifth and last interviewee responded with caution that the north is a geographic area and not all the residents are from the same tribe though the majority speaks Oshiwambo. Thus it is dangerous to assume that people involved in murder-suicide are all Oshiwambo-speaking.

The last participant eventually emphasized that the tribe is immaterial; it is the problem that needs to be addressed to restrain the murder-suicide and suicide in particular, everywhere in Namibia.

2.3.12. Impulsivity

According to the WHO (2000), suicide is an impulsive act like any other impulse which is transient and lasts for a few minutes or hours. The WHO (2000) says that the impulse to commit suicide is triggered by the negativity of the day to day events.

Nevertheless, several studies explain the link between impulsivity and suicidal behaviour in various ways. For example, Joiner (2005) regards the association between impulsivity and suicidal behaviour as indirect. The reason why Joiner (2005) links impulsivity to suicidal behaviour is only because impulsivity facilitates the exposure to provocative and painful experiences. Therefore, Joiner (2005) believes that people can only "acquire the

ability to enact lethal self-injury, and are thereby at an increased risk for suicide, if the desire for death is in place” (p. 188).

Even though, Sharma, Sharma and Bano (2009) view suicidal acts as often impulsive, in their study, Sharma et al. (2009) reported suicide acts as dependent on the severity of the intent to die and on how quick the certain method is capable to cause death. According to the WHO (2009), the intent to die may differ even within a short period of time (a day, several hours or even less), therefore in order to prevent suicide effectively, monitoring of risk is an essential component.

2.4. Effects of attempted suicide

The occurrence of attempted suicide is referred to as a “traumatic event that affects everybody” (Bryan, Brophy, Cunningham & Schwarz, 2006, p. 4). Thus, the survivors often feel stranded without knowing how to act around or treat the attempter. According to Bryan, Brophy, Cunningham and Schwarz (2006), emotions may emerge among the survivors and they may experience the following feelings: anger towards the suicide attempter, guilt, anxiety and sense of insecurity, shame, powerlessness, helplessness, lack of control and feelings of betrayal.

2.4.1. Effects of attempted suicide on the suicide attempters

People who have attempted suicide suffer from mixed feelings afterwards because of the bad label on the event of suicide or suicide attempt. Generally, some of the mixed feelings that the suicide attempters experience are such as feelings of guilt, shame and anger that is associated with the failure of the suicide. According to Vatne and Naden (2011), the feelings of guilt and shame after suicide attempts are as follows: guilt as the

feelings surrounding the painful or embarrassing event that is a bit like a taboo because it is something that one cannot talk about with everybody. Shame is understood as being about fear of others' evaluation of the suicidal act and one's own attitude to the suicidal act. Additionally, Bryan, Brophy, Cunningham and Schwarz (2006) explain that after a suicide attempt, suicide attempters often feel ashamed by what they have done.

In their study, Crocker, Clare and Evans (2006) reported of a participant who was ashamed because of the failure to commit suicide. This participant interpreted her attempt as a failure experience, a failure to problem-solve or regain some sort of control in a helpless situation. Additionally, Vatne and Naden (2011) also explained of a participant in their study who got angry when waking up the next morning after the suicide attempt and realized that had not made it (or is still alive). In the same line, Strong (2009) explained a story of Samantha Heames who survived a suicide attempt. The Heames' story partly read that "the moment you realize you are still alive, it would have to be something like an *emotional hurricane*, it is too much to handle". In Heames' story, as explained by Strong (2009), the most difficulties Heames experienced during the recovery process were guilt and depression. Heames felt guilty because most of the people who visited her in hospital said they were so sad and scared. Strong (2009) said that this did not only make Heames feel guilty but it also caused her emotional pain to be near people who visited her. Heames' situation led her to depression, self-pity and self-loathing. Vatne and Naden (2011) also concurred with Heames's story. In their study, they reveal how guilt after a suicide attempt can be a burden that may be inflicted on the attempter's children, spouse, siblings, parents and significant others. Therefore, in Heames' story as written by Strong (2009), Heames hated to be alive, especially as everybody knew she had tried to commit suicide. Heames felt crazy and nothing could

make her happy; she lashed out, she could not control her feelings, she needed people and at the same time she wanted to be alone. Strong (2009) further wrote that these cycles repeated from time to time in Heames' life time of the recovering process. Sun and Long (2013) explain that the healing and recovering process of an attempt to suicide is slow and difficult, therefore the suicide attempters need the support networks around them.

Apart from that, Sun and Long (2013) revealed the feelings of after suicide attempts in a different view. In their study, they discovered that most of the participants were not thinking of their children or families at the time of the attempt as they were so overwhelmed by their own turmoil. Therefore it is only after the attempt that is when they were feeling that "they could not leave their children to deal with all the mess they had caused" (Sun & Long, 2013. p. 33). Additionally, Sun and Long (2013) further explained that suicide attempters have realized after the attempts that their children needed them.

On the contrary, Orri, Paduanello, Lachal, Falissard, Sibeoni and Reva-Levy (2014) explained that some of the suicide attempters have attempted suicide as a way to put the blame on others and to make them feel guilty through remorse. For example, "I wanted to die to make my parents or my ex feel guilt", or "I did it to punish my mother".

2.4.2. Effects of attempted suicide on families/relatives, friends and significant others

In most cases the survivors of the suicide attempters are left not knowing what to do after the suicide attempt incidence. According to Bryan, Brophy, Cunningham, and Schwarz

(2006), after the suicide attempt, the survivors feel scared to talk to the suicide attempter as they think they may trigger another attempt or make them feel worse by talking about their feelings. Therefore, Bryan, et al. (2006) further noted that suicide attempt events leave the survivors suffering emotionally from feelings of “anger at the person who made the attempt, guilt, anxiety and a sense of insecurity, shame, powerlessness, helplessness, a lack of control, and betrayal” (p. 4). The WHO (2009) states that “the emotional impact for family and friends affected by completed or attempted suicide may last for many years” (p. 3).

In a case when a child attempted suicide, Buus, Caspersen, Hansen, Stenager and Fleischer (2013) report that the child’s parents suffer severely emotionally, and they are socially traumatized and disempowered because of their child’s suicidal behaviour which has threatened to corrupt all interpersonal relationships in the entire family. According to Bryan, Brophy, Cunningham and Schwarz (2006) when a child attempts suicide, you may feel that you failed your job as a parent, because you feel you could have known what your child was thinking and or planning. Therefore, Buus, et al. (2013) explained that parents suffer from anger and blame towards themselves because they regard themselves as being responsible for their child’s situation.

Buus et al. (2013) further indicate that parents are also left with feelings of blame, anger and hatred towards the child who attempted suicide because of his/her strategic manipulation that is affecting the family relationship. Additionally, parents often suffer from isolation. According to Buus et al. (2013), the child’s disruptive behaviour and suicide attempt brings a moral stigma in the entire family. Attempted suicide also has a negative impact on the siblings of the suicide attempter. Bryan et al. (2006) explained

that on many times, the siblings feel strange and uncomfortable as they are left without knowing how to act or treat their suicide attempt sibling.

2.4.3. Effects of attempted suicide on children

In the case of a parent's attempted suicide, Bryan et al. (2006) explain that children may feel that it is their fault and they are to be blamed for the suicide attempt. They may start to be withdrawn or misbehave for weeks or months following the incidence. Bryan et al. (2006) further say that children might also experience physical pain symptoms such as stomach aches. In the study conducted by Buus et al. (2013), two issues were discovered in relation to how children are affected by the suicide attempts of their fellow child/sibling; such as, other children might behave the same way as their parents, for example they might become sensitive or protective towards the suicidal child. Or they may develop hatred and conflict towards either their parents or the suicidal child because of the neglect they are experiencing since all their parents' attention and focus is only on the suicidal child.

2.5. Effects of suicide

According to Shneidman (as cited in Clark & Goldney, 2000, p. 467), while about one million people worldwide commit suicide annually, for every death it is approximately six people who suffer from intense grief. Therefore, Clark and Goldney (2000) aver that about six million people are estimated to be bereaved each year through suicide. Holmes and Rahe (as cited in Clark & Goldney, 2000, p. 467) view the death of a close member as one of the greatest of life's stresses; therefore the normal adjustment to the loss can be as long as four years.

Even though every grief process is always difficult, Pompili et al. (2013) explain that grieving by suicide is different from other griefs because it is shocking, painful, unexpected and even more challenging. In addition, Afunde (2008) notes that suicide leaves the bereaved in shock, anger, guilt and in a pool of asked and unasked questions. Afunde (2008) further explains that bereaved people are also left dumbfounded, horrified, traumatized and embarrassed after a suicide incidence. Additionally, Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti and Zisook (2012) state that bereaved people are at a high risk of developing major depression, post-traumatic stress disorder, suicidal behaviours and a prolonged form of grief that is called complicated grief.

2.5.1. Effects of suicide on families/relatives, friends and significant others

Clark and Goldney (2000) highlight some of the grief phases which were identified by several sources. These grief phases serve as the stages where a bereaved person or close individuals may go through when the suicide incidence occurs.

2.5.1.1. Shock

This is the first stage that the bereaved mostly experience when they hear the suicide news or discover the deceased body. “The bereaved may relive the visual image of discovering the body, feelings and smells associated with cleaning up residue of the deceased” (Clark & Goldney, 2000, p. 470).

2.5.1.2. Relief vs. family disaster

This stage is experienced differently from family to family. According to Seguin (as explained by Clark & Goldney, 2000, p. 470) some families feel that the suicide

incidence has resolved existing problems and threats while to some families it is a disaster. Clark and Goldney (2000) note that families who struggled for years with a depressed individual with frequent suicide threats may feel relief after the suicide as their family life is going back to normal.

2.5.1.3. Guilt and blame

Feelings of guilt and blame are among some of the emotions that are commonly experienced by bereaved people after death by suicide. Pompili et al. (2013) stress that in addition to pain and suffering, bereaved people also suffer from the unending “why” questions. Pompili et al. (2013) further explain that bereaved people often blame themselves for failing to predict death, or to have effective interventions or to prevent suicide. Moreover, according to Clark and Goldney (2000), bereaved people may blame themselves for the poor relationship and for being unaware of the normal difficulties of communicating with someone suffering a mental illness prior to suicide. They may feel that they were supposed to identify the signs and symptoms on the suicide victims, thus they feel guilty of not having identified them.

Owing to the failure of preventing suicide, Pompili et al. (2013) assert that bereaved people may be at risk of depression, abusing alcohol or other substances, as they suffer from unbearable psychological pain that may even lead them to consider taking their lives if they are not given adequate professional help. In their study, Pompili et al. (2013) further explained feelings of guilt and shame as including some forms of self-blame, depression, humiliation, rejection, abandonment, loss, worthlessness, failure, embarrassment and unlovability.

“Some bereaved seem unconsciously to use their guilt to punish themselves” (Clark and Goldney, 2000 p. 473). This might be because they are overcrowded by mixed feelings of confusion and regret. Furthermore, according to Clark and Goldney (2000), the suicide note may also trigger strong feelings that influence the bereaved to assume that they have responsibility and thus they may feel guilt for the suicide victim’s death.

According to Clark and Goldney (2000), some families feel that they did all they could, while others, even if they had participated in the deceased’s care, they may still have unrealistic feelings of remorse. Therefore, guilt may also be felt at the sense of relief created by the death.

Clark and Goldney (2000) and Afunde (2008) concur that surviving partners suffer from the in-laws’ and the family’s blame, as well as community gossip and shame over the death. Instead of the surviving partner receiving support from in-laws/family and community after the death of the spouse, he/she will be abandoned and flooded with criticism, condemnation and social stigma. Clark and Goldney (2000) say that this may reinforce perceived feelings of rejection as the blame from others may also cause hatred and separation among the bereaved people.

2.5.1.4. Stigma, loss of trust and social isolation

Stigma plays a role in the bereavement by suicide. Feelings of stigma that link with suicide are different across individuals and they depend on the severity of the suicide effect. According to Clark and Goldney (2000), stigma also appears to be culturally-based. Clark and Goldney (2000) further explain that in spite of stigma absence, feelings of shame may arise due to guilt, blame, rejection and gossip. Therefore, most of the

bereaved people develop feelings of isolation and they also lose trust in other people as they feel that they have been betrayed by the deceased whom they had trusted.

The stigma associated with suicide is not a new issue. Parrish and Tunkle (2005) say that suicide in a family might result in social shame, tainted family reputations, lowered property values and hasty funerals. As a consequence of stigma in some families, “death by suicide remains a topic more often whispered than spoken aloud” (Parrish & Tunkle 2005). In other families, death by suicide is referred to as a “conspiracy of silence”, that according to Parrish and Tunkle (2005) only well-intentioned friends and loved ones may decide who is allowed to know the cause of death. In most cases, children are among some of the people to whom the cause of death has been concealed. Parrish and Tunkle (2005) further explain that decisions about whether funeral arrangements are open or kept private depend on family wishes.

From a religious perspective, in some of the cases as explained by Parrish and Tunkle (2005), death by suicide has historically prevented a religious funeral or burial in a church graveyard (hallowed ground), because suicide was viewed as a sin.

2.5.1.5. Suicidal thoughts and fear of another suicide

After a death by suicide, the bereaved may think of committing suicide in order “to re-join the deceased and to complete unfinished business” (Clark and Goldney, 2000, p. 475). In the same line, Jordan (as cited in Kuhnell, 2012, p. 2,) argues that suicide rates in families of suicide descendants were twice as high as in families in which no suicide had occurred. In addition, Clark and Goldney (2000) note that fears about a repeat family suicide may cause complications. Thus families may become too much protective,

for example parents may worry about the risk to younger siblings when they reach the age at which the older child committed suicide.

Furthermore, Clark and Goldney (2000) explain that adolescents may have difficulties dealing with the boundaries between themselves and a role model who died by suicide or they may feel fated to die. This may result in a copycat suicide, especially if the suicide of a celebrity is being reported in the media. According to Pirkis and Blood (as cited in Haw, Hawton, Niedzwiedz and Platt, 2012) “there is evidence that the copycat effect is more prominent where media coverage is extensive and the suicide glamorized or reported upon in detail” (p. 101).

2.5.1.6. Anger

The bereaved are not only overwhelmed by the feelings of guilt, shame, blame and or stigma, they are also getting angered by the deceased as he/she committed suicide. According to Clark and Goldney (2000), anger at the deceased may result from the emotional pain and sadness about the loss, especially if the bereaved person knows the reason why the deceased committed suicide, or if he/she was blamed in the suicide note.

2.5.2. Effects of suicide on children

When death occurs in a family, children not only suffer from the loss but also from the grief neglect. According to Kuhnell (2012), children become the forgotten mourners and often their grief is not validated. Packman et al. (as cited in Kuhnell, 2012, p. 1) aver that children are often told to put their grief on hold so that they cannot upset their parents further. Thus, children have to hold back their feelings as they are prevented to talk about the deceased.

Furthermore, Devita-Reaburn (as cited in Kuhnell, 2012, p. 1) explains that during the mourning process children are told to be strong for their parents who have suffered a greater loss. As a result, White (as cited in Kuhnell, 2012, p. 2) argues that this may cause a long-term effect on children as they may only process their losses during adulthood. Correspondingly, Joiner (2005) says that children who have lost their parents by suicide at an early age appear to confer risk for suicide later in life.

Additionally, Afunde (2008) concurs that suicide has devastating effects on both children and youngsters within the neighbourhood. As an effect, Afunde (2008) explained that the children of his brother in-law who died by suicide have been looked upon as dull, lifeless and they always remember the scene in the room where their father committed suicide. As a consequence, Afunde (2008) further explained that the bereaved children of his late brother in-law ended up leaving the house and living somewhere else to get away from the environment that constantly remind them of the suicide.

Maris, Berman and Silverman (2000) identified the following grief reactions which the bereaved children go through when they lose a close person by suicide.

2.5.2.1. Shock and numbness

This is the first grief reaction that the bereaved children experience as the suicide news is communicated to them. Some children tend to feel, think or react in an abnormal way because of the emotional shock that is caused by suicide news. According to Parrish and Tunkle (2005), in the aftermath of death by suicide, children are often in a state of shock that is compounded by both age-related experiences and emotions and by feelings of guilt and bewilderment.

2.5.2.2. Sadness

Maris, Berman and Silverman (2000) aver that tearfulness and sadness are common reactions among grieving children. However there are some children with few signs of distress. Gilgun (2012) says that they tend to develop a long-term mild depression called dysthymia. These are some of the bereaved children that Gilgun (2012) indicated as seeming sad and quiet, working extra hard to please others and having temper outbursts.

2.5.2.3. Anger

Suicide incidences lead bereaved children to become angry towards the deceased, towards themselves and others. According to Gilgun (2012) grieving children may become angry and destructive; they may hurt themselves or others. They may hurt animals or destroy others' property. Gilgun (2012) further explains that the bereaved children may also harm themselves through reckless behaviours, through drugs, alcohol use and they may get involved in violence or sex at early ages.

2.5.2.4. Anxiety

According to Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti and Zisook (2012), when parents die by suicide, children may feel abandoned or rejected by the most people whom they trust with their most basic needs. Therefore, Gilgun (2012) notes that bereaved children believe that their parents do not love them thus they committed suicide. Gilgun (2012) further explains that suicide incidences may make the bereaved children regard themselves as bad and unworthy, thus the deceased parent did not care to leave them. However, bereaved children are not only left worrying about themselves but they also worry about the remaining parent as Maris, Berman and Silverman (2000) say

that grieving children also experience fears of what will happen when the remaining parent dies.

2.5.2.5. Shame

The stigma that the community has on the suicidality issues has an effect on the children's grief reaction. "Children may be ashamed of being seen as grieving differently from peers" (Maris, Berman & Silverman 2000, p. 546). Thus, some children may suppress their grief and it causes this to have long effects on their adulthood.

2.5.2.6. Guilt

Mourners "often replay events up to the last moments of their loved ones' lives, digging for clues and warnings that they blame themselves for not noticing or taking seriously enough" (Young et al., 2012, p. 180). This is not happening to bereaved adults only but bereaved children as well as they are trying to understand why their loved ones made the decision to end their lives. Therefore, Maris, Berman and Silverman (2000) say that children may often believe they are to be blamed of what happened and they also worry about negative interactions with the deceased.

2.5.2.7. Physical problems

"Frequent illnesses and somatic complaints are common in children who are grieving" (Maris, Berman & Silverman, 2000). If children's grief is not dealt with, they may suffer disturbances as explained by Parrish and Tunkle (2005), such as sleeping and eating disturbances and as a result it may lead grief stricken children to substances use or abuse.

2.5.2.8. Academic problems

Death by suicide can cause a negative impact on the academic performance of the bereaved children. According to Maris, Berman and Silverman (2000), bereaved children may experience confusion, concentration difficulties, memory lapses, and a preoccupation with the deceased. As a result, this may lead bereaved children to be frequently absent from school, have poor academic performance and or even dropping out of school.

2.5.3. Effects of suicide on the community

“Human beings do not live in isolation but they are social beings by nature” (Afunde, 2008, p. 143). They are not only part of families, but belong to the community as well. Therefore, death by suicide does not only injure the family and close individuals; it also has negative effects on the entire community. Being part of the community, the suicide victim had a responsibility in his/her respective community, therefore, if a community member commits suicide he/she leaves a gap in the community. Afunde (2008) states that the suicide victim deprives the society of the good he/she should have contributed to society. Afunde (2008) further explains that death by suicide leaves the mourning community with a deep experience of pain, unfinished businesses and without any opportunity to say good bye. According to Afunde (2008), death by suicide may lead to the withdrawal of support networks in the community because of the discomfort and upset feelings that neighbours and friends are experiencing.

Afunde (2008) emphasizes that although natural death is inevitable to any living person on earth and every one will die sooner or later, it is not an easy task for both the society and the family to get over the task of mourning in the event of death by suicide.

2.5.4. Effects of suicide on the health care professionals (e.g. social workers, psychologists, psychiatric nurses and doctors)

The health care professionals such as therapists, social workers, psychiatric nurses and doctors as explained by Takahashi et al. (2011) are said to be more prone to encounter suicidal ideation in clients/patients and those that have attempted or committed suicide than any other health professionals. This is because the psychologists, social workers, psychiatric nurses and doctors are the ones working directly with the suicidal clients/patients. Horn and Tanney (as cited in Parrish & Tunkle, 2005, p. 98) indicate that some complex issues such as grief, stigma, anger and self-blame are common issues noted in the health professionals when suicide occurred.

Furthermore, Clark and Goldney (2000) explain that a health care professional who was dealing with a person who died by suicide often suffers the feelings of personal loss, fear for one's reputation and anger at the deceased for the disruption he/she have caused. Physical sickness, depression, irritation, fears and deterioration in interpersonal and professional relationships are some of the experiences mentioned by Clark and Goldney (2000) that may happen to the health care professional who lost a client or patient by suicide.

According to Parrish and Tunkle (2005), in the same line as Maris, Berman and Silverman (2000), the health care professional might be occupied by fear of losing

professional credibility and the fear to meet the bereaved family as they may evoke a sense of blame and failure. According to Jobes (as cited in Parrish and Tunkle, 2005, 98), the health care professionals tend to develop feelings of self-doubt and incompetence that may lead to the fear of dealing with suicidal clients/patients in the future.

Takahashi et al. (2011), state that the health professionals may experience feelings of worthlessness because of the inability to prevent the client/patient's death. In addition, Clark and Goldney (2000) say that the health care professional may distant him/herself from patients/clients and colleagues, or the opposite of over-involvement in the professional role, absenteeism and even willing to change the career. As a consequence, Maris, Berman and Silverman (2000) state that those who have lost a patient/client to suicide show high levels of intrusive thoughts relating to patient/client suicide as well as avoidance of situations that might remind them of the suicide.

However, the death of the client or patient by suicide does not only negatively influence the health care professionals' behaviours but positively as well. In the study conducted by Linke, Wojciak, and Day (2002), it was reported that a small number of staff improved on note keeping, increased the likelihood to seek support and peer supervision following the loss of a client or patient by suicide.

2.5.5. Effects of suicide on the economy

McDaid and Kennely (2009) claim that "in addition to the emotional suffering caused by suicide and attempted suicide, the cost to the nation and or region in the case of suicide or attempted suicide is increasingly recognized as a significant burden" (p. 359).

Furthermore, McDaid and Kennely (2009) indicate two types of costs and their effects on suicide. The two types of costs are categorised as direct and indirect costs. According to McDaid and Kennely (2009), direct costs are costs that include the demands placed on the emergency services as well as the use of potential life-saving interventions, police investigations and funerals. While indirect costs or lost output costs refer to a fact that as a result of the premature death, the individual loses the opportunity to contribute to the economy, whether this is through paid work, voluntary activities, or family responsibilities such as looking after one's children.

According to Afunde (2008), economic hardships set mostly in where the suicide victim was the main breadwinner of the family. Therefore, the aftermath is that the bereaved family will face financial constraints. In suicide cases, Afunde (2008) explains that there are legal and insurance problems involved. For example most insurance companies have strict conditions towards suicide cases that can result in a great financial loss for the family.

2.6. The theoretical framework of the study

This study was grounded in the theoretical framework of the Suicide Professional Model (SP Model) according to (Appalsamy, 2000). This model explains the process of suicide and highlights the preventative strategies to suicide reduction. It recognizes the contribution of predisposing stressors to the development of vulnerability to suicide as well as protective factors. The three stages of this model are: the Ideation Dominance Phase (ID), the Affect Dominance Phase (AD) and the Satiation Phase. The model thus assumes that the reality of suicide is processual, and that the potentially suicidal individual goes through different phases. Lekka, Argyriou and Beratis (2006) explain the

suicide process by describing suicidal behaviour as a continuum of gradually increasing seriousness; whereby attempters may feel that life is not worth living. Hence, the thoughts of taking one's life start as the individual starts to seriously consider suicide, suicide planning and suicidal attempts.

According to Appalsamy (2000), the ID phase is characterized by different suicide ideations, thus the individuals engage in an internal "court-drama" thinking of whether to kill themselves or not and also thinking of how to go about killing themselves. For example, one interviewee as reported in the study conducted by Vatne and Naden (2011, p. 308) said that "and there I was sitting in the evening, counting pills, with a bunch in each hand, shall – shall not, shall – shall not, but something held me back".

Furthermore, this is the phase that the WHO (2000) regards as a see-saw battle (ambivalence) when the suicidal people have the mixed feelings of the wish to live and the wish to die. The WHO (2000) further explained that in this phase many people are not willing to die, it is just that they are unhappy with life thus they have an urge to get rid of the pain. Pavulans, Bolmsjo, Edberg and Ojehagen (2012) called end the pain as "the only way out of endless suffering". Pavulans, et al. (2012) further explain that the endless sufferings include feelings of being sad, anxious, scared, empty, lonely, rejected, weak and worthless; experiences of failure, meaninglessness, disappointment and hopelessness. The endless sufferings are the main reason behind the recurrence of suicide ideations especially if there is no help to the person in pain or who is suffering. For example, Orri, Paduanello, Lachal, Falissard, Sibeoni and Reva-Levy (2014) reported that one interviewee had been changing but close people or family members could not realize it until such a time when she/he ran away from home. Prabhu, Molinari, Bowers

and Lomax (2010) identified two ways in which choices of the range of life narrowed into; such as finding a solution to intolerable pain or ceasing the pain by ending one's life.

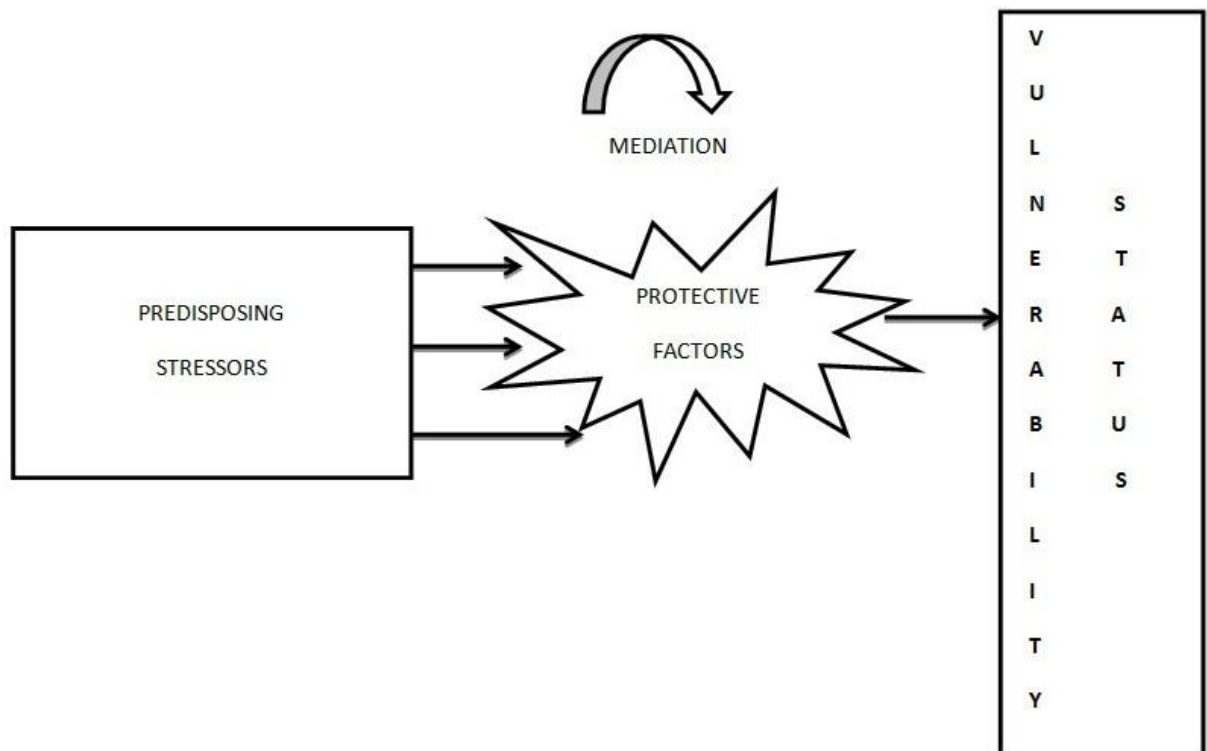
Additionally, Appalsamy (2000) identified protective factors that are recognized by the SP model that can keep an individual alive. The protective factors are such as personality, interpersonal and familial protective factors. Furthermore, Appalsamy (2000) explicated that the personality protective factors include the adaptive capacity of the individual, resiliency, autonomy and control. The interpersonal factors comprise of the available social support, whilst familial protective factors consist of family cohesion and warmth. In addition, Berman and Jobes (as cited in Appalsamy, 2000, p. 154) stated that good physical health represents a possible protective factor.

According to Schneidman (as cited in Appalsamy, 2000, p. 155), the longer an individual continues engaging in the court drama, the greater the death thoughts will be reduced by other existential concerns. As a result the suicidal affect will be build up. Appalsamy (2000) explained that the suicidal affect occurs when the intolerable mental anguish and the presence of psychological pain is suppressed by the presence of ambivalent suicidal ideation. The excessiveness of the suicidal affect will end on the beginning of the Affect Dominance Phase (AD). Appalsamy (2000) stated that the AD phase is characterized by a continuum of PPA (physiopsychache) from low to high levels. This is whereby an individual engages in a form of incongruent catharsis such as writing and engaging in the poem about suicide (low PPA levels) or engaging in a form of quasi-primal fight-off (high PPA levels). According to Appalsamy (2000), the quasi-prima fight off that contributes to high PPA levels are such as intense spasmic crying, clenching of fists,

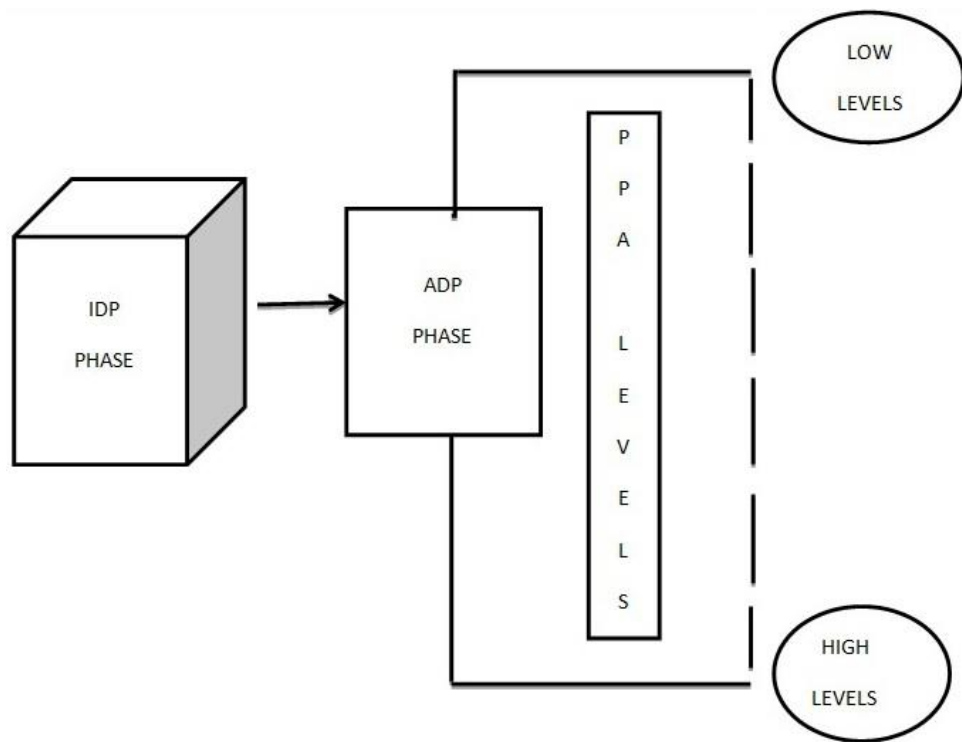
tensing of the body, and a high degree of difficulty in breathing and panic episodes. Janov (as cited in Appalsamy, 2000, p. 155) said that the suicidal pain and mental anguish are ventilated into the form of a quasi-primal scream that results into a cathartic effect.

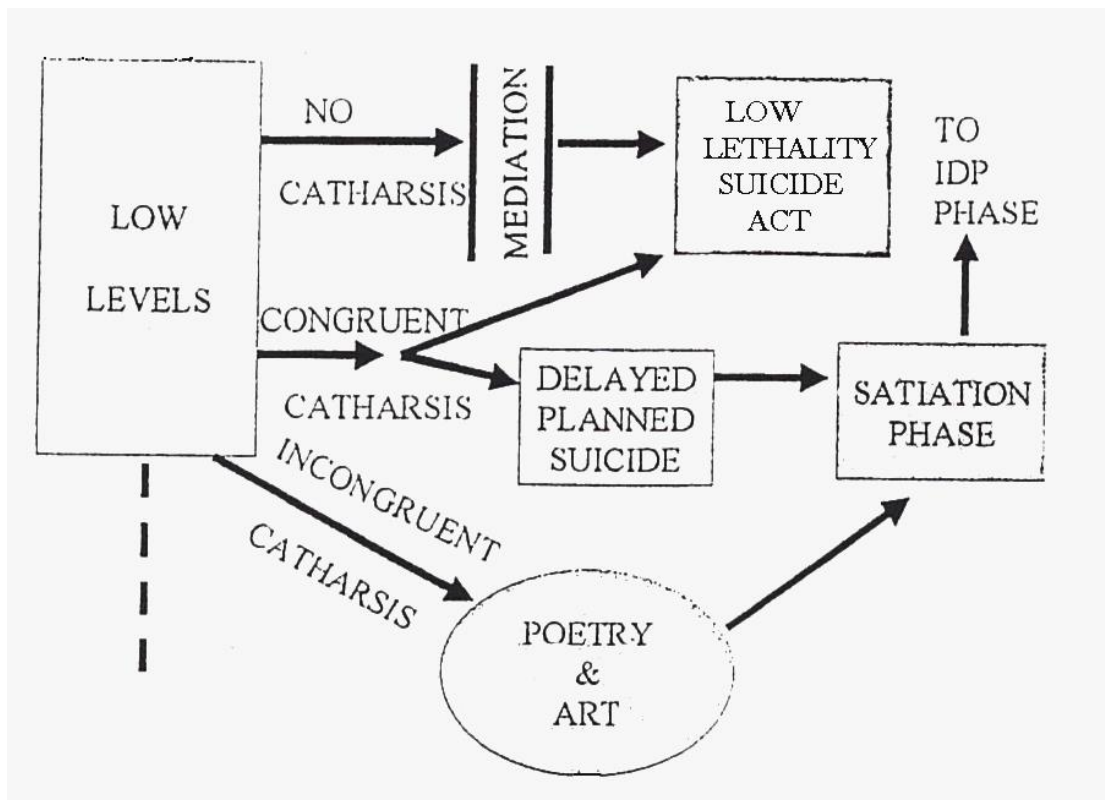
“In engaging in forms of incongruent catharsis, the individual goes through a Satiation Phase in which there is a relative mental calm, physical exhaustion, cognitive clarity, and emotional stability” (Appalsamy, 2000, p. 155). This is what Sun and Long (2013) referred to as the tipping/turning point. According to Sun and Long (2013), tipping/turning point is when the suicidal persons come to an understanding that they did not want to die, they only need help to learn how to tolerate intense feelings. However, Appalsamy (2000) argued that if no therapeutic intervention takes place, the individual will once again go through the suicide processual cycle, starting again from the Ideation Dominance phase.

Eventually, Appalsamy (2000) emphasized that the SP model has not yet been formally validated, nonetheless it represents a challenging and yet fascinating enterprise for future suicidological studies. However, the researcher believes this model is valid for the Namibian context because it facilitates understanding of the suicide process and also highlights the preventative strategies to suicide reduction. Below is the Suicidal Processual Model (SP Model) as illustrated in figure 2.

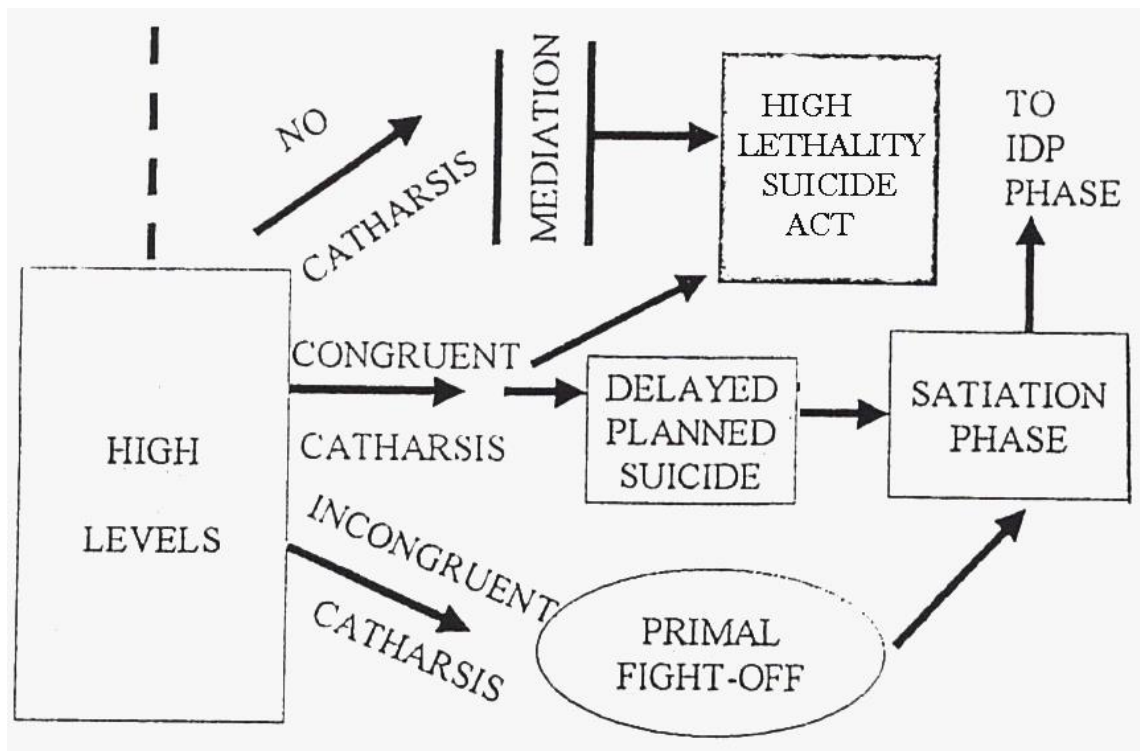


Flow Chart A

**Flow Chart B**



Flow Chart C



Flow Chart D

Figure 2: The Suicide Processional Model (SP Model): A theoretical framework for understanding the process of suicide (Appalsamy, 2000)

2.7. Summary of the literature review

The researcher used relevant sources from previous studies using a systematic review process. Sources reviewed for this literature include the EBSCOHOST database, SAGE publications, text books, newspapers and social media such as facebook. The most common key words which were used to review the literature with regards to the causes of attempted suicide are: attempted suicide, suicide, effects of attempted suicide, experiences of attempted suicide, Ohangwena region.

The most common causes of attempted suicide and suicide as per the reviewed literature are physical illness, unemployment and inadequate financial resources, poverty,

depression, family history of suicide, bereavement, previous suicide attempts, substance abuse, relationship problems, family problems, aggression and violence, and impulsivity. The researcher also looked at the effects of attempted suicide and suicide in order to understand the circumstance of suicide attempt and suicide better. The appropriate theoretical framework was also reviewed during the literature review.

The methodology employed during this study is explained in the following chapter. Research instruments, procedures, data analysis and ethics are illustrated in the following chapter.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

The methods used in the current study are presented in this chapter. The motive behind this study is enlightened by describing the aim and objectives of the study. The study's population and sample are indicated and explained. Research instruments, procedures, data analysis and ethics observed during this study are also stipulated in this chapter.

3.2. Aim of the study

Different studies are conducted with various reasons, either because of the researcher's curiosity, organizational needs or other forms of motivation. According to Neuman (2011) the purposes of studies can be organized into three groups, namely to explore a new topic, describe a social phenomenon, or explain why something occurs. The current study is an exploration study that enables a researcher to explore the causes of attempted suicide in the Ohangwena region. This means that the researcher does not know the reasons for the occurrences and increases of attempted suicide in the Ohangwena region. "The aim of the study is to find out the truth which is hidden and which has not been discovered as yet" (Kothari, 2011, p. 2). Therefore, the purpose of this study was to contribute to closing the knowledge gap that exists concerning the causes of attempted suicide in the Namibian context, especially in Ohangwena region.

3.3. Objectives of the study

The objectives of this study were five-fold. Specifically, the study aimed:

- to investigate the causes of attempted suicide in Ohangwena region,
- to find out the effects of attempted suicide on suicide attempters,
- to understand the experiences and feelings that the suicide attempters experienced during and after suicide attempts,
- to determine the support systems available for suicide attempters, and
- to explore the suicide attempters' views with regards to suicide prevention in the Ohangwena region.

3.4. Research design

Since this study sought for an understanding of the causes of suicide attempts, a qualitative approach was utilised. Fouché and Schurink (2011) point out that the qualitative researcher is concerned with understanding rather than explaining, with naturalistic observations rather than controlled measurement, with the subjective exploration of reality from the perspective of the insider. In addition, Neuman (2011) says that qualitative researchers speak a language of cases, contexts and of cultural meaning. This means that they are more focused on detailed examinations of cases that arise in the natural flow of social life. The researcher used a phenomenological design to obtain descriptions of participants' experiences with regards to the suicide phenomena. The purpose of phenomenology as explained by Fouché and Schurink (2011) is to understand the phenomena under study on their own terms and provide a description of the human experience as it is experienced by the participant.

3.5. Population

The population for this study comprised people who attempted suicide in Ohangwena region. These are the actual people who have attempted suicide and experienced the crisis of the suicide attempt in the Ohangwena region.

3.6. Sample

The sample was drawn from the three districts of Ohangwena region, namely Eenhana, Engela and Okongo. The sample consisted of twenty (20) participants who were purposively selected from the social workers' case registry. These were ten (10) suicide attempters from Eenhana District, because this district has the highest statistics of attempted suicide cases, five (5) suicide attempters from Engela District, and five (5) suicide attempters from Okongo District. The sampling population were roughly even numbers of males and females between the ages of 21 to 54. Since there was a small number of participants meeting the criteria for example, researcher wanted to recruit participants between the ages of 18 to 40 as they were reported as people with the highest suicide attempt cases. However, researcher ended up recruiting people of any age referred to by social workers, and those participants responded positively and were included in the present study. This meant that the social workers responded positively to the ideal for participants to be invited for the study by completing a consent form indicating their willingness to participate in the study. Another criterion for the selection was that, participants must be referred to by Social Workers; must have attempted suicide for the past two years (between 2012 and 2013 respectively). One can argue that recruiting a sample that has been referred by social workers recently will in part ensure validity. Researcher felt that participants with more recent experience are able to

remember and talk in much more details surrounding their circumstances at the time. However a much more flexible approach might have yielded a larger responded group from other regions. Participants must be living within the Ohangwena region and must not be accommodated in any institution such as hospitals, prison etc.

The non-probability purposive sampling was employed using quota sampling to reflect the distribution of suicide attempt cases in Ohangwena region. Sarantakos (2005) regards purposive sampling as a judgmental sampling because the choice of participants is being guided by the judgment of the investigator. Thus in this regard, the researcher purposively chose subjects who were relevant to the study. The researcher also went on to employ the quota sampling method. Sarantakos (2005) explains quota as a set of participants chosen from a specific population group, where the researcher defines the basis of choice and determines the size of the quota.

According to Neuman (2011) quota sampling is a non-random method whereby the researcher first identifies general categories, then narrows down to a pre-determined number in each category. Sarantakos (2005) explains that quota sampling method “does not require sampling frames, it is relatively effective and can be completed in a very short period of time” (p. 165). Considering the sensitivity of the study this was the most appropriate method.

3.7. Research instruments

A semi-structured interview schedule was used. Twenty participants who have attempted suicide in Ohangwena region were interviewed. The researcher used a self-developed interview guide, field notes and an audio recorder to collect data during interviews. The

face-to-face semi-structured interview was carried out in order to get participants' points of view about the suicide phenomenon and to explore the negative impact it has on the lives of the suicide attempters. Patton (2002) postulates that the open-ended responses can allow the researcher to understand the world as seen by the participants. In the same way, Sarantakos (2005) recommended the use of open-ended or free answer questions as they allow participants to state their answers in a way they see appropriate, in their own way and in their own words. Therefore, in this study a self-developed interview, consisting of open-ended questions as focus questions, was utilised. Examples of questions include: What made you consider taking your life? How has your life changed since you attempted suicide? How would you explain your experiences and feelings of attempted suicide?

Prior to data collection, the researcher conducted a pilot study using three participants (one participant per district) and that helped to ensure the validity of the study. Researchers such as Ray (1994) quoted in (Chan, et.al 2013) argued that in phenomenological research questions are not pre-determined but rather the researcher follows the cues of the participants. Englander (2013) on the other hand suggests that one or two questions be formulated to explore the phenomenal under study. The pilot conducted following the suggestions by the two scholars above did not yield the results sought and thus researcher opted for pre determined open ended questions. This enabled the participants to use their own discretion in relating their experiences of attempting suicide. One of the purposes of a pilot is to test the relevance of a research instrument, and should the instrument not work to assist in attaining the research objectives, the researcher may revise it. This is what has been done in this case.

Moreover, probes were used to get clarification to answers as well as examples that may be required.

According to Ray (as cited in Greef, 2011, p. 349), the phenomena of experience should be probed with the participant until “the thing itself” is illuminated and described. In addition, follow-up questions were used “to pursue the implications of answers to the main questions” (Greef, 2011, p. 349).

Since most of the inhabitants of Ohangwena region are Oshiwambo-speaking, the interview schedule was prepared in English (Appendix A) and then translated to Oshiwambo. The researcher is an Oshiwambo-speaker and is fluent in the Oshiwambo language. Moreover, each interviews lasted approximately two (2) hours.

3.8. Procedures

The researcher was granted ethical approval to conduct the research activities by the University of Namibia’s School of Postgraduate Studies (Appendix C). Permission to carry out the current study was also given to the researcher by the Ministry of Health and Social Services (Appendix D).

The participants were selected from the cases in the registry of the Developmental Social Welfare Services (DSWS) of the Ministry of Health and Social Services in all the three districts. The interviews took place in the community at the participants’ residence and at the social workers’ offices in the three mentioned districts. Potential participants were contacted via telephone to make appointments to visit them, to build a relationship,

introduce the purpose of the study and to emphasize the importance of the study. The participants' telephone numbers were obtained from the case registry books in the social workers' offices. Moreover, the interviews were conducted in a conducive environment to the participants such as their respective houses or social workers' offices. Owing to the sensitive nature of the study, the researcher conducted pre- and post-interview counselling sessions with each research participant. During the interviews, notes were taken and the interview was audio-recorded for a more accurate transcription of the interviewees' insights.

3.9. Data analysis

The data gathered was analysed by re-reading the transcripts, replaying the audio recordings and re-examining the collected information. When reviewing materials, notes were taken to prepare the interpretation and compilation of a narrative report. Thematic content analysis was employed as a technique of data analysis that enabled recurrent themes, ideas and beliefs to be identified. According to Burnard, Gill, Stewart and Chadwick (2008) thematic content analysis involves analysing transcripts, identifying themes and categories that emerges from data. Therefore, in this study thematic content analysis was applied to gather and analyse the content of texts such as words, meanings, ideas, themes and other communicated messages spoken by the participants during interviews.

The researcher crystallized the data with the participants. "Crystallisation is a better lens through which to view the components in qualitative research" (Maree, 2007. p. 41). When data is crystallised, the researcher is able to attend to voices that differ from his or her own understanding of the phenomena under discussion. For example, during the

interview, when subjects mentioned that they saw the “darkness”, the researcher asked the participants to clarify what they meant by darkness.

3.10. Research ethics

“Research should be based on mutual trust, acceptance, cooperation, promises, and well-accepted conventions and expectations between all parties involved in a research project” (Strydom, 2011, p. 113). Therefore the following ethical principles were adhered to in this study:

3.10.1. Written informed consent

The purpose of the study was explained to the participants. Participants were asked to give consent to participate in the study, thus the forms of informed consent were given to the participants to sign (Appendix B). According to Silverman (2010) consent has to be freely given in order to be valid.

Nevertheless, Silverman (2000) viewed that initial consent may not be enough, especially when the researcher is audio recording the interviews. In such a case, Silverman (2010) suggests a further consent on how data may be used. Thus for this study, in addition to the written consent that was signed by the participants, the researcher further asked permission to audio record the interviews. The researcher also explained the purpose of audio recording. Participants were also assured that they can withdraw any time from the research if they feel like not continuing anymore.

3.10.2. Voluntarily participation

Participation in this study was voluntary and no one was forced or coerced in any way to participate.

3.10.3. Avoidance of harm

Strydom (2011) maintains that, during participation in research, there is a fact that the negative behaviour of the past might be recalled to memory during the investigation and this could bring the renewal of personal harassment or embarrassment on the participants. For this reason, the researcher provided pre- and post-counselling to avoid any harm caused by memories. The researcher established rapport by breaking the ice through asking general questions. The researcher explained the purpose and the importance of the study. Pre-counselling prepared them for the interviews. Since every respondent's self-report was different, post-counselling was based on the individual respondent's self-report.

3.10.4. Anonymity

According to Neuman (2006), a researcher has to protect privacy by not disclosing the participant's identity after the information is gathered. Thus the names of the participants and districts were anonymous throughout this study. Participants and districts were given pseudo/fictitious names to protect their identity, such as participant 1 or District 1 (D1).

3.10.5. Confidentiality

There was a limitation of access of others to the private information that was collected as part of this study. Only the researcher and supervisor had access to the information. The

data has been kept in a secure place and locked in a cabinet in the office of the social worker, until it will be destroyed. Additionally, the researcher provided counselling services to the participants before and after the interviews, because sharing their experiences of suicidal incidences was expected to trigger negative emotions.

3.11. Summary of methodology

The aim of this chapter was to discuss the methods and instruments used and the procedures which were applied to collect data in this study. Owing to the nature and purpose of this study, the qualitative method was utilised to understand the causes of suicide attempts in Ohangwena region.

The research instruments used to collect data for this study were a semi-structured self-developed interview guide, field notes and an audio recorder. Data was collected from the three districts in Ohangwena region, namely, Eenhana district, Engela district and Okongo district. The researcher was granted ethical approval to conduct the research activities by the University of Namibia's School of Postgraduate Studies. Permission to conduct the current study was also given to the researcher by the Ministry of Health and Social Services. Importantly, this chapter further discussed how the participants were ethically protected. All the participants gave their consent to voluntarily participate in the present study by signing the written informed consent. The researcher provided the pre- and post-counselling to all the suicide attempters who participated in this study to avoid any harm that could have been triggered by negative emotions as they were sharing their suicidal attempts incidences. The identity of the participants and districts were protected by allocating pseudonyms, such as participant 1 or District 1 (D1). Data has been kept in a secure place to maintain confidentiality.

The next chapter entails the results and discussions of the data collected in this study. Data was collected, analysed, interpreted and narrated to describe the reasons behind the suicide attempts in Ohangwena region as they were given by the participants during the interviews.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1. Introduction

This chapter presents the results and discussions of the data that was collected from the three districts in Ohangwena region. To maintain confidentiality, district names will not be revealed. Rather pseudonyms will be used, namely, District 1 (D1), District 2 (D2) and District 3 (D3). The sample of the study consisted of 20 participants who had attempted suicide. The sampling criteria were implemented as described in chapter three. Thematic content analysis was employed as a technique of data analysis.

Data crystallisation was used. The researcher verified raw data during interviews by asking participants to verify whether their interpretation of what they have shared with the researcher is correct. Furthermore, the researcher grouped the quotes of each participant based on the similarity of the content. Similar sub-themes were identified and grouped into larger categories to identify themes and build general categories. The study identified four categories, thirteen themes and fourteen sub-themes to describe the meaning of the causes of attempted suicide as experienced by participants. The categories, themes and sub-themes are illustrated in Table 2. Participants' views with regards to suicide prevention in Ohangwena region were also discussed in this chapter.

4.2. Socio-demographic data of the participants

In this study, the demographic information of the participants was collected to depict the sex, age range, marital status, place of residence, family status, number of children,

educational level and the employment status of the people who attempted suicide in Ohangwena region. The researcher believed that knowing the demographic information of the participants helps to give a clear picture of the characteristics of the people who attempted suicide in Ohangwena region. Therefore, the socio-demographic data of the people who have attempted suicide in Ohangwena region is presented in Table 1 below.

Table 1: Socio-demographic data

Variable	Frequency
Sex	Female: 12 participants Male: 8 participants
Age range	21-54 years old
Marital status	Single: 13 participants Married: 1 participant Co-habiting: 4 participants Widowed: 1 participant Separated: 1 participant Divorced: 0
District	District 1 (D1): 5 participants District 2 (D2): 5 participants District 3 (D3): 10 participants
Family status	Living alone: 2 participants Living with relatives: 16 participants Living with friends: 2 participants Others: 0
Number of children of participants	Only 1 child = 2 More than 1 child = 13 No children = 5

	Children's age ranges (1 month - 31 years old)
Educational level	No education: 0 Primary education: 15 participants High school: 4 participants Tertiary education: 1 participant
Employment status	Unemployed: 10 participants Self-employed: 2 participants Full-time employed: 6 participants Part-time/casual employed: 1 participant Student/learner: 1 participant Pensioner: 0

Of those suicide attempters who have participated in this study, twelve were women and eight were men. According to Joiner (2005), women are estimated to be three times more likely to attempt suicide than men. In contrast, Joiner (2005) argues that men are approximated to die by suicide as they use lethal tools and they are more exposed to guns, physical fights and to self-injecting drug use. However, District two (D2) has shown more men than women who have attempted suicide compared to Districts 1 and 3. This result is consistent with Schlebusch (2012) who explained that there is a higher rate of suicide among women than men in countries such as rural China.

The participants' ages ranged between 21 years and 54 years, with the highest representation being in the category of 21-25 years and 26-30 years. These results concur with Joe, Stein, Seedat, Herman, and Williams (2008). In their study, Joe et al. (2008) explained that the risk factor for suicide attempters is highest in the age groups of 18-34 years. Category 21-25 is represented by a number of seven attempters, followed by the

category 26-30 years being represented by five attempters. The category of 31-35 and 51-54 years, each is represented by two attempters while category 46-50 is represented by three suicide attempters. This is an indication that the problem of attempted suicide in the Ohangwena region is high in adults. Similarly, this result is supported by the World Health Organization (WHO, 2013), as it indicates that the suicide problem is more prevalent among the adults as from the ages of 15-44 years old in some countries. As far as the marital status of the participants is concerned, those who are single formed the largest group of participants with a total of thirteen. Second placed were participants living in cohabitation with a total of four. The last three were as follows: one married, one widowed and one separated respectively. This study indicates that there is a high rate of attempted suicide in single people and those who are cohabitating, and this is unlike other studies such as the WHO (2009) that show that there is a high representation of suicide rates on the divorced/separated people.

Regarding the place of residence, the study indicated a high representation of ten participants living in district three (D3), while both districts one (D1) and two (D2) had the same number of five participants. As per the study sample, D3 was found with the highest statistics of attempted suicide cases, therefore a high number of participants was drawn from D3. This can be also a reason of two different perspectives; either awareness raising on suicide prevention were done very well in District 3 which enabled the inhabitants to be aware of where to go for help. Otherwise, despite the suicidal behaviour problem in the Ohangwena region generally, District 3 might be a particular crisis district compared to other two districts with regards to the suicide attempt problem.

Owing to the time limitations, this study did not get to explore the precise fact of why District 3 has a high number of suicide attempt cases compared to other districts; however, this gap is left for future researches in the Ohangwena region to find out more about this particular phenomenon.

The highest number of the family status was represented by participants who were living with their relatives (16 participants). Participants who were living alone and those who were living with their friends both were represented by two participants respectively. The study also revealed that the majority of people who have attempted suicide in the Ohangwena region are those who are living with their relatives. This is not a surprise because in the Oshiwambo cultural context, people do not live alone or live with friends. Oshiwambo culture believes in extended families. Participants who reported that they are staying alone or with friends in this study, are those staying away from their families/relatives' houses for employment reasons, thus they might be renting or temporarily accommodated by friends.

The results of this study also indicated that fifteen of the participants had no children. This finding is in the same line with Joiner (2005) who viewed the matter of having children as a protective factor against suicide. Fifteen of the participants have attained primary school, while four participants went up to high school. Only one of the participants had tertiary education. This is an indication that most of the people who have attempted suicide in the Ohangwena region only have primary education.

With regards to (un)employment, nine participants were unemployed, followed by six participants who were full-time employed, two self-employed, while two more were learners and one was in part-time/casual employment. The association between

unemployment and suicidal behaviour concurred with those by several studies (Maris, Berman & Silverman, 2000; Moosa, Jeenah & Vorste, 2005; Yurýev, Varnik, Varnik, Sisask & Lepp, 2000). This study revealed that it is not only unemployed people that are at risk of suicide or suicide attempts in the Ohangwena region; however employed people are also affected in a way. The study findings go along with the findings of several studies such as Yurýev et al. (2000) who also viewed unemployment, inadequate financial resources and financial problems as the leading factors that negatively affect both unemployed and employed people.

4.3. Categories, themes and sub-themes identified on the present study

Looking at the causes of attempted suicide as identified in this study; categories, themes and sub-themes were developed to give meaning to it and they are illustrated in Table 2 below.

Table 2: Categories, themes, and sub-themes identified

Categories	Themes/Sub-themes
Reasons given for suicide attempts	Interpersonal relationship problems.
	Relationship problems with family.
	Relationship problems with community.
	Financial problems.
	Mental health related problems.
	Hallucinations.

	Impulsivity.
	Previous suicide attempts.
	Negative emotions towards the self. Feelings of hopelessness.
Impacts of suicide attempts on attempters	Effects of suicide attempts.
Experiences and feelings of an attempter	Depressive symptoms. Sign of depressed moods.
	Method of suicide attempts.
	Episode of suicide attempts.
	Family and community reactions towards an attempter. Family reactions. Community reactions.
	Feelings of suicide attempts. Feelings of death.

	Feelings of anger. Feelings of remorse. The re-occurrence of suicidal ideations after suicide attempts.
	Coping mechanism. Religious beliefs. Professional help.
Support system for suicide attempters	Family and friends support.

4.3.1. Reasons given for suicide attempts

Five themes emerged in this category and these are interpersonal relationship problems, financial problems, mental health related problems, previous suicide attempts and negative emotions towards self.

4.3.1.1. Theme 1: Interpersonal relationship problems

Two sub-themes namely relationship problems with family and relationship problems with community were identified.

4.3.1.1.1. Relationship problems with family

Most of the participants experienced relationship problems with their families prior to their suicide attempts, and they tend to ruminate on a variety of topics such as anger,

disappointments, blame on alcohol abuse and feelings of shame. The relationship problem with the family involved partners, children and relatives.

Participant 1 (D1) was distressed over a lady who answered her boyfriend's phone: *"I was angry when I called my boyfriend then the phone was answered by his girlfriend... since then, the suicidal thought just started"*.

Participant 1 (D1) further explained that the lady answered her in a bad way such as: *"what do you want? You are just a dead body speaking. You will die and leave this man for me"*.

Participant 3, 4, 5 (D1) and 7, 8 (D2) all expressed disappointments in their relationships with their families and this led them to the decision of taking their lives. For example, participant 3 (D1) reported that she was pregnant but her partner told her to either terminate the pregnancy or commit suicide. She noted that: *"I did not know what to do and what to do with the pregnancy"*.

Participant 4 (D1) explained that: *"there is no peace between my uncle (father's brother) and myself. My uncle is the one who do not have peace with me. My father died in 2010, survived by 36 children. My father had a shop that was given to us (his children) after his death, however our uncle did not wanted us to inherit our father's property or to stay in our father's place"*. Participant 5 (D1) said: *"I was hurt by my grandmother who said bad words to me"*, Participant 7 (D2) said: *"I have been disturbed by my children as sometimes you talk to them but the way they are answering is not acceptable"*. Participant 7 (D2) further explained her disappointment by her children as she gave an example that she talks to her children repeatedly but there is no improvement. Participant

8 (D2) reported that: *“I was hurt by my family, they disappointed me. They have been saying bad words to me, for example, you do not even look for a job, you are just depending on our mother and you are even having children”*.

Some participants reported that alcohol consumption had contributed to their suicidal ideation. Participant 11 (D3) said: *“we were drunk, my boyfriend and I. My boyfriend does wrong things when he is drunk and he tends to sleep with other women in my presence. That day, when I talked about it, he beat me up; therefore I decided to commit suicide”*.

Participant 12 (D3) reported his feelings of shame in the following way: *“I slept with someone who is not of my age, because I was drunk, and she is not even beautiful. Tomorrow morning my uncle’s wife asked me, saying, “I have seen you followed by one woman ... Again a girl from my uncle’s house started to laugh and says that she remember the day I went out with an ugly woman”*. Participant 18 (D3) indicated shame in the following way: *“I had been dating a boyfriend whom I realized was HIV positive, and I went to tell my family members. One of the members in my family revealed the HIV status to his friends and since then they have been bullying / mocking me. I then decided to take my life”*.

4.3.1.1.2. Relationship problems with community

Some of the participants reported relationship problems with the community as the cause of suicide attempts. Topics entailed in this sub-theme are such as mistreatment and accusations of negative behaviours. Participant 7 (D2) reported the community mistreatment she went through such as being talked to as if talking to a small child or

sometimes when she is just passing by and one says she/he hates you or she/he does not even want to look at you. Participant 8 (D2), 16 and 17 (D3) all said that they were accused of things they did not do or for what they were not; participant 8 (D2) explained that anything that happened at their village/community such as theft for instance, he had been accused of being responsible. Participant 16 (D3) said that she was accused of being a mother. She noted that: *“We were having a beauty pageant at school, and then I won. One teacher accused me and told the judges that I am having a child. Judges believed him because they do not know me. Then they changed me from the first winning position to the second position. Later my fellow learners start to tease me thus I decided to commit suicide”*.

Participant 17 (D3) reported that her suicidal ideation started when she was accused of revealing other people’s HIV positive status. She stated that: *“I was accused of talked about the HIV positive status of other people. Therefore, later I was called in for the traditional court hearings and all the people were against me”*.

4.3.1.2. Theme 2: Financial problems

This study identified financial problems as one of the main themes in the category of the reasons of suicide attempts in the Ohangwena region. Participant 14 (D3) reported: *“my suicidal thoughts were caused by financial problems. Problems were so many that I found myself going to cash loans and ended up drinking alcohol and gambling”*. Participant 6 (D2) also said that he also experienced financial problems as a contributing factor to his suicidal ideation. He reported: *“some monies are needed at school while some are needed for socialization. I was in a relationship with my girlfriend and she was too demanding. The situation led me to cash loan because if I tell my family, they will*

not feel good about it. I am in debts, and some debts are caused by her (girlfriend). She jeopardizes my work and she has been giving me some headache”.

4.3.1.3. Theme 3: Mental health related problems

The theme of mental health related problems pointed out issues related to mental problems that contribute to suicide attempts such as hallucinations and impulsivity which serve as the main sub-themes of this theme.

4.3.1.3.1. Hallucinations

Several participants indicated the experiences of hallucinations at the time of their suicide attempts. Some of the participants explained that it was not their intention to attempt suicide, but they were rather hearing voices instructing them to commit suicide. For example, Participant 2 (D1) reported: *“It was something within me pressurising me and telling me to go and commit suicide. I was not willing to do so but that thing is just pressurising me. Sometimes I do hear a voice telling me to commit suicide”*. In addition, Participant 2 (D1) explained his hallucinations experience: *“when I was on my way home, I was like visualising two roads/ways instead of one. When I entered my room the situation get worsened. I just saw the darkness; I heard the voice telling me that take a knife now. And then I was trying to use it. I heard the voice again telling me to put back the knife and use a rope instead”*.

Similarly, Participant 4 (D1) described her experience of hallucinations that: *“in the next morning after my uncle insulted me, I just saw the darkness and heard a voice telling me that kill that child, and then you go and commit suicide in the bush”*. Participant 9 (D2)

indicated that: *“I was visualizing seeing people in my room. I just saw something dark like shadows of people on my face and when I woke up there was no one”*.

4.3.1.3.2. Impulsivity

Most of the participants explained the suicide attempt act as a quick moment that may happen without thinking carefully of what you are doing. Participants shared their experiences of the occurrence of the suicide ideations. For example Participant 1 (D1) reported: *“it was just a short time, the time that my boyfriend’s girlfriend answered me. It did not take long time”*. Participants 4 (D1) and 5 (D1) indicated that their suicide ideations just started the very moment they heard offensive words from their relatives. For example Participant 5 (D1) noted that: *“it was just that time when my grandmother said bad words to me”*. Participant 16 (D3) pointed out that he just thought of committing suicide within three hours. Participant 15 (D3) and 17 (D3) explained that it only took them one day to think of committing suicide. For example Participant 15 (D3) shared her experience of suicide ideation after the death of her husband by suicide. She reported that: *“I just experienced it suddenly. When I woke up, I just thought of committing suicide”*. Additionally, Participant 17 (D3) explicated more in detail: *“I was acting fast while people are away, so that when they come they will just find a corpse”*.

In contrast, Participants 3 (D1), 8 (D2), 11 (D3), 12 (D3), 14 (D3), 18 (D3) 19 (D3) and 20 (D3) all explained that they had been gradually thinking of taking their lives for over a period of time from one month to nine months. Participants 14 (D3) further explained that his suicidal ideation had been intermittent.

4.3.1.4. Theme 4: Previous suicide attempts

This theme indicates the re-occurrence of suicidal behaviour in the participants of the three districts in Ohangwena region. Several participants reported that they had attempted suicide before. District 3 (D3) came out with the largest number of participants who had previous suicide attempts compared to the other two districts whereby in District 1 (D1) there was only one participant who had attempted suicide before, while in District 2 (D2) none of the participants had attempted suicide before. These findings illustrate how serious is the suicidal behaviour problem in District 3. Five out of ten participants from District 3 reported to have had attempted suicide before; two of them attempted suicide three times before, while three of the participants had attempted suicide for two times before. Several participants such as participant 14 (D3) reported that even though they had attempted suicide once, they had been experiencing suicide thoughts for so long prior to their attempts.

4.3.1.5. Theme 5: Negative emotions towards the self

This theme pointed out the negative emotions that the participants had towards themselves which they reported led them to suicide attempts. The negative emotions towards the self that came out in this study are such as hopelessness feelings. Therefore, the feeling of hopelessness emerged as a sub-theme from this theme.

4.3.1.5.1. Feelings of hopelessness

Participants related how the feeling of hopelessness to the changes they thought could take place if they could have died. Some participants linked hopelessness by specifying their circumstances, while others related hopelessness to all areas of their lives.

Participants 12, 16 and 18 (D3) described feeling of hopelessness relating to numerous circumstances such as to the peace of family members and to the community or friends; and accusations. For example, Participant 18 (D3) reported that people would feel much at ease when she is no more: *“It will be good that no one will see me anymore. People who have been accusing me of being HIV positive will stop talking about me”*. Participant 16 (D3) in contrast reported that her suicidal ideation started when her teacher accused her of having a baby and being dead would ease the pain.

In addition, Participant 20 (D3) indicated that his feelings of hopelessness were related to emotional breakdown because his partner left him for another man: *“I experience a problem in my life caused by thoughts because my wife left me for another man”*. He went on to explain further in the interview that: *“I thought taking my life would be better than suffering”*. Participant 2 (D1) pointed out that his feelings of hopelessness were related to problem solving: *“I was thinking that I was solving the problem and my soul is going to rest and be free from problems”*. Participant 8 (D2) reported that his feelings of hopelessness were related to the allegations he received from his community and family: *“I just thought of committing suicide so that the allegations notes will be placed on my grave stone”*.

4.3.2. Impact of suicide attempts on attempters

This category looked at the impact of suicide attempts on the participants since the occurrence of the suicide attempt in their lives. The effects of suicide attempt on attempters was the only theme that appeared out of this category.

4.3.2.1. Theme 6: Effects of suicide attempts on attempters

This theme presented the consequences of the suicide attempts as they were mentioned by the participants during the interview. A great number of participants indicated various effects of the suicide attempt aftermath and they also described how their lives have changed after suicide attempts. The effects included the psychological effects and physical effects. Psychological effects include unconsciousness and confusion, while physical effects are such as pain, vomiting and visible marks, especially on the necks of the participants who had hanged themselves. Most of the psychological effects were temporary as they were only experienced during the first weeks of suicide attempts, while several physical effects such as visible marks may take time to fade away or might become permanent marks or permanent effects.

There are some participants who have experienced both psychological and physical effects; Participants 8 (D2), 12 and 17 (D3) are among them. For example Participants 8 (D2) and 12 (D3) reported that they were unconscious after they attempted suicide and they were left with visible marks on their necks.

In addition, Participant 17 (D3) explained that: *“I appeared confused and looked like a mentally disturbed person”*. Concurrently, she also signified that *“I had difficulties drinking and eating due to throat pain. I also experienced hearing problems”*. Participant 13 (D3) mentioned that she was confused after the suicide attempt and she also had neck pain as a result of the suicide attempt. She further reported: *“I did not know if people who came to rescue me were really aiming to help me. When they rescued me, I felt like they were the ones who wanted to kill me. Thus I grabbed my child and ran away. I ran away to escape the death that I felt like they were causing me. I do*

not know what kind of situation I was in. Participant 9 (D2) mentioned about suffering from chest and neck pains as a result of her suicidal attempt.

Furthermore, Participants 5 (D1), 15 and 16 (D3) revealed that they vomited after their suicide attempts. Participant 15 (D3) reported: *“I was unconscious, vomiting and I was not talking because my voice was gone.* Participant 15 (D3) further added that: *“I was scared and I was in pain”.* Participant 16 (D3) explained that after the suicide attempt, she was vomiting and she became weak and pale. Participants 10 (D2) and 20 (D3) are among some of the participants who were unconscious and found themselves in hospital. For example, Participant 20 (D3) noted: *“I found myself at the hospital casualty but I could not recall what happened”.*

Apart from psychological and physical effects, most of the participants described the positive change in the lives they have experienced after the suicide attempt or as effects of the suicide attempts. The positive change was noted when participants received counselling services, advice and support from families, friends, neighbours and or communities.

Contrary to the rest, Participant 2 (D1) explained how his life changed positively since he was taken to a traditional healer for treatment. Therefore he further explained that his situation made him to believe that people cannot commit suicide out of their own will unless there is something wrong in their mind that can only be healed by a traditional healer.

The majority of the participants indicated that they are no longer suicidal and they are not thinking of suicide any more as they have realised that suicide is not a solution.

According to Participant 7 (D2): *“even people who have been talking about me they are no more talking much about me. I have also noticed a good improvement on my children since the incidence of attempted suicide”*. Participant 11 (D3) spoke about the change that took place between her boyfriend and herself. She stated: *“we do not drink anymore; we realised that alcohol is driving us into the wrong doings. We found peace in the house. We have no more problems”*.

Participant 17 (D3) explained how her life changed on the cautious manner. She said that since the suicide incident: *“If a visitor comes to our house and tells me something, I do not respond, I rather go to a trusted person or call my husband for advice. Or if I am not interested in that visitor I go to my room and pretend as if I am not feeling well”*.

In spite of the positive change that Participant 5 (D1) experienced, she also expressed that the only challenge she has been experiencing since the very first time after she was discharged from hospital was getting scared when she heard her grandmother’s voice.

However, a few of the participants such as Participant 3 (D1) said that they did not experience any changes since the suicidal attempts. Participant 3 (D1) reported: *“I still can’t see any change. I even lost appetite for three months now since I attempted suicide”*. This is an indication that these participants were still be suicidal. According to Appalsamy (2000) if no therapeutic intervention takes place, individuals will once again go through the suicide processual cycle, as indicated in the theoretical framework of this study. This is what has happened to these participants.

4.3.3. Experiences and feelings of an attempter

The majority of the participants experienced suicide attempts and feelings differently, before, during and after the suicide attempts. Therefore, the themes which emerged from this category include depressive symptoms, methods of suicide attempts, episodes of the incidence of suicide attempts, family and community reactions towards the suicide attempter and the feelings during and after the suicide attempts.

4.3.3.1. Theme 7: Depressive symptoms

Most of the participants expressed their depressive symptoms before and after suicide attempts. The only sub-theme identified from this theme is the sign of depressed moods.

4.3.3.1.1. Sign of depressed moods

Some participants described their experiences prior to their attempts in very simple language. Topics from depressed moods included negative feelings and emotional depression. Participant 7, 9 and 10 (D2) identified factors that led to depression such as struggling with identifying feelings of depression.

Participant 7 (D2) for example identified her feelings by describing her thoughts in the following way: *“my suicide ideation was caused by anger and I had no other way to escape it”*. The participant then further explained later in the interview: *“I felt like people were disturbing me. I wanted them to leave me alone so that they can be happy as they want”*. In contrast, Participants 9 and 10 (D2) reported that they struggled to identify it when they felt depressed. Participant 10 said (D2): *“I would not know the feelings of suicidal thoughts at the time because I was so down. My idea was just to kill myself*

because there was nothing better than others anymore". Similarly, Participant 8 (D2) described feelings relating to emotional depression: "I had been thinking of suicide till I got very thin which caused me to cry often".

4.3.3.2. Theme 8: Method of suicide attempt

In this theme, the methods of attempted suicide which were used by the suicide attempters in the Ohangwena region were identified as hanging, ingesting tablets/pills, substance abuse and burning. Fifteen participants attempted suicide by hanging, using ropes, belts, wires, shoe laces and the head/hair scarf. Two participants attempted suicide by ingesting tablets/pills, one participant through abuse substance (alcohol), one tried to burn the house while the other participant said he could not remember what happened or what he used as he was unconscious.

4.3.3.3. Theme 9: Episode of suicide attempt

This study allowed the participants to describe in detail what happened during or at the time of the suicide attempt. This theme was developed to outline the participants' experiences of suicide attempts. Topics enlightened from this theme are such as instructions to commit suicide, ambivalent behaviour and painful experiences.

Several participants including Participant 2 (D1) and Participant 4 (D1) both described their suicide attempts as they were implemented upon hearing voices that were instructing them to kill themselves. Participant 2 (D1) noted: *"when I was instructed to commit suicide, I hanged myself, the rope broke then I fell down. When I fell down, I felt something was squeezing me down. Although, my eyes were closed, I saw something in the form of waves coming across me, but I could not tell of what it was. I heard the voice*

saying you are stupid; the rope you have taken is not strong. That thing has been squeezing me down and strangled and held my neck until I got tired and I was no longer moving. Then I heard the voice saying yeah you are now dead”.

Participant 8 (D2) explained his ambivalent behaviour during the time that he was trying to commit suicide: *“I took the rope, tied it on the roof of my corrugated iron room. I stayed a little bit on the bed quiet thinking of what to do. After some time I stood up, crying and then I hanged myself. The rope broke then I stayed a little bit unconscious. Later on, I took a wire and I tied it on the same roof, then I hanged myself again. The wire got broken as well, but I was completely unconscious”.*

Participant 12 (D3) described the three consecutive episodes of his suicide attempts in more detail: *“The first day, I was just in my room at night, and then I decided to hang myself. I tied the rope on the stick, and then I jumped. The stick broke when I jumped. When hanging did not work, I was thinking of burning myself in the hut, then I thought of other people in the house, then I withheld my decision. From there, I did not know how I slept, I just fell asleep. The second attempt happened when I was on my way from school, I pulled out my shoe laces then I hanged as well. Shoe laces were not as well strong, they broke. I rushed home to get a rope. When I went home I found people in the house so I could not do anything. On the last episode, I took a rope again, I went in the field, I tied the rope tightly, and then from there I do not know what happened further because I was unconscious”.*

Some of the participants spoke about not remembering what happened after they attempted suicide. For example Participant 11 (D3) reported: *“I hanged myself. Then*

later, I just found myself in hospital. I cannot remember the whole picture of the episode but what I can remember is just that I hanged myself with a head/hair scarf”.

Similarly, several participants reported of being unaware of what they were doing. Participant 20 (D3) said: *“I was very out of my mind. I did not know what I was doing. I understand I took a wire, tied it to a tree and on my neck and jumped. Apparently the wire broke and I tied it again, then apparently someone rescued me”.*

Several participants such as Participant 15 and 17 (D3) regard their attempt episodes as painful experiences. Participant 15 (D3) explains further: *“the rope was painful but I was not able to take it out as I had tied it far up”.*

4.3.3.4. Theme 10: Family and community reactions towards suicide attempters

This theme presented the reaction and experiences from the family and community towards suicide attempters after the incidences of suicide attempts. Both positive, negative and non-reactions were identified.

4.3.3.4.1. Family reactions

The majority of the participants reported some positive reactions towards them after the suicide attempt. Participant 14 (D3) reported: *“My parents, sisters and brothers all wanted to talk to me when they heard of what had happened. Some of them even paid me a visit. Each one wanted to comfort me. No one came to me or phoned to blame me, each one came with good ideas, advising me and telling me of what I have to do”.*

Even though the majority of the participants received positive reactions, several participants however received negative reactions from their families. For example,

Participant 12 (D3) reported that: *“My family was asking me a lot of questions, especially my mum who was insisting to know the truth. And I knew, once I told her the truth, she would tell the entire world. Apart from that, my mum has also been complaining that I wasted her money simply because she has paid for the transport that brought me to hospital when I attempted suicide”*.

Differently, Participants 5 (D2) and 13 (D3) reported the non-reactions from their families. However, they both explained the lack of communication that has existed prior to the suicide attempts, however even when they attempted suicide, their families did not say anything.

4.3.3.4.2. Community reactions

In this sub-theme, subjects such as positive and negative comments and judgmental reactions were drawn to give meaning to what participants experienced.

A great number of participants reported to have experienced positive reactions from the community. Even some of those for whom the suicidal attempts were caused by the community such as Participants 13 and 17 (D3), they reported a good reaction from the community since the suicide attempts.

Moreover, a few of the participants reported negative reactions from some of the community members. For example, Participant 1 (D1) reported of being teased and judged in her community. She said some of the community members: *“tease me and regard me as a fool as they say only fools commit suicide”*. Additionally, Participant 1 (D1) further said that some of the members of the community blamed and judged her for the attempted suicide because of the non-important issues as a reason. Both Participant 1

(D1) and Participant 14 (D3) reported that they have received judgmental questions such as: *“how can you do that?”*

Participant 7 (D2) mentioned an example of the negative comments she has received from some members of the community such as: *“we do not care about your death, beside we do not care about you”*.

On the contrary, several participants reported of not hearing anything from the community because some participants have not gone back to their community since the suicidal incidence, while some participants said that they did not meet the community members since the suicidal attempts till the time of this study’s interview. These are the participants who moved to other areas of Ohangwena region as a consequence of attempted suicide.

4.3.3.5. Theme 11: Feelings of suicide attempts

One of the main interests of this study was to learn about the feelings the participants experienced at the time of attempting suicide and after the attempt. Three sub-themes were developed to describe the participants’ feelings. The three sub-themes in this category are such as: death feelings, feelings of anger and feelings of remorse. Despite the focus of this category being mainly on feelings, the occurrence of suicidal thoughts after the suicide attempts will be also appear underneath.

4.3.3.5.1. Death feelings

Death feelings: this is how the researcher describes the participants’ feelings as most of them reported death as it was their only option. This study allowed the participants to

share how they were feeling at the moment they were trying to commit suicide. Participants explained how their situations devastated them and left them with no hope of life or with no other option rather than killing themselves.

Most of the participants felt that they had to die to escape their intolerable pain and problems. For example, Participant 12 (D3) indicated: *“I felt I had to die because if I continue living, people will keep on talking about this”*. Participant 16 (D3) noted: *“I felt my thoughts were right, thus it only took me a few hours to attempt suicide. I wanted to die so that I can leave this world and its problems.”* Participant 18 (D3) reported: *“I had no fear. I gave myself to death. I felt that was the end of my life, I will be no more”*.

In the same line, Participant 13 (D3) stated: *“I was killing myself to leave the problems. I felt I was suffering”*.

Furthermore, several participants associated the death feelings to darkness as an experience they perceived at the moment of their suicide attempts. Participant 15 (D3) pointed out that when her death feelings got strong she could not see anything else as she was only seeing darkness at the time of the attempt. Similarly, Participant 20 (D3) regarded death feelings as a difficult feeling because what one can see is just the darkness.

4.3.3.5.2. Feelings of anger

Even though anger is one of the causes of suicide attempts, in this study anger was more expressed after the suicide failure. For example Participant 12 (D3) stated that: *“I got even angrier. I wanted to get out of hospital, nurses asked me to come back to the*

hospital ward. I did not want, they called a security guard and tied me to a bed, and thus you can see these marks”.

4.3.3.5.3. Feelings of remorse

Most of the participants indicated feelings of remorse as one of the after suicide attempt feelings. Simultaneously, blame over suicide attempt actions was also identified in the participants' arguments. Participant 8 (D2) expressed his feelings of remorse in a self-blame manner: *“I blame myself for what I did and I realize that what I was doing is wrong. I broke my mother’s heart”*. Participant 10 (D2), 11 (D3) and 15 (D3) describe feelings of remorse by questioning themselves of what could have happened to their children if they were dead. For example, Participant 15 (D3) pointed out that: *“I could have just left my children without anyone to care for them, same way as my husband”*. Additionally, Participant 15 (D3) blamed herself more: *“I was asking myself why I attempted suicide. I blamed myself for deciding to commit suicide simply because someone else committed suicide”*. Participant 4 (D1) stated that: *“I was asking myself that if I was dead, I could have just disappointed my family especially my elder brother who is responsible for paying my children’s studies at the University of Namibia”*.

Although suicide attempts left many participants with feelings of remorse, Participant 14 (D3) was left with different views. It seems he wanted his problems to be understood. He stated that: *“all of the people, my family and my colleagues understood that I was having problems. I feel like I am relieved a bit. I learnt a lesson, I found out the cause of the problem and I gained the knowledge that if the problem is like this I can handle it in this way”*.

4.3.3.5.4. The occurrence of suicidal thoughts after suicide attempts

This study also looked at the occurrence of the suicidal thoughts to determine if the participants were still suicidal and how often do they think of suicide after their suicide attempts. Therefore, this theme was developed. A great number of participants said that they are no longer suicidal. However, two of the participants (Participant 3, D1 and Participant 13, D3) indicated that they were still suicidal during the interview. According to Participant 3 (D1), she was still experiencing suicidal feelings for many times, especially during the night. She further explained that if suicidal thoughts start, she does not even sleep. Participant 13 (D3) reported that: *“I am still feeling like I want to die, especially when I am hurt. Sometimes I am thinking of committing suicide when my daughter is asleep. It occurs many times. I am still suicidal”*.

Even though Participant 9 (D2) indicated that he was not thinking of suicide at the time of the interview, he also stated that he cannot say much because he feels like the suicidal thoughts are not yet completely gone. Similarly, Participant 20 (D3) also reported of not having suicidal thoughts at the interview period. However, he also explained that sometimes suicidal thoughts occur such as once a month. Participant 20 (D3) further explained that: *“I just feel suicidal whenever someone teases me, or calls me names such as ‘shipombolume ove’ (a man without a wife). However, the suicidal thoughts are no longer strong”*.

4.3.3.6. Theme 12: Coping mechanisms

Several participants mentioned the coping mechanisms which helped them to cope with their suicide attempts. Two sub-themes that emerged at this point are religious beliefs and professional help.

4.3.3.6.1. Religious beliefs

Most of the participants believed that their religious beliefs helped them to survive, cope and bounce back after the incidences of suicide attempts. Participant 3 (D1) and 13 (D3) believed that they had survived and coped through prayers. For example Participant 3 (D1) reported that: *“I coped by prayers. My grandmother taught me how to pray”*. Participants 8 (D2) and 16 (D3) thanked God for saving them from suicide and also for making them realize that suicide is against God’s will.

Moreover, Participant 11 (D3) explained how her religious beliefs got strengthened after the suicide attempt as she indicated that she is more likely to go to church now compared to the past. She also expressed the good feelings that she experiences whenever she is in church. Furthermore, she explained that she realized that the self-killer does not have an everlasting life, meaning that if she kills herself she will never have the everlasting life. Similarly, Participant 17 (D3) explained that she told her husband that she wanted to continue going to church so that she can get over the suicidal thoughts.

4.3.3.6.2. Professional help

Most of the participants said that they received counselling services, comfort, support and advice, and that helped them to cope with their suicide attempts. For example

Participant 1 (D1) indicated that: *“I received counselling when I was hospitalised. I am also getting support and advice from some of my friends”*. Participant 5 (D1) said that a social worker made her understand and she accepted what the social worker told her. Similarly, Participant 14 (D3) mentioned that: *“since I was attended to by a social worker, I do not think of suicide anymore”*. He further explained that his family and social worker gave him different ways of solving problems such as: *“If I have a problem I should not leave the problems to myself alone anymore, rather I must tell someone else”*. Additionally, Participant 16 and 20 (D3) both noted that they coped through counselling services. Participant 16 (D3) reported that she learned to cope with difficult situations via counselling sessions, thus she does not think of suicide anymore. Meanwhile, Participant 20 (D3) illustrated that: *“counselling services helped me to avoid anger and to cope with teasing”*.

Furthermore, there are participants who coped with suicide attempts on their own different ways based on the assistance they received. For example, Participant 9 (D2) pointed out that: *“I coped by the comfort, support and good advice from those who have heard and those whose hearts were touched by what happened”*. In contrast, Participant 6 (D2) seemed to be still dealing with his coping mechanisms as he stated that: *“I am still trying to handle life problems because I am still in those debts, but I am just carrying on, I still have to solve them bit by bit until I complete it”*.

4.3.4. Support system for suicide attempters

Most participants described their various sources of support systems, which includes family and friends. The theme that emerged from this category is family and friends' support.

4.3.4.1. Theme 13: Family and friends support

Some of the participants explained their relationship with both family and friends as good, while other participants said that they only have a good relationship with either the family or friends. Several participants described that their relationship with the family either changed to good or to bad after the suicide attempt. However, each participant described how he/she felt being supported. For example, Participant 2 (D1) said: *“My family supported me because the day I was discharged is the same day they took me to the traditional healer”*. Participant 20 (D3) said: *“My family members support me more emotionally, but my friends support me both emotionally and materially as they give me food and money when I need money to go to hospital”*. Participant 12 (D3) reported that his friends support him more than his family. He further said: *“my family loves me but my mother does not like me like she likes other kids. I feel I am supported most by my sister; I think my mother does not like me”*.

Participant 3 (D1) explained her relationship with family members as varying from person to person, as she said some of her family members told her not to think too much about her problems, some are fine with her, some bad-mouthed her concerning her suicidal attempts, saying such things as: *“that stupidity of yours is what made you attempt suicide”*. However, she further reported that she always gets encouragement and motivation from her grandmother, as she stated that: *“My grandmother always said you will be fine and she always prayed for me”*.

Apart from that, Participant 16 and 18 (D3) reported a good relationship with their family after suicide attempts. Participant 16 (D3) compared the way she is being treated after suicide with an egg, as she said: *“If a human being can be compared to how an egg is being handled, that is how they are caring for me now”*, meaning she is well cared for now compared to the past before she attempted suicide. Participant 16 (D3) also reported about her relationship with friends, whom she regarded as: some friends are good while some are bad, because: *“some friends can advise you that suicide is not right, while other friends can remind you that you tried to commit suicide”*. Participant 17 (D3) reported that: *“I ended my relationship with friends; I am just focusing on my husband and children”*, while Participant 18 (D3) said that he has had a good relationship with his friends ever since.

4.4. Suicide attempters’ views with regards to suicide prevention in Ohangwena region

The participants of this study were asked to give their views on what they think should be done to prevent the problem of suicide in the Ohangwena region. Many participants gave their views based on their experiences or on the help they have received during their suicidal attempts, while other participants gave their views in general. Views or responses in this question are not grouped into themes; however they are listed below as follows:

4.4.1. Awareness campaigns

Most of the participants gave their recommendations of the suicide prevention to be addressed through awareness campaigns and this includes community meetings and

prevention programmes. Participants further recommended the media to take part in suicide prevention awareness campaigns. Participants also recommended for the provision of counselling services. For example Participant 1 (D1) encouraged for the initiation of awareness campaigns and motivated for the provision of counselling services and advice from elders.

Participant 1 (D1) further suggested that the culture of holding evening gatherings has to be revived in the households so that people can discuss the phenomenon of suicide. Participant 2 (1) recommended that the awareness campaigns have to start with friends so that if they happen to notice strange behaviours in a certain friend then he/she can be taken to hospital for first aid, and then after that to the experts such as traditional healers.

Participant 17 (D3) requested for the social workers and the community councillors to collaborate and organize community meetings where people's problems can be discussed. Additionally, Participant 5 (D1) requested that: *"if it is possible to have suicide prevention programmes that will include dramas/movies through televisions and churches"*.

4.4.2. Increase the number of social workers

Several participants asked for the number of social workers to be increased in the field. Participant 16 (D3) said that it is better to: *"Increase social workers, not only in hospitals but in the villages as well, we need social workers around"*. In contrast, Participant 9 (D2) stated that: *"it does not help even if social workers' centres are being increased, because if it is time for someone to die, he/she will just die. Social workers are not the*

ones increasing suicide. It is not social workers' fault, because they do not know who is going to commit suicide".

4.4.3. Counselling services

Most of the participants motivated for the provision of counselling services to all the people who have suicidal behaviours and all those who have attempted suicide. For example, Participant 3 (D1) requested counsellors and the social workers to continue providing counselling services and also to emphasize the importance of counselling services whenever they are conducting the awareness meetings. Participant 4 (D1) suggested that: *"there should be a special day for all of us who have experienced or are experiencing suicidal thoughts to be called in for counselling services. It is a pity that it is not easy for the social workers to go from house to house and do presentations; otherwise this may help those who will be found with suicidal thoughts to change. I am suggesting this because I know that problems are there in the houses"*.

Moreover, Participant 18 (D3) encouraged people to be in contact with the social workers' offices and she also asked the social workers to call people in for interventions. Similarly, Participant 20 (D3): *"encouraged the social workers to continue giving counselling services to people in problems"*.

4.4.4. Lessons on the dangers of using cash loans

Participant 6 (D2) gave his views based on his own experience. He reported that: *"through my experience, people must be aware of the danger of cash loans"*. Cash loans are micro-financing institutions / companies that offer loans to the employed people; mostly those who have low income. These loans are refunded within a certain agreed

period of time with interest. Often the loans receivers struggle or fail to refund the loans and this is what happened to Participant 6 (D2) and he did not know of what to do anymore therefore he attempted suicide. Thus he recommended for lessons on the danger of cash loans to be offered at the work places in order to prevent the use of cash loans which eventually results in suicidal behaviour as what happened to him. Participant 6 (D2) suggested that parents and social workers can help on how one can deal with funds. He further suggested that: *“there must be certain organisations that have to deal with financial assistance, people who may be there to give advice on how people should deal with their own funds”*.

Eventually, Participant 6 (D2) also gave tips on how to deal with debt issues. He reported that he looked for solutions with regards to his own debts issue and he got the following tips, which he believed can also benefit his fellow people, thus he decided to share them during the interview. Tips of handling issues as provided by Participant 6 (D2) are:

- *Avoid having lots of insurance policies*
- *Avoid going to cash loans without serious problems (such as death or hospital issues)*
- *Try to talk to a trusted person who can give you good advice*
- *Avoid taking things on credit, rather save and buy cash*

4.4.5. Prevention of mistreatment

Participant 10 (D2) related the question to his own experience; he responded that he would not know of what should be done to prevent the suicide problem, *“because suicide*

is caused by what is happening among various families. It depends on mistreatment among the families. The mistreatment to us men is what causes us to commit suicide when we are badly treated by women. Women need to be told, hold meetings with them, may be they will understand better so that they do not treat men badly". This participant referred to bad treatment as cheating and adultery, as his wife happened to be unfaithful, and this is what led him to attempting suicide.

4.4.6. Education

Most of the participants recommended that people have to be educated. For example Participant 14 (D3) was of the opinion that many people may happen to attempt suicide because of lack of information. Therefore, he stated that education is important, and communities need to be educated. Participant 14 (D3) stated that "*school children need sessions to know what to do if they find themselves in such situations*". He also suggested that since Ohangwena region is the region with the highest suicide and attempted suicide cases, there is a need of contacting other regions in order to know how they manage to have few suicidal cases. Participant 7 (D2) however said that: "*I cannot really say much of what should be done because people are unique and they have unique problems. The social workers should try to visit the villages and educate the people*".

4.4.7. Prevention of substance abuse

Participant 12 (3) also gave information according to his situation. Therefore, he advised young people to stay away from alcohol, drugs and sexual practices. He also recommended the price of alcohol to go up as he believed that there is no way one can

tell people to stop drinking. This is because substance use makes people to do things that they may regret such as stealing and to avoid prison, the person might commit suicide.

4.4.8. The need of special investigations

Participant 13 (D3) reported that: *“there is a need for investigations of all those who have attempted suicide to see if there is something wrong in their minds and in their blood. The government should hire people who can examine the mind of people who have attempted suicide to see if their minds are fine. It is worrisome because even small children are committing suicide, for adults one may say, it might be thoughts, then how about small children?”*

Participant 13 (D3) further suggested that: *“may be doctors should also help us to do the proper assessment whenever suicide attempters are brought to hospital rather than let the person go back home without proper or adequate treatment. Because there are some cases where a person is being sent to hospital after a suicide attempt, however, at hospital he/she is only given panado and told to go home. It is only the lucky persons who have been sent to the social workers; otherwise nurses are just providing panado and they tell you that “committing suicide is not a solution’ without thinking of referring you to a doctor or a social worker”.*

In addition, Participant 13 (D3) further emphasized on the need for suicidal cases to be investigated urgently upon the incidence being reported.

4.5. Discussion

This study aimed to investigate the causes of attempted suicide in the Ohangwena region. The collected data was analysed and several causes and contributing factors to attempted suicide were established. The findings were compared with the previous researchers that the current study reviewed. The discovered findings were organized according to the categories, themes and sub-themes. These include the following:

4.5.1. Reasons given for suicide attempts

This category serves as the main area of the study, because the purpose of the current study was to investigate the causes of suicide attempts in the Ohangwena region. Therefore the reasons as to why participants attempted suicides in Ohangwena region are presented in this category. The present study identified various causes of attempted suicide as they were provided by the participants. Participants described their reasons of attempted suicide uniquely as per their experiences. The category of reasons given for suicide attempts also appears to be the second largest category encompassing five themes. Themes emerged from this category are such as interpersonal relationship problems, financial problems, mental health related problems, previous suicide attempts and negative emotions towards the self.

4.5.1.1. Interpersonal relationship problems

This was the most common problem reported in the present study as expressed by many participants. This finding is supported by previous sources such as the WHO (2000) who regards interpersonal relationship problems to be one of the life stressors. Quarrels with

spouses, family, friends and lovers, rejection and financial problems were identified as some of the interpersonal relationship problems that lead to suicide by the WHO (2000).

Relationship problems with the family and community are the topics which emerged from the theme of interpersonal relationship problems. The participants mentioned issues such as anger, disappointment, blame on alcohol abuse and feelings of shame as some of the difficulties encountered on the relationship with their families.

The relationship problems with family in this study include problems with participants' partners, children and relatives. For example, participant 1 (D1) noted that: *"I was angry when I called my boyfriend then the phone was answered by his girlfriend....since then, the suicidal thoughts just started"*. This finding is in the same line with the previous literature such as Löhr and Schmidtke (2004), who in their study have identified the problems associated with female suicide attempters such as smothering love, infidelity, battering and denial of affection. Participant 7 (D2) explained that her suicidal thoughts were aroused when her children disturbed her as sometimes she talks to them but they answer her in a disrespectful manner. While the participant 8 (D2) explicated that her suicidal thought was awakened by the mistreatment he experienced from his family that he regards as having bad mouthed him. This finding is in the same line with previous sources such as Suto (2007) who identified lack of contact, breakup of intimate relationships, conflicts, poor communication, misunderstandings between parents and children or vice versa, relationships with employees and attempters as some of the factors associated with the relationship problems that eventually result in suicide attempts.

Even though some of the studies such as Rutter and Estrada (2006) acknowledged the family as the main protective factor of suicide, this study found out that the problems

within the families are one of the major contributing factors. Thus, the previous sources such as McGlothlin (2006) recommended that marriage and family counsellors have to be aware of the links between suicide and families, and also to look at the impact of suicide on the family members.

This study found some of the external factors that also contribute to suicide attempt such as the relationship problems with the community. Mistreatment and accusations of something that the participants did not do are some of the problems experienced by the participants from their communities and this led them to suicide attempts. For example participant 7 (D2) explained how she had been treated like a child and being hated for no apparent reason in her community. Similarly, participant 8 (D2) explained being accused of everything bad happening in their communities such as theft. Shilubane, Ruiter, Bos, Van den Borne, James and Reddy (2012) also reported that false accusations and feelings of rejection in the disturbed relationship of the family and community members are some of the potential causes of suicide attempts especially in young people. In their study, Shilubane et al. (2012) found out that most of the participants suffered emotional stress as they had no one to share problems with or to rely on.

Meanwhile, Shilubane et al. (2012) further indicate the lack of awareness among the participants about the available professional services in the community as one of the important facts. To the best of the researcher's knowledge, the topic on the link of the relationship problems with the community and suicide attempts seems to be less researched. Therefore, future researchers are encouraged to study further about the link between the relationships problems with the community and suicide attempts.

4.5.1.2. Financial problems

The findings of this study also indicate an association between financial problems and suicidal attempts. Several participants in this study explained that their financial problems were linked to cash loans, alcohol consumption and gambling. For example Participants 6 (D2) and 14 (D3) both spoke of how financial problems led them to using cash loans services, alcohol consumption, and gambling, which eventually caused their suicidal attempts.

Previous studies such as Kalischuk (2010) pointed out how both people with inadequate finances and people with financial problems try other means such as gambling in a bid to increase their financial resources. This is an indication that people might go for cash loans or gambling to solve their financial problems. For example Participant 6 (D2) went to cash loans because it was not easy for him to tell his family about his debts. Similarly, Participant 14 (D3) articulated that: *“problems were so many that I found myself going to cash loans and I ended up drinking alcohol and gambling”*. Kalischuk (2010)’s findings also explained that people who gamble do not just lose money, but also lose the family unit, relationships, and communication with their family members, while their children are said to lose attention from their parents.

4.5.1.3. Mental health related problems

A mental health related problem was identified as the third theme in the category of the reasons given for suicide attempts. The findings of this study indicated an association between mental health related problems with suicide attempts and suicide. Previous studies including those by Cheah, Schmitt and Pridmore (2008) also support the findings

of the current study. In their study, Cheah et al. (2008) referred suicide as a major public health concern which is often associated with mental disorders. Therefore, Cheah et al. (2008) argued that literature on the suicide of people who do not have a mental disorder is scarce. Randall, Wallad, Finlayson, Sareen and Martens (2014) also concur with the present study and other previous literatures, as in their study Randall et al. (2014) wrote of an estimation of about ninety percent of suicide cases as mental illness related.

Some sub-themes which emerged from this theme are hallucinations and impulsivity. The findings of this study show that hallucinations occur in two ways such as hearing voices and visualizing non-existent things. For example Participants 2 and 4 (D1) both reported that they were instructed to commit suicide while Participant 9 (D2) said that he was visualizing people in his room and he was also seeing dark things like people's shadows. Several participants who experienced hallucinations as the cause of their suicidal attempts reported that they did not intend to attempt suicide but they were forced by the voices that instructed them to commit suicide.

Impulsivity, the second sub-theme in the theme of mental health related problems, was widely reported by the majority of the participants. Owing to the participants' experiences, their attempts enabled them to describe suicide as a quick moment that may happen without thinking carefully of what you are doing. Several participants including Participants 4 and 5 (D1) reported that their suicidal attempts began the very moment they heard offensive words from their relatives. This finding concurs with the study of Cheah, Schmitt and Pridmore (2008) who also related impulsivity to suicide. Nevertheless, several studies have different findings on the linkage between impulsivity and suicidal behaviour. According to Joiner (2005), even though impulsivity facilitates

the exposure to provocative and painful experiences, people can only acquire and enact lethal self-injury that leads to suicide risks if they wish to die. Therefore, Joiner (2005) regards impulsivity in relation to suicidal behaviour as an indirect variable.

4.5.1.4. Previous suicide attempts

This finding is strengthened by the previous literature (such as De Leo, Bille-Brahe, Kerhof & Schmidtke, 2004; Obida, Clark & Govender, 2013; the WHO, 2009; Wang, Chou, Yeh, Chen & Tzeng, 2013). Despite the support that the study findings have on the previous sources, the results of this study indicate a high rate of previous suicide attempts in District 3 only. Both Districts 1 and 2 reported a high rate of participants who have attempted suicide for the first time. This result is not surprising because District 3 is the district with the highest cases of suicidal behaviour in Ohangwena region compared to the other two districts. Interestingly, even some of the participants who have attempted suicide for the first time from District 3 such as Participant 14 (D3) is reported to have been experiencing suicidal thoughts for so long prior to their attempts.

4.5.1.5. Negative emotions towards the self

In the researcher's view, the fifth theme in the category of the reasons given for suicide attempts is one of the aspects that need to be explored more in future researches. This theme however emerged based on the negative feelings that the participants had and which led them to suicidal attempts. The majority of the participants described their negative emotions as linked to feelings of hopelessness. A feeling of hopelessness is the only sub-theme that was encompassed from this theme.

In this study, participants expressed their feelings of hopelessness to what they thought could have happened after their deaths if they would be dead through suicide, for example in relation to peace for family members, community, and friends. For example, Participant 8 (D2) who has suffered accusations of some wrong doings reported his feelings of hopelessness as: *“I just thought of committing suicide so that the allegations notes will be placed on my grave stone”*.

Participant 20 (D3) reported that: *“I thought taking out my life would be better than suffering”*.

4.5.2. Impacts of suicide attempts on attempters

The impact of suicide attempts on attempters became the second category in this study. The emergence of the theme on the effects of suicide attempts is in the same line with previous sources such as Bryan, Brophy, Cunningham and Schwarz (2006) that referred to the occurrence of attempted suicide as a traumatic event that affects everybody.

4.5.2.1. Effects of suicide attempts

The current study highlights the effects of suicide attempts in two ways, such as the psychological effects and physical effects. The psychological effects as described by the participants are such as unconsciousness and confusion, while physical effects include pain, vomiting and visible marks left on participants who attempted suicide by hanging. Several participants such as Participant 8 (D2) and Participant 12 (D3) reported that they experienced both psychological and physical effects; they both explained that they were unconscious after they attempted suicide and they were left with visible marks as effects of suicide attempts.

Participant 17 (D3) stated that: *“I appeared confused and looked like a mentally disturbed person”*. Concurrently, she also signified that: *“I had difficulties drinking and eating due to throat pain. I also experienced hearing problems”*. This is an indication that attempters do not only suffer from problems that cause them to attempt suicide but they also suffer the consequences of the attempts. This finding is supported by Strong (2009) who has narrated a story of Samantha Heams (an attempter survivor). According to Strong (2009) as explained Heams’ story: *“the moment you realize you are still alive, it would have to be something like an emotional hurricane, it is too much to handle”*.

Although this topic focused more on the effects of the attempted suicide on an attempter, several studies (such as Bryan et al., 2006; Buus, Caspersen, Hansen, Stenager & Fleischer, 2013; the WHO, 2009) explained further how the close people (especially family children, siblings, parents and friends) are affected by suicide attempts. The WHO (2009) reported that “the emotional impact for family and friends affected by completed or attempted suicide may last for many years” (p. 3). According to Bryan et al. (2006), people who are affected by suicide attempts will suffer emotionally from feelings of anger at the person who made the attempt, guilt, anxiety and a sense of insecurity, shame, powerlessness, helplessness, and a lack of control and betrayal. At the end, this will again contribute to the effects of suicide attempts on an attempter, as he/she is also thinking how his/her attempts will affect the close people. Therefore, an attempter may again suffer from anger and guilty. Apart from that, the present study discovered that the topic of the impact and effects of suicide attempt on the attempters is under researched. Future researches on this topic are therefore encouraged.

Furthermore, the present study also placed an interest on how the suicide attempters' lives changed as a result of attempted suicide. Several participants acknowledged that there was a positive change in their lives after their suicide attempts. Participant 11 (D3) reported that: *"we do not drink anymore; we realised that alcohol is driving us into the wrong doings. We found peace in the house. We no longer have problems"*.

On the contrary, there are also a few participants who reported that they do not see any positive change in their lives. These are the participants who were still suicidal during the interviews such as Participant 3 (D1). Therefore it was essential for the researcher to provide pre- and post-counselling before and after the interviews. The researcher also referred back the participants who were still suicidal to their districts' social workers for further psychosocial services. The researcher encourages the participants to form a support group of people who have attempted suicide and those who have suicidal thoughts.

4.5.3. Experiences and feelings of an attempter

This is the biggest category in this study with six themes emerging from it. The themes that emerged from the category of the experiences and feelings of an attempter are depressive symptoms, method of suicide attempts, episode of suicide attempts, family and community reactions towards an attempter, feelings of suicide attempts and coping mechanisms.

4.5.3.1. Depressive symptoms

The findings of this study are much in agreement with those of Lönnqvist (2000) and Yaldizli, Kuhl, Graf, Wiesbeck and Wurst (2010), who also supported that there is a

strong interrelationship of depression and suicide. In their study, Yaldizli et al. (2010) pointed out that some of the depressive symptoms are crying, loss of interest, weight changes, sleep disturbances, restlessness, and feelings of low energy, sense of worthlessness or guilt, loss of concentration, hopelessness, suicide ideation and delusions or hallucinations.

The current study compared the findings discovered on depression symptoms with the above mentioned ones because according to Yaldizli et al. (2010), not all of the depressive symptoms are associated with suicidal behaviours. Therefore, to conclude that the participants of this study had depressed symptoms, a comparison was essential. Moreover, the most identified depression symptoms related to suicidal attempts in this study included crying, hopelessness, suicide ideation and hallucinations.

This study also acknowledges that people who have attempted suicide did not only experience depression before their attempts but also after they attempted suicide (or when their plan of committing suicide failed). The present study pin-pointed the signs of depressed moods as a disorder that specified the sign of depressive symptoms which was experienced by the participants. Topics emanating from depressed moods as identified in this study are such as negative feelings and emotional depression. Participants described their depressed moods as related to their negative feelings; for example Participant 7 (D2) reported that: *"I felt like people were disturbing me. I wanted them to leave me alone so that they could be as happy as they wanted"*. Emotional depression was described by Participant 8 (D2) who explained that: *"I had been thinking of suicide till I got very thin, which caused me to cry often"*.

4.5.3.2. Method of suicide attempt

The present study finds it interesting to determine the method used to attempt suicide in Ohangwena region. This theme therefore presents the findings on the methods that were used by the participants for their attempts. This finding illustrates that hanging, ingesting tablets/pills, substance abuse and burning are the methods that were used for suicide attempts. Hanging came out as relating to a great number of participants, which means that most of the people who have attempted suicide in Ohangwena region used the method of hanging that employs ropes, belts, wires, shoe laces and head/hair scarfs as tools of suicide attempts. In spite of the differences of the methods used per country in this study, Kisting (2012) and Schlebusch (2012) are in the same line with the present findings as they identified the commonly used methods of both suicide and suicide attempts as hanging, shooting, poisoning/overdosing, gassing and burning.

4.5.3.3. Episodes of suicide attempt

The current study discovered some aspects of areas of suicide attempt experiences that were not investigated in most of the literature. The episode of suicide attempt is one of the interesting discoveries in which participants enlightened their experiences of what happened as from the beginning to the end of the suicide attempts. Many participants associate their attempts' episode experiences to the specific behaviours such as instructions to commit suicide, ambivalent behaviour and painful experiences.

Participant 2 (D1) explained his experiences of how he acted upon instructions for committing suicide as he got them through hallucinations. He reported that: *“when I was instructed to commit suicide, I hanged myself, the rope got broken then I fell down.*

When I fell down, I felt that something was squeezing me down. Although my eyes were closed, I saw something on the form of waves coming across me, but I could not tell what exactly it was. I heard a voice saying you are stupid; the rope you have taken is not strong. That thing squeezed me down and strangled my neck until I got tired and I was no longer moving. Then I heard the voice saying yeah you are now dead”.

Ambivalent behaviours were also recognized during the suicide attempts episodes. It has been previously associated with several literatures including the Affect Dominance Phase (AD) of the *Suicide Processional Model*, which is grounded in this study. The WHO (2000) as seen under the theoretical framework of the present study, described ambivalence as a see-saw battle whereby the suicidal people appeared to have mixed feelings of the wish to live and the wish to die. This description is very connected to the ambivalent behaviour of Participant 8 (D2) as he reported that: *“I took a rope, tied it on the roof of my corrugated iron room. I stayed a little bit on the bed quiet, thinking of what to do. After some time I stood up, crying and then I hanged myself”*. The WHO (2000) explains that in this phase many people are not willing to die, it is just that they are unhappy with life, thus they are urged to get away from the pain.

Furthermore, several participants such as Participant 15 and 17 (D3) described their attempt episodes as physically painful experiences; they expressed how it is painful (physical pain) when one hanged. Participant 15 (D3) reported that: *“the rope was very painful but I was not able to take it out as I had tied it far up”*.

4.5.3.4. Family and community reactions towards suicide attempters

Family and community reaction towards suicide attempters is the fourth theme in the category of the experiences and feelings of an attempter. This theme as well was explored differently in this study rather than in the other studies. Two sub-themes such as family reactions and community reactions emerged from it. Participants expressed their experiences in three different topics such as positive reactions, negative reactions and the non-reactions that they received from either the family or community after their suicide attempts.

4.5.3.5. Feelings of suicide attempts

This theme is most likely to fit together with the previously mentioned theme of the impacts of suicide attempts on attempters, but owing to the uniqueness of the findings of the present study, it was made to stand on its own. Participants expressed that their feelings of suicide attempts in various sub-themes consisted of death feelings, feelings of anger and feelings of remorse. Even though the re-occurrence of suicidal ideations after suicide attempt is a non-feelings aspect, this study found it as a relevant area to the feelings of suicide attempts category. Therefore it appears underneath.

In the sub-theme of death feelings, participants expressed their strong feelings towards death. For example, Participants 12 and 16 (D3) both reported that they were feeling that they had to die to leave the problems behind and to end their pain. Their feelings of death are supported by Pavulans, Bolmsjo, Edberg and Ojehagen (2012) as it can be seen from the theoretical framework of this study. Pavulans et al. (2012) regards ending the

pain as the only way out of endless suffering. Most of the participants indicated that they gave themselves to death as it was the only choice left in their lives.

Feelings of anger are well known as associated with both suicidal behaviours and the after suicide attempt. However, in this study the feelings of anger were more expressed after the suicide attempts failure. The relationship between feelings of anger and the after suicide attempt is strongly supported by previous literatures such as Vatne and Naden (2011) and Strong (2009). In the story of Samantha Heames (an attempter survivor) as narrated by Strong (2009), Heames hated to be alive, she was feeling crazy and nothing could make her happy, she lashed out and she could not stop her feelings. Concurring with this view, the current study findings also depicted several participants who got angry when their suicide attempts failed. For example Participant 12 (D3) said that he got angrier after he failed to commit suicide. Participant 12 (D3) also explained how he wanted to sneak out of hospital but fortunately nurses saw him and called the security guards.

In the present study many of the participants indicated their worries and fear of what the outside world would say, as everyone knew that they wanted to commit suicide. Vatne and Naden (2011) also wrote about the fear of others' evaluation of the suicidal act and one's own attitude to the suicidal act, as it slows down the suicide attempter's recovery.

According to Crocker, Clare and Evans (2006), participants get ashamed when attempts fail and they interpret their failure experience to a failure to problem-solving.

Anger after a suicide attempt is not only experienced by an attempter but also those affected by the suicide attempt too. For example Participant 12 (D3) reported: "*when I*

got out of hospital, my mum was complaining and saying bad things". According to Bryan, Brophy, Cunningham and Schwarz (2006), people affected by suicide attempts suffer from feelings of anger at the person who made the attempt, including feelings of guilt, anxiety and a sense of insecurity, shame, powerlessness, helplessness, a lack of control and betrayal.

The emergence of the sub-theme of feelings of remorse is consistent with other studies that associate remorse and after suicide attempts, for example Sun and Long (2012). The great number of participants expressed their feelings of remorse by blaming themselves over their suicidal attempts. For example Participant 8 (D2) stated that: *"I blame myself for what I did and I have realized that what I was doing is wrong. I broke my mother's heart"*. Participant 15 (D3) expressed her remorseful feelings by asking herself of what could have happened to her children if she was dead. However, according to Sun and Long (2012), their study revealed that most of the attempters do not think of their children or families at the time of the attempt as they are so overwhelmed by their own turmoil, therefore during the after attempts is when they can feel that they cannot leave their children to deal with all the mess they have caused.

On the contrary, the findings of this study reveal that not all of the participants were blaming themselves over remorse. Several participants such as 14 (D3) who seems that he wanted his problem to be understood explains that: *"all of the people, my family and my colleagues understood that I was having a problem"*. To add on to this, according to Orri, Paduanello, Lachal, Falissard Sibeon and Reva-Levy (2014), some suicide attempters attempted suicide to blame others, for example saying that: *"I wanted to die to make my parents or my ex to feel guilt. I did it to punish my mother"*.

The re-occurrence of suicidal ideations after suicide attempts were reported by several participants. The present study identified some of the issues that trigger the re-occurrence of suicidal ideations in the participants, and these include hurting, teasing and calling names. For example Participant 13 (D3) said that: *“I am still feeling like I want to die especially when I am hurt”*. Another example of the participants who were found with suicidal ideations re-occurring during the interview was Participant 20 (D3) who reported his suicidal ideation to have re-occurred when he was being teased or called names such as *‘shipombolume ove’ (a man without a wife)* simply because he does not have a wife. Pavulans et al. (2012)’s study finding also support this study’s findings. In their study, Pavulans et al. (2012) pointed out endless pain as the main reason behind the re-occurring of suicidal ideations among the people in pain or who are suffering. In this case, effective interventions and preventative methods of suicidal ideations are recommended and therefore they are essential.

4.5.3.6. Coping mechanisms

In spite of the study aim of investigating the causes of attempted suicide, information on the participants’ coping mechanisms was also collected. Two themes emerged on the coping mechanisms category, which are religious beliefs and professional help. Some of the participants revealed how their religious beliefs helped them to survive, cope and bounce back after their suicide attempts. For example some participants said that they have survived and coped through prayers; Participant 3 (D1) reported: *“I coped by prayers. My grandmother taught me how to pray”*. While other participants such as Participant 8 (D2) and 16 (D3) got to realize that suicide is against God’s will.

Many participants acknowledge the professional help they received from social workers and community counsellors.

Counselling services was identified as a key element that helps the participants to cope with their situations and the after feelings of suicide attempts. Participant 16 (D3) said that she learned how to cope with difficult situations via counselling sessions. Even though most of the participants appreciate the services of counselling received, several participants are still struggling to cope because the causes of their suicidal attempts are not yet solved. For example Participant 6 (D2) reported that: *“I am still trying to understand how to handle life’s problems because I am still in those debts, but I am just carrying on, I still have to solve them bit by bit until I complete it”*. The previous studies such as Holtman, Shelmerdine, London, and Flisher (2011) argued about social workers’ manners towards attempters. In their study, Holtman et al. (2011) revealed that suicide attempters who have received counselling after suicide attempts described the hospital’s social workers as unpleasant and disrespectful towards them as they were threatened with incarceration. The present study did not go beyond this investigation; therefore, in this regard future researches are motivated to investigate if the unpleasant and disrespectful manner is also a case among the social workers in the Ohangwena region.

4.5.4. Support system of the suicide attempters

The fourth and last category of this study consisted of one theme which is family and friends’ support.

In the theoretical framework section of this study, it was reported how Appalsamy (2000) wrote about the interpersonal and familial protective factors that are consistent with the

category of the support system of the suicide attempters. According to Appalsamy (2000), the interpersonal factors comprise the available social support while familial protective factors encompass family cohesion and warmth. Hence it was important for the present study to determine the support systems of the participants to see if attempters in Ohangwena region have support networks available. According to Sun and Long (2012), the healing and recovering process of an attempt to suicide is slow and difficult, therefore the suicide attempters need some support networks around them.

4.5.4.1. Family and friends support

Some participants gave a high note of recognition to their family and friends' help and support while others reported that they have no good relationship with either the family or friends. Interestingly, among the participants who appreciated the support from the family is Participant 2 (D1) who noted that: *“my family supported me because the day I was discharged is the same day they took me to the traditional healer”*. This participant believed that his suicidal ideation was healed by a traditional healer; therefore future researches are challenged to investigate the effectiveness of traditional healers' intervention on the prevention of suicide ideation.

Several participants pointed out that one may not get support from the entire family but at least there are specific family members who are supporting them. For example Participant 3 (D1) regarded her grandmother as her strong support in the family, as she is the only one who motivated, encouraged and prayed for her unlike other family members who bad-mouthed her and referred her suicide attempts as her own stupidity.

On the friendship support note, several participants have spoken about good and bad friends. Participant 16 (D3) reported of the support she got from good friends in the form of getting advice from them, such as that suicide is not a right thing to do. At the same time Participant 16 (D3) referred to the bad friends who always remind her of her suicidal attempt. Reminding attempters about their previous attempts was found as a trigger to the repetition of suicide attempts. Shilubane et al. (2005) explained that attempters are often feeling uncomfortable when their previous attempts are brought back.

4.5.5. Suicide attempters' views with regards to suicide prevention in Ohangwena region

This study found it important to gather information on the views of the suicide attempters with regards to suicide prevention in Ohangwena region. The highlights which emerged from suicide attempters' views include awareness campaigns, increasing the number of social workers, counselling services, lessons on the dangers of cash loans, prevention of bad treatment, education, prevention of substance abuse, and the need of special investigations. These are the areas of recommendations made by suicide attempters with regards to the prevention of suicide in Ohangwena region.

4.5.5.1. Awareness campaigns

Most of the participants including Participant 1 and 5 (D1) recommend for the initiation of awareness campaigns on suicide prevention through different approaches such as community meetings, prevention programmes and the media. These are the well-known approaches to reach out to the nation at large with regards to preventing people from

committing suicide. The awareness campaign recommendation is in line with previous literatures such as Sun and Long (2013), who wrote that many nations set targets to reduce the high incidences of suicide with the aim of preventing people from committing suicide and providing adequate care services to those that have attempted suicide.

4.5.5.2. Increase the number of social workers

Some of the participants realized a need or a gap of manpower; therefore they used this study platform to demand for an increase in the social workers in the field. Participant 16 (D3) reported that there is a need to *“increase social workers, not only in hospitals but in the villages as well, we need social workers around”*. Even though several participants recognized the need of social workers, Participant 9 (D2) had different views towards increasing the social workers. He argued that *“it does not help even if social worker centres are increased because if it is time for someone to die, he/she will just die”*.

4.5.5.3. Counselling services

Professional help (counselling) is among the services that the participants requested through their views with regards to the prevention of suicide in Ohangwena region. In this study, the participants motivated for the continuation of the provision of counselling services. Participants 3 (D1) and 20 (D3) encouraged the social workers and counsellors to continue giving counselling services and emphasising the importance of counselling services. In other studies such as Meel (2013), a concern was raised on the adequacy of training, which is slightly in line with the present study as well. According to Meel (2013), many of the primary care physicians are not trained enough on the area of the psychosocial aspects of health care and therefore they do not provide the necessary risk

reduction counselling during their physician-patient encounters. The questions stimulated here are: are the social workers in Ohangwena region trained enough on how to deal with suicide related issues? Do we have specialized social workers on the issues of suicide in Ohangwena region or in Namibia at large? This gap is left for the future researches to fill.

4.5.5.4. Lessons on the dangers of using cash loans

Several participants reported their involvement with cash loans, which contributed to financial problems with the end resulting in suicide attempts. The present study is in agreement with previous studies (such as Maris, Berman & Silverman, 2000; Moosa, Jeenah & Vorster, 2005; Yurýev, Varnik, Varnik, Sisask & Leppi, 2010), who wrote about the link of suicide mortality, unemployment, inadequate financial resources and financial problems as has been previously mentioned. Unemployment, inadequate financial resources and financial resource problems might be the driving force behind the cash loans as people try to increase their income. Based on experience, Participant 6 (D2) warned people to be aware of the danger of cash loans and also the participant shared some tips on dealing with debts.

4.5.5.5. Prevention of mistreatment

The present study found out that some relationship problems either with the family or community are some of the leading causes of suicidal behaviour in Ohangwena region. This is in accordance with the recommendation of the prevention of bad treatment, and it was also supported by various studies such as Shilubane et al. (2012). Participant 10 (D2) related his views on his experiences, therefore he recommended that meetings must

be held, especially with women as they are the ones causing the bad treatment in the families and it leads men to attempt suicide.

4.5.5.6. Education

The participants of this study identified the knowledge gaps on the suicide prevention related matters. Therefore many of the participants recommended that people, children and communities need to be educated on how to prevent suicidal behaviour in Ohangwena region. Participants viewed lack of information as the main contributing factor to suicide attempts. Participant 14 (D3) stated that education is important; therefore communities need to be educated. This is particularly so because the Ohangwena region is one of the regions with the highest suicide cases in Namibia (Kisting, 2012). Participant 14 (D3) suggested for the improved information sharing, for example Ohangwena region needs to contact the regions with few cases of suicidal behaviour and learn how they are managing to control their suicidal situations in their respective regions.

4.5.5.7. Prevention of substance abuse

The findings of this study indicated a link between substance abuse and suicidal behaviours. This finding is in harmony with previous studies such as Berglund and Ojehagen (as cited in Keeley, Corcoran & Bille-Brahe, 2004, p. 165), who reported the estimations of all suicides committed by alcohol and drug addicts to be at 25% and 50%. In relation to this, Participant 12 (D3) recommended that alcohol prices have to go up because no one can prevent people from drinking.

4.5.5.8. The need of special investigations

The need of conducting a special investigation to people who have attempted suicide was raised to see if there is anything wrong in their blood and minds.

One of the participants showed her concern because even children in Namibia and in Ohangwena region in particular are committing suicide. Shinana (2011) indicated that the age range of people who died by suicide in the Ohangwena region is between 11 and 93 years. Therefore, Participant 13 (D3) emphasized that all the suicidal cases have to be referred to social workers for counselling services and he also requested for suicide attempt cases to be investigated urgently upon the report of the incidence.

4.6. Summary of results and discussions

The results and discussions of the data collected were presented in this study. The study identified four categories, thirteen themes and fourteen sub-themes. The category of reasons given for suicide attempts was found as the main category of this study as it presented the causes of suicide attempts in Ohangwena region. The causes of attempted suicide were identified and themed as: interpersonal relationships problems (which includes relationships with family and relationships with the community), financial problems, mental health related problems (including hallucinations and impulsivity), previous suicide attempts and negative emotions towards the self (including feelings of hopelessness).

Despite the study purpose, which was to investigate the causes of suicide attempts in Ohangwena region, the researcher went beyond the study purpose to get fully detailed information about suicide attempters. Therefore, the effects of suicide attempts and the

experiences and feelings before and after suicide attempts were also investigated. Furthermore, the study also investigated the support systems of people who have attempted suicide in Ohangwena region. Eventually, the suicide attempters' views with regards to suicide prevention in Ohangwena region were discussed during the study interviews.

The following chapter which is the last chapter for this study focuses on the conclusions, the limitations of the study and recommendations for practical implementation and future research.

CHAPTER FIVE

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presents the conclusion and limitations of the present study. Recommendations for practical implications are also provided in this chapter to suggest and determine the future suicide prevention interventions and programs and future research.

5.2. Conclusions

The findings of this study are a representation of the three districts of Ohangwena region; Eenhana district, Engela district and Okongo district. As participants are unique individuals, they as well presented the causes of their suicide attempts differently.

Findings of the present study as interpreted and discussed in the previous chapter (chapter 4) were also linked to the theory and the foregoing chapters. The establishment of early findings and the study's theoretical framework received a high reputation that was confirmed in the present study findings.

The aim of this study was to investigate the causes of suicide attempts in Ohangwena region. Therefore, the reasons behind the alarming suicide attempts in Ohangwena region were discovered. The reasons include: interpersonal relationship problems, financial problems, mental health related problems, previous suicide attempts and negative emotions towards the self. Intolerable pain was found as the main contributing factor behind the causes of suicide, hence a majority of the participants revealed that they

did not want to commit suicide, “it is just that they are unhappy with life thus they are urged to get away of the pain” (WHO, 2000). In order to get a better understanding of the suicide attempters and their circumstances, this study did not only look at the causes but also investigated the impacts or effects that the suicide attempts have on the attempters. In a way, the study also discovered the experiences and feelings of an attempter with regards to the suicide attempts before and after. The coping mechanisms of the participants were also identified to determine their strength to embark upon the daily life challenges. The present study also recognised the support systems of the suicide attempters to see if there are support networks available for them.

Moreover, the participants’ views with regards to the suicide prevention in the Ohangwena region were also collected during this study, and the findings read as: awareness campaigns, increase the number of social workers, counselling services, lessons on the danger of cash loans, prevention of bad treatment, education, prevention of substance abuse and the need of special investigations. Essentially, this study may be useful in laying a foundation to improve the current situation by highlighting the causes of attempted suicide in Ohangwena region.

5.3. Limitations of the study

This study was only conducted in Ohangwena region, thus findings cannot be generalized. Ohangwena region is the second biggest region in Namibia, but considering the sample of twenty people which was designed for the present study; it is not enough to represent the whole region, since the three districts also serve people from the neighbouring country Angola. Therefore, the quantitative surveys are encouraged to be conducted in Ohangwena region so that a big number of suicide attempters can be

reached out in the future. Nonetheless, many suicide attempters in Ohangwena region live far in remote areas; this was another challenge that was discovered during this study as some suicide attempters were hard to reach. For suggestions for the future, in order to reach a big number of people who have attempted suicide in the region, researchers are encouraged to make use of clinics and fixed outreach points in the villages instead of the three districts only. As stated in chapter one of this study, there are twenty nine clinics and 136 fixed outreach points (i.e. points in villages that are visited by nurses/health workers from the district hospitals in Ohangwena region).

5.4. Recommendations

Even though suicide attempts continue to be an alarming public health concern worldwide and in Namibia, there is a high potential for preventive interventions. Knowing the causes of suicide attempts in Ohangwena region is a stepping stone for prevention programs. Suicide attempters' views with regards to suicide prevention in Ohangwena region are the key aspects that need to be considered when planning for suicide prevention interventions and programs as they have had personal encounters in this subject.

5.4.1. Recommendations

Based on the identified causes of the attempted suicide and the needs raised on the suicide attempters' views with regards to suicide prevention in Ohangwena region, this study is recommending the following:

There is a need to promote suicide prevention awareness campaigns in the entire region. Participants have emphasized on education; they advocated the community to be

educated on the prevention of suicide since many people may attempt suicide because of a lack of information. As per the attempters' request, the Ministry of Health and Social Services is recommended to increase the number of social workers in Ohangwena region for the suicide attempts to be reduced and prevented. The Ministry of Health and Social Services needs to strengthen their technical support and to provide special trainings on how to deal with suicidal clients through the use of the social workers in the regions.

Family therapies, joint sessions and community relationship interventions need to be taken seriously since interpersonal relationship problems were identified as some of the main causes of attempted suicide in Ohangwena region. There is also a need to implement community-based suicide prevention programs to address the local needs. Budgeting and financial management needs to be promoted in Ohangwena region as it was presented in this study that several participants fell victim to cash loans that were intended to improve their financial situations which at the end led them to suicidal attempts.

Mental health related problems are a very important topic which needs to be considered when it comes to suicide related issues. Several participants who attempted suicide in Ohangwena region reported hallucinations and impulsivity as the reasons behind their suicide attempts. Social workers therefore need to strengthen attempters' coping mechanisms to enable them to cope with the experiences and impacts of suicide attempts.

Support groups with suicidal people are essential, thus there is a need for them to be established in order to avoid stigma of attempts aftermath and to prevent suicide re-attempts.

Participants also urged all the suicidal people to be attended to by the social workers before leaving hospitals and they also requested all the attempted suicide related cases to be acted on upon reporting and to be handled as emergency cases. The prevention of substance use and the need for special investigations were among the recommendations that were made by the suicide attempters during the interview. Based on the study recommendations and suggestions made in this study, there may be an improvement on suicide attempts prevention and reduction in Ohangwena region if the prevention programs may be employed.

5.4.2. Recommendations for future research

The findings of this study include an incident of one participant who was taken to a traditional healer after he had attempted suicide and he believed that he was healed by the traditional healer. This awakened the curiosity of the researcher to know more and determine if a traditional healer can heal suicide attempts. Therefore, future researches are suggested to investigate the link between suicidal behaviours and traditional healers.

In addition, one of the participants also raised a concern that children in Namibia and Ohangwena region are also committing suicide. One may wonder why children are attempting or committing suicide. In this regard, future researchers are also challenged to conduct some investigations on why children are attempting suicide or committing suicide.

A negative emotion towards the self was one of the identified themes in the present study, which to the best knowledge of the researcher seems to be a less explored phenomenon. Therefore future research is motivated to explore more about its relations

to suicide attempts. The knowledge gap was also discovered to have a bearing between the relationship problems with the community and the suicide attempts. Future researchers are therefore urged to feel motivated to explore this topic further.

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APPENDIX A: Interview Schedule

INTERVIEW SCHEDULE

SEMI-STRUCTURED QUESTIONS

The aim of this research is to explore the causes of attempt suicide in the Ohangwena Region. All data and information collected in this research will be kept confidential. The names of all the interviewees will be anonymous during the process of data analysis. Participants may be given pseudonyms to protect their identity in the final report.

DEMOGRAPHIC INFORMATION

Sex:

Male ☐ Female ☐

Age:

What is your marital status?

Single ☐ Married ☐ Cohabitation ☐ Widowed ☐ Divorced ☐
Separated ☐

Where do you live?

Okongo District ☐ Eenhana District ☐ Engela District ☐

What is your family status?

Living alone ☐ Living with relatives ☐ Living with friends ☐

Others:

Do you have children?

☐ ☐

Yes No

If yes, how many?

What are their ages?

What is highest educational level you attained?

No education ☐ Primary school ☐ High school ☐ Tertiary Education

What is your employment status?

Unemployed ☐ Self-employed ☐ Full-time employment ☐

Part-time/casual employment ☐ Student/Learner ☐ Pensioner ☐

CAUSES OF ATTEMPTED SUICIDE

What made you consider taking your life?

For how long had you been planning to take your life?

How many times have you attempted suicide?

What change did you think will take place due to suicide?

EFFECT OF ATTEMPTED SUICIDE

How has your life changed since you attempted suicide?

EXPERIENCES OF ATTEMPTED SUICIDE

How would you explain your experiences of suicide attempt/s?

How would you explain the family's reactions towards you after the suicide attempts?

What are the community reactions towards you after your suicide attempt?

FEELINGS OF ATTEMPTED SUICIDE

How would you describe your feelings at the time of attempting suicide?

What were your feelings after the suicide attempts?

How are your feelings now towards suicide?

How often do you feel suicidal now/at present?

How do you cope with your feelings of suicide now?

SUPPORT SYSTEM

Describe your relationship with your family and friends?

Do you have anyone to talk to about your problems or the way you feel?

Yes ☐ No ☐

If yes, how does he/she help you?

In your opinion, what is professional help in relation to suicide attempts/feelings?

Where do you think one can get professional help in relation to suicide attempts/feelings?

What do you think can be done to prevent the problem of suicide in the Ohangwena Region?

How or what would you advise someone with suicidal behaviours/thoughts?

I have asked you many questions, is there perhaps a question or questions that you might want to ask me? Also, if there is anything/something important that you think I should have asked?

Thank you for your time and participation!

APPENDIX B: Informed Consent Form

UNIVERSITY OF NAMIBIA

FACULTY OF HUMANITIES AND SOCIAL SCIENCE

DEPARTMENT OF HUMAN SCIENCES

SECTION OF SOCIAL WORK AND COMMUNITY DEVELOPMENT

INFORMED CONSENT LETTER (read aloud to the participant)

Title of Study: *Causes of attempted suicide in Ohangwena region: A social work exploration*

Principal Investigator:

Ms. Tuhafeni R. Katota

P O Box 1585

Oshakati

Phone: 065 263023/5 (w) / 0812848663

E-mail: marydawid@yahoo.co.uk

July 2013

Dear Participant

This letter is an invitation to participate in a study I am conducting as part of my Master degree in the field of Social work at the University of Namibia under the supervision of Dr. Elizabeth N. Shino. I would like to provide you with more information about this study and outline what your involvement would entail if you decide to take part.

Suicide is a major public concern in Namibia, particularly in the Ohangwena region. It has become one of the leading causes of death and is increasing at an alarming rate. The latest Namibian statistics, from 2009, indicate 23 suicide cases per 100,000 (Smith, 2011).

Ohangwena region reported the highest number of suicide cases for the second time in 2011 when 90 people died due to suicide. Moreover, suicide attempts in the Ohangwena region have been increasing as from 2010. The ever increasing rate of suicide and attempted suicide cases in Ohangwena region is worrisome therefore, the researcher is interested in investigating the causes of attempted suicide in Ohangwena region.

Understanding the causes of attempted suicide will enable social workers to develop effective prevention and intervention programmes and help the suicide attempters to cope with the stigma and painful memories of suicide attempts.

This interview will take approximately two hours to complete. Participation in this interview is voluntary and you can choose not to answer any individual question or all of the questions. However, I hope that you will participate in this interview since your views are important. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. The researcher will make all the efforts to maintain your confidentiality, including assigning code names/numbers for participants that will be used on all researcher notes and documents. This means your name will not appear in either thesis or reports resulting from this study, anonymous quotations may be used.

At this time, do you want to ask me anything about the interview? Or even if you have any question later on, you can always contact me at 0812848663 or by email: marydawid@yahoo.co.uk. You can also contact my supervisor, Dr. Elizabeth N. Shino, at (061) 206 3807 or email: eshino@unam.na

I would like to assure you that this study will adhere to the highest ethical consideration.

I am looking forward to speaking with you and thank you in advance for your assistance in this project.

Yours sincerely

Tuhafeni R. Katota

Student/Principal investigator

INFORMED CONSENT FORM

By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and I can choose not to answer any individual question or all of the questions. I voluntarily agree to take part in this study. I have the option of allowing the interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that quotations will be anonymous. With full knowledge of all foregoing, I agree from my own free will to participate in this study.

Participant's Signature.....

Date.....

Interviewer's Signature.....

Date.....

APPENDIX C: Ethical Approval To Conduct Research Activities

☎ (+264 61) 206 4673
 Fax: (+264 61) 206 4604
 E-mail: mapaure@unam.na
 Website: www.unam.na



240 Marouthe Noem, Pave Avenue
 Private Bag 13301
 Windhoek
 NAMIBIA

PRO-VICE CHANCELLOR: ACADEMIC AFFAIRS & RESEARCH Research and Publications Office

STUDENT	Tuhafeni Rebecka Katota	RESEARCH AND PUBLICATIONS OFFICE
STUDENT NUMBER	200211552	Ref: EC/FHSS : 1/2013

Title: *Causes of Attempted Suicide in Ohangwena Region- A Social Work Exploration*

To: Ms. T. R. Katota

From : Ms. P. Claassen- Ethics Committee Member

Date : 7 October, 2013

SUBJECT: ETHICAL APPROVAL TO CONDUCT RESEARCH ACTIVITIES

Your application for Ethical Clearance to the Research and Publications Office (RPO) was APPROVED as follows:

Your research activities will be for the completion of your **Masters Degree** in the field of Social Work at the University of Namibia under the supervision of Dr. Elizabeth Shino.

Approval is subject to the following conditions:

- That you adhere to the University of Namibia's Research Policy;
- That you adhere to the University of Namibia's Research Ethics Policy.

If you agree to these conditions, please **sign a copy** of this letter and return it the Research and Publications Office at your earliest convenience, to ensure that your research activities can start.

Please cite the above **Reference Number** and your **Student Number** in all your future correspondence on this Research Project.

Wishing you all the best in research activities!

Sincerely,

Pam Claassen

Student Declaration:

I agree to adhere to the above conditions to adhere to the University of Namibia's **Research Policy**; and the University of Namibia's **Research Ethics Policy**

Name TUHAFENI R. KATOTA Signature [Signature] Date 08.10.13

cc. Prof. I. Mapaure- UNAM Research Coordinator

Dr. C.N.S. Shaimemanya Director : Postgraduate Studies

Dr. E.N. Shino – Main supervisor

APPENDIX D: Permission From Ministry Of Health And Social Services



9-0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032510
Fax: (061) 222558
E-mail: eshaama@mhss.gov.na

Enquiries: Ms. E.N Shaama

Ref: 17/3/3

Date: 24 October 2013

OFFICE OF THE PERMANENT SECRETARY

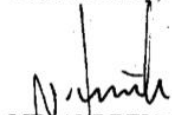
Ms. Tuhafeni. R. Katota
P.O. Box 1585
Oshakati
Namibia

Dear Ms. Katota

Re: Causes of attempted suicide in Ohangwena region: A social work exploration

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your Master of Arts (Social Work) Degree;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of the study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


MR. ANDREW NDISHISHI
PERMANENT SECRETARY

"Health for All"