NEAR EAST UNIVERSITY
INSTITUTE OF GRADUATE STUDIES
GENERAL PSYCHOLOGY PROGRAM

INVESTIGATING TYPICAL RISK FACTORS THAT LEAD TO SUICIDE ATTEMPTS AMONG YOUNG ADULTS

NOKUFIKA MPUMELELO MKHATSHWA

MASTER'S THESIS

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ACCEPTANCE / APPROVAL

We as the jury members certify the 'Investigating Typical Risk Factors that Lead to Suicide Attempts Among Young Adults' prepared by the Nokufika Mpumelelo Mkhatshwa defended on 29/ June / 2021 has been found satisfactory for the award of degree of Master.

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DECLARATION

I Nokufika Mpumelelo Mkhatshwa, hereby declare that this dissertation entitled 'Investigating Typical Risk Factors that Lead to Suicide Attempts Among Young Adults' has been prepared by myself under the guidance and supervision of Dr. Gloria Manyeruke in partial fulfillment of the Near East University, Graduate School of Social Sciences regulations and does not to the best of my knowledge breach any Law of Copyrights and has been tested for plagiarism and a copy of the result can be found in the Thesis.

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ABSTRACT

INVESTIGATING TYPICAL RISK FACTORS THAT LEAD TO SUICIDE ATTEMPTS AMONG YOUNG ADULTS

This study aimed to investigate the typical risk factors that lead to suicide attempts among young adults at Raleigh Fiktin Memorial Hospital (RFM), eSwatini. There has been a rise in the number of cases of young people attempting suicide in eSwatini. This study identified social factors as risk factors for suicide. 66 patients responded to the study. The study revealed that there is no significance by age and interpersonal needs, social support or acquired capability for suicide. There is no correlation between acquired capability for suicide and social support, perceived burdensomeness, and thwarted belongingness. The study also revealed that there is a negative correlation between social support and perceived burdensomeness and thwarted belongingness. The study revealed that there is no significant difference between capability for suicide according to gender. There is significant difference between social support according to employment status; employment has generally been considered a risk factor for suicidal ideation and behavior. There is significant difference in thwarted belongingness and perceived burdensomeness according to current living situation. This could be because social isolation has arguably been the strongest and most dependable predictor of deadly suicidal behavior. There is significant difference between social support according to residential area within the sample. The results could be attributed to urbanization in the city. Future research should apply the study in the whole of eSwatini in order grasp better insight from a larger representative sample. Researchers are recommended to explore beyond social factors in order gain more insight regarding the phenomenon.

Keywords: eSwatini, Young Adults, Suicide Ideation, Attempted Suicide, Social Support

ÖZ

GENÇ YETİŞKİNLERDE İNTİHATE GİRİŞİMLERE YÖNELİK TİPİK RİSK FAKTÖRLERİNİN ARAŞTIRILMASI

Bu çalışma, eSwatini'deki Raleigh Fiktin Memorial Hastanesi'nde (RFM) genç yetişkinler arasında intihar girişimlerine yol açan tipik risk faktörlerini araştırmayı amaçladı. eSwatini'de intihar girişiminde bulunan gençlerin sayısında artış oldu. Bu çalışma, sosyal faktörleri intihar için risk faktörleri olarak tanımladı. 66 hasta çalışmaya yanıt verdi. Çalışma, intihar için yaşa ve kişilerarası ihtiyaçlara, sosyal desteğe veya kazanılmış yeteneğe göre bir önem olmadığını ortaya koydu. İntihar için kazanılan yetenek ile sosyal destek, algılanan külfet ve engellenen aidiyet arasında bir ilişki yoktur. Çalışma ayrıca sosyal destek ile algılanan külfet ve engellenen aidiyet arasında negatif bir ilişki olduğunu ortaya koymuştur. Araştırma, cinsiyete göre intihar yeteneği arasında anlamlı bir fark olmadığını ortaya koydu. İstihdam durumuna göre sosyal destek arasında anlamlı farklılık vardır; istihdam genellikle intihar düşüncesi ve davranışı için bir risk faktörü olarak kabul edilmiştir. Engellenen aidiyet ve algılanan külfet arasında mevcut yaşam durumuna göre anlamlı farklılık vardır. Bunun nedeni, sosyal izolasyonun, ölümcül intihar davranışının tartışmasız en güçlü ve en güvenilir yordayıcısı olması olabilir. Örneklem içinde yerleşim yerine göre sosyal destek arasında anlamlı farklılık vardır. Sonuçlar şehirdeki şehirleşmeye bağlanabilir. Gelecekteki araştırmalar, daha geniş bir temsili örneklemden daha iyi içgörü elde etmek için çalışmayı eSwatini'nin tamamında uygulamalıdır. Araştırmacıların, fenomenle ilgili daha fazla içgörü elde etmek için sosyal faktörlerin ötesini keşfetmeleri önerilir.

Anahtar Kelimeler: eSwatini, Genç Yetişkinler, İntihar Düşüncesi, İntihar Girişimi, Sosyal Destek

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ABBREVIATIONS

ACSS-FAD	Acquired Capability for Suicide Scale-Fearlessness about Death
APA	American Psychological Association
CDC	Centers for Disease Control and Prevention
INQ	Interpersonal Needs Questionnaire
IPTS	Interpersonal Theory of Suicide
RFM	Raleigh Fiktin Memorial Hospital
SPSS	Statistical Package for Social Sciences
WHO	World Health Organisation

CHAPTER 1

Introduction

According to King, Strunk, and Sorter (2011), young adult suicide is the third highest cause of death among young people It is crucial to know what mental health battles look like among young adults. Young adults are particularly vulnerable to mental health related illnesses-with up to 25% of them experiencing mental health related illnesses each year. Despite the high frequency of young adult mental health related illnesses, young adults are the least likely to seek assistance. Young people often express a greater level of frustration or anger, even over small things, in addition to feeling sad or withdrawing from friends and family (Marcus et al, 2012). According to Gutman (2005), shifts in mood are common among young adults and sometimes the extreme emotional pain that they experience becomes unendurable. Given young adults' aversion to seeking help, new strategies of reaching out to these hard-to-reach individuals must be explored.

The Centers for Disease Control and Prevention (CDC) describes suicide as a death caused by a self-directed harmful behavior, with hope of death due to that behavior. It is a result of many things going wrong at the same time for the individual, a sense of loss of control (Crosby et al, 2011). Individuals must not only be physically or psychologically vulnerable but must also have the means to commit suicidal behavior.

Individuals usually also lack necessary factors, such as social support from friends and family, religious beliefs, coping skills, and task-oriented skills that allow a person to deal with crisis or severe psychological distress in times of crisis (WHO, 2012).

According to Edwin Shneidman's body of work, the core of suicidal thoughts is attributed to mental pain which he termed psych-ache. It is the intensity of mental pain that is intolerable for an individual. Frustrated and unmet demands, emotions of guilt and shame, a sense of abasement, loneliness, and other forms of worry all contribute to psych-ache (Verrocchio et al., 2016).

Social support and belonging are believed to have the potential to increase or decrease a one's outlook on life. Social support, according to Schwarzer and Leppin (1991), refers to the characteristics and attributes of social connections, such as the availability of help and the actual support received. It is likely to occur through an interactive process and entails a sense of selflessness and mutual respect. According to MacMillan and Chavis (1986), the sensation, belief, and expectation that one belongs and has a position in the group, as well as a sense of acceptance by the group and a readiness to sacrifice for the group, are all part of the sense of belonging and identification.

Only a few studies have attempted to relate a person's quantity of social interactions with suicidal behavior. A greater number of social interactions have been significantly associated with decreased odds of suicide or suicide attempt (Milner et al., 2015). This implies that suicide prevention programs that promote enhanced social ties at the individual, familial, and broader society levels may be successful (Milner et al., 2015). This previous statement suggests that individuals with a higher number of social connections could have a lower risk of suicide than those with less social connections. The founder of the traditional sociological paradigm of suicide studies, Emile Durkheim, concluded that the following two variables have the greatest impact on suicide: social cohesion and social impact on individuals in terms of their standards, aspirations, limitations, individualism, and unrealistic expectations (Rodziński et al, 2017).

The concepts of perceived burdensomeness and thwarted belongingness were introduced by Thomas Joiner, whose approach to suicidology is in line with the two identified variables of social support and belonging in this study. Perceived burdensomeness has two distinct aspects; it first described as self-hatred and secondly described as the conviction that one's death is more precious than one's life to others. Perceived burdensomeness may develop as a result of situations in which one feels he or she is a burden to others (Rodziński et al, 2017).

Thwarted belongingness is characterized as an interpersonal concept with several dimensions, including a sense of alienation or disconnection from others, a lack of reciprocal care, and having no one to turn to for support. Social separation, spousal death, divorce, family conflicts or crime, or childhood sexual exploitation are all examples of such circumstances (Rodziński et al., 2017).

1.1 Statement of the Problem

There has been a rise in the number of cases of young people attempting suicide in eSwatini, according to reports by the Royal eSwatini Police (Rumbidzai, 2015). Suicide carries a stigma, and mental health facilities are often unavailable in eSwatini. The eSwatini Ministry of Health acknowledges that there is proof of high suicide rates that are not being treated properly (Pengpid & Peltzer, 2020). Therefore, the rise in suicide attempts among young adults can be mitigated by understanding the contributory risk factors that lead to suicide.

The Kingdom of eSwatini, previously Swaziland, is a small landlocked country in southern Africa with a population of 1.45 million people and a per capita income of $9800 USD (Pigoga et al., 2020). It is regarded as a country with a lower middle-income status. eSwatini's health system is organized on four levels and is focused on primary health care (PHC).

Primary health care facilities, such as health centers, public health units, rural clinics, and a network of outreach sites; community-based care, where rural health motivators, faith-based healthcare providers, volunteers, and traditional practitioners provide care, support, and treatments; five regional hospitals; and three national referral hospitals (Magagula, 2017).

Mental health services in eSwatini are limited and centralized, according to the Mental Health Atlas (2011). The National Psychiatric Referral Hospital, located in the country's central part, is eSwatini's only psychiatric hospital. Mental health needs to be prioritized in eSwatini because most clinics lack a manual on how to monitor and treat mental health related issues. Many primary health care providers also lack basic mental health expertise. eSwatini currently lacks a mental health policy, and its mental health legislation, which was last updated in 1978, is out of date (WHO, 2011).

In Manzini, eSwatini, the Raleigh Fiktin Memorial Hospital (RFM) is a 350-bed regional referral and teaching hospital. In the outpatient section, the hospital serves approximately 500 patients every day (ENHI, 2019). RFM aims to improve the health of all men, women, and children who need medical assistance. It intends to accomplish this by providing high-quality preventive, promotive, curative, and rehabilitative treatment in accordance with the Ministry of Health and Social Welfare's National Health Policy as well as the eSwatini Nazarene Health Institution's Mission (ENHI, 2019).

1.2 Aim of the Study

This study is conducted to investigate the contributory risk factors associated to the current prevalence of suicidal ideation or attempt among young adults at RFM, eSwatini. It focuses on social factors as possible contributory risk factors for young adult suicide. Based on the existing literature, the study predicts that patients with low levels of social support, high levels of perceived burden, and thwarted belonging are more likely to exhibit suicidal behaviors. There is an expected negative correlation between the level of social support and suicidal behaviour.

Patients who exhibit high levels of perceived burdensomeness and thwarted belongingness are more likely to exhibit suicidal behaviour, thus a positive correlation between high levels of perceived burdensomeness and thwarted belongingness regarding suicidal behaviour is expected.

The scales used in this study measure social support, perceived burdensomeness, thwarted belongingness, and capability for suicide.

The following research questions will guide the study:

1. What is the relationship between social support and capacity for suicide?

2. What is the relationship between perceived burdensomeness, thwarted belongingness and capacity for suicide?

3. Are there any gender differences in social support and interpersonal needs on capacity for suicide?

4. Are there any differences in capacity for suicide, social support, and interpersonal needs according to marital status, employment status, living situation, residential area, history of previous suicide attempt, and history of psychological disorder diagnosis?

1.3 Significance of the Study

eSwatini has done the minimal research on suicidal ideation, which is the starting point of suicide (Almansour & Siziya, 2017). There is need to further expand the body of research in eSwatini regarding suicide ideation to better equip mental health professionals with skills that are necessary and relevant for its environment. Early identification of these contributory risk factors will also bring awareness to mental health prevention and treatment methods that address eSwatini and its identified needs. It will further strengthen therapeutic programs as well as help create new diagnostic and treatment techniques.

The overall objective of the eSwatini health sector as indicated by the eSwatini Ministry of Health is to provide individuals, families, and the community with high-quality preventive, curative, and rehabilitative health care services and this study concurs with that motion. Among young adults in eSwatini, the rate of suicide attempts has increased. According to a study by Rumbidzai (2015), eSwatini has a very high suicide rate. Statistics released by the Royal eSwatini Police show that between January 2014 and January 2015, 160 people committed suicide, of which 126 were men. 160 people in 12 months implies that approximately 13 people committed suicide in a month, which is a staggering number for the population of eSwatini.

Rumbidzai (2015), further revealed that counselors were historically only found at psychiatric hospitals as counseling is synonymous with mental illness, which is also stigmatized in eSwatini cultures. Seeking mental health care is viewed as a weakness especially within the male community. These statements raise awareness for the need to currently normalize and educated on the value of seeking mental health care services.

According to Amitai & Apter (2012) suicidal behavior continues to be a significant clinical concern and a leading cause of death among young people yet various suicidal behaviour studies have been carried out. Studies have been carried out on suicide theories spanning multiple backgrounds, including biological, psycho-dynamic, cognitive-behavioural and developmental (Van Orden et al., 2010). Advancing the understanding of underlying sociological issues in suicide among young adults would aid clinicians to achieve more efficient prediction, prevention and treatment.

Previous literature has suggested that people who participate in studies, regardless of the care they receive, seem to have improved health outcomes. Therefore, the previous statement implies that the participants will benefit from the study despite the outcome. This study is necessary for gaining a better understanding of young adults within their social environment and their relationship regarding suicide. A better understanding is necessary for creating more sensitive and efficient mental health public policy in eSwatini, for example.

1.4 Limitations

- This study uses standardized questionnaires with close-ended questions. There is a probability for the study to have restricted outcomes as a result.
- The researcher cannot generalize the data gathered from Raleigh Fiktin Memorial Hospital across eSwatini as this would lack validity. This study only represents a sample of participants accessed only from RFM.

1.5 Definitions

- **eSwatini:** eSwatini, officially the Kingdom of eSwatini, sometimes written in English as eSwatini, and formerly and still commonly known in English as Swaziland, is a landlocked country in Southern Africa.
- **Young adults:** The Society Adolescent Health and Medical Association uses the 18-25 age group to represent the young adult age group because there is no formal international agreement on what constitutes a young adult (Walker-Harding et al., 2017).
- **Suicide ideation:** it is defined as having plans to terminate one's life (Nock et al., 2008).
- **Attempted suicide:** Suicide attempts are known as non-fatal behaviors in which individuals deliberately put themselves at risk of death (Barzrafshan et al., 2016).
- **Social support**: Social support is the impression and reality that one is cared about that one can get help from others, and, most importantly, that one is a member of a supportive social network (Williams et al., 2004).

CHAPTER 2

LITERATURE REVIEW

This chapter examines the theoretical and empirical literature on suicide. The chapter is divided into eight sections: young adults, suicide, social support, belonging, theories on suicide according to Shneidman, Durkheim, and Joiner. It lastly examines previous literature related to suicide.

2.1 Young Adults

According to Walke-Harding et al. (2017), young adulthood is a distinct and critical developmental stage marked by significant unmet health needs as well as differences in access to adequate treatment, state of health, and high death rates. Several studies have been published highlighting the main health problems of this post-adolescent age group.

The Society for Adolescent Health and Medicine uses the age of 18-25 years to represent the young adult age group because there is no formal international agreement on what age constitutes young adulthood. In terms of psycho-social development, young adults face different challenges and milestones than youth and adults. They must transition from school to work ambition, from parental guidance to personal responsibility, from living with their parents to establishing their own family, from the child health care system to

the adult health care system (Walker-Harding et al., 2017). The context of the greater world, which is continually moving, also influences these challenges and milestones. These young and emerging adults now live in highly connected global cultures where the milestones that traditionally defined when adulthood began are either being questioned internationally or are no longer as consistently applicable to young adults today as they once were thought to be (Walker-Harding et al., 2017).

2.2 Suicide

The Centers for Disease Control and Prevention (CDC) describes suicide as a death caused by a self-directed harmful behavior and any desire to die as a result of that behavior. This is the result of the individual having many problems at the same time, namely the feeling of losing control (Crosby et al., 2011). Individuals must not only be physically or psychologically vulnerable, but must also have the means to commit suicide, and must lack the necessary factors, such as social support from friends and family, religious beliefs, coping skills, and problem-solving skills that provide comfort and allow people to deal with crises or severe psychological distress in times of crisis (Berman, 2009).

Suicide was further described as the act of deliberately ending one's life. Non-fatal suicidal thoughts and behaviors are more accurately divided into three categories: suicidal ideation, suicide plan, and suicide attempt. Suicidal ideation is defined as a planned end of life. The suicide plan refers to devising a specific method to end life. Finally, suicide attempt refers to participating in a potentially self-destructive behavior, which has at least some intention of dying (Nock et al., 2008).

One of the clearest findings in the suicide literature is that people who commit suicide often experience social alienation and withdrawal prior to their deaths (Trout, 1980). Loneliness and suicidality have been shown to be linked in several studies. Patients' loneliness is widely cited by loved ones as a contributing factor in their attempts to commit suicide.

More single people died by suicide in the United States than married people, according to Jordan and McIntosh (2011). Therefore, implying that the failure or loss of significant relationships may be a contributing factor to the urge to die.

Every 15–25 suicidal attempts, one person commits suicide. Suicide accounts for around 1.5 percent of all deaths, according to the World Health Organization (WHO, 2014). Suicide was the 15th most common cause of death in 2012, according to the Centers for Disease Control and Prevention. However, in the specific age group of 15–29-year-olds, death by suicide ranked as the most common cause (Rodziński et al., 2017).

According to Arria et al. (2009), many risk factors discovered in suicide study, such as perceived social support and parent-child conflict, could be areas of intervention. More research is needed to see if these risk variables can be adjusted to minimize suicidal ideation. Researchers and clinicians face distinct obstacles when it comes to suicidal thoughts and behaviors in college. The transition from late adolescence to early adulthood is frequently marked by significant tensions resulting from acclimating to a new social environment and growing academic demands (Arria et al., 2009).

Even though clinicians have a multitude of information on suicide, one of the most difficult challenges they have is generating accurate predictions. Suicide risk must be precisely estimated in order to select the appropriate treatment choices, make hospitalization decisions, and monitor the patient's behavior (Rodziński et al., 2017).

2.3 Theoretical Framework

In a theoretical context, several suicidal behavior studies have been conducted, covering many contexts of suicidology, including biological, psycho-dynamic, cognitive-behavioural, and developmental etiologies (Van Orden et al., 2010). Suicidal behavior, according to biological theories, is caused by the coexistence of two biologically related diathesis (Mann, 2003). According to the psycho-dynamic theory, unconscious drives, intense affective states, a desire to escape psychological distress, existential drives for meaning, and disturbed connection cause suicide (Leenaars, 2004).

Cognitive-behavioural theories, on the other hand, propose that hopelessness is a causal factor that leads to suicide (Van Orden et al., 2010). Suicidal behavior remains a significant clinical issue and a major cause of death in young people, according to Amitai and Apter (2012). Increasing clinicians' awareness of the underlying cultural and sociological problems in suicide among young adults could possibly lead to more effective prediction, prevention, and treatment. This study refers on suicide theories according to Shneidman, Durkheim, and Joiner (2017).

2.4 Social Support

Several suicide theories suggest that social connections play a key role in the etiology of suicide. According to Durkheim's sociological model, suicide is caused by numerous dysfunctional social processes, one of which is a lack of social integration (Durkheim, 1897). Unmet needs for connection are one of the factors that contribute to suicide, according to Shneidman's cubic model of suicide (Shneidman, 1987). According to the interpersonal theory of suicide, the desire to belong to caring and supportive relationships is so strong that when it is denied, it adds to a capability for suicide attempt (You et al., 2011). Several research studying the association between suicidality and belongingness, which is the degree to which people believe themselves to be meaningfully attached to gratifying and good relationships or social groupings, have backed up the interpersonal theory of suicide (You et al., 2011).

People are identified and understood not just as individuals, but also as members of specific social groups, such as age groups, economic groups, or cultural groups, through social categorization. People socialize based on their previous interactions with people from various groups. They are continually refining their social categories while interacting with one another. As a result, their actions are influenced (Trepte & Loy, 2017). Individuals transition into a unique mixture of various social categories during their lives; thus, the set of social identities that make up one's self concept is unique (Stets & Burke, 2000)

According to Kleiman & Riskind (2013), friends and family members who provide psychological and material support are referred to as social support. The positive impacts of social support have been well-documented in sociology and psychological research. Many psychology research show that even knowing that social assistance is available can improve one's health and mood. According to recent research, people's perceptions of social support may protect them from committing suicide (Kleiman & Riskind, 2013).

According to Kleiaman & Riskind (2013), utilized or enacted social support is the practical application of social assistance for psychological or physical benefit. Suicidal people frequently put off seeking help, a practice called as assistance denial, which is particularly common among college students (Yakunina et al., 2010). People who are aware of and then use the assistance provided by others may be eligible for additional benefits not accessible to those who are merely aware of assistance. This could include adaptive inferential input from other sources, exposure to positive events, and actual suicide attempt interruption (Kleiman & Riskind, 2013).

According to Arris et al. (2009), among young people, a lack of social support from family and friends is a significant predictor of suicide thoughts. Higher levels of social support in college students tend to protect against suicide conduct through enhancing self-efficacy or reducing stress. Social isolation and alienation, or a sense of failure to belong, on the other hand, may have a significant impact on suicide behavior (Joiner, 2005). Despite the well-known links between suicidal thoughts, social support, and depression, few research has looked at how these three issues interact (Arries et al., 2009).

2.5 Belonging

Our desire to belong, like other psychological conceptions, may be traced back to our prehistoric ancestors, when group life and collaboration were critical for safety and survival. People lived in tiny groups, sharing chores such as hunting, gathering, and sentinels. In ancient times, a person who desired to do it alone was unlikely to endure very long (Allen, 2019). Similarly, an individual's rejection by a group would have been devastating. One argument for why fear of rejection remains today is that it is a human feature that dates to our prehistoric ancestors (Allen, 2019).

According to Rogers (1951), belonging is a distinct and subjective experience that links to a need for interpersonal connection, the need for positive regard, and the desire for positive regard. Participation with, or proximity to, others or groups does not guarantee a sense of belonging. Rather, a sense of quality, meaning, and happiness with social interactions leads to a sense of belonging.

Sense of belonging, according to Hagerty et al. (1992), is a notion that is comparable to but distinct from loneliness, alienation, and social support, as well as quantitative assessments of social contact. They defined sense of belonging as the feeling of being a vital member of a system or environment. A sensation of belonging to a location or even an event can also be referred to as belonging. As a result, it is a complicated and dynamic process that is unique to everyone (Allen, 2019). The sense of belonging is described as an interpersonal need construct based on a universal and urgent need to belong. We continue to seek and maintain this need. Although we work hard to belong, we are deeply used to providing a sense of belonging to others as further stated by Allen (2019).

Suicidal ideation, according to Durkheim (1897), is caused by self-centered, socially isolated, and unstable thinking. When society loses control of a person's emotions, they may commit suicide. This implies that an individual needs to be integrated into a community to ensure a stable quality of life, an individual has an intrinsic need for belonging.

Hargety et al. (1992), as quoted by Marty (2012), identified two defining psychological aspects of sense of belonging: value and fit. An individual must feel appreciated, needed, and accepted, as well as fit in with and complement their surroundings. They also believed that people must have the energy and prospective desire to participate in social activities, which they called antecedents to a sense of belonging. They then used the terms belonging-psychological and belonging-antecedent to describe these two distinct components. Their definition of belongingness is very similar to the IPTS.

According to Allen (2019), a lack of belonging has terrible and disastrous physical and psychological impacts on people. It can lead to feelings of worthlessness, and feelings of worthless can lead to suicide to suicidal ideation (APA, 2003). Belonging and social rejection are at odds. The two experiences are fundamentally opposed. Previous literature has indicated that social pain, such as social exclusion, can elicit a brain response like physical pain (Eisenberger et al., 2003). Suicidal people often have a negative vision of the future because of their poor self-concept, and they feel hopeless, worthless, and want to die. Suicide is viewed as means to end pain (Beck and Rush, 1978).

Self-concept is a mental construct that describes the perceptions of individual's strengths, skills, and personal defining characteristics. Initially, self-concept is quite vague, flexible, and changing, but as time goes on, these self-images grow more constant and become more precise and distinct (Tanvir et al., 2013). Individuals who attempted suicide had a much worse self-concept, as well as higher degrees of depression and hopelessness, than non-suicidal patients, according to Tanvir and colleagues (2013). This statement implies that there is a positive correlation between low self-concept and suicidal relations.

2.6 Edwin S. Shneidman's Concepts on Suicide

Edwin S. Shneidman is the founder of a modern-day view on suicide. The extensive study of suicide is reflected in his work. His contributions on suicide are some of the essential studies in the field. His work is fundamental to suicidology (Leenars, 2010). Shneidman shared his aversion to suicide medicalisation, which he sees as a human condition in nature.

According to Shneidman, suicide is not an illness but rather but as a series of acts with a common end point (Flamenbaum, 2009). An individual who wishes to end his life, according to Shneidman, is attempting to find a way out, to flee, to separate himself or herself, and to cease to exist (O'Connor, 2011). Shneidman describes suicide as a mental distress disorder that he termed as psych-ache.

Psych-ache derives from frustrated and unfulfilled desires, feelings of remorse and shame, feelings of humiliation, depression and different symptoms of anxiety (Nock, 2014). For example, health problems and being left by a partner can lead to psych-ache. Psych-ache is when psychological agony exceeds an individual's level of tolerance to the point where death is considered as the only way out, suicide becomes a viable option (Flamenbaum, 2009). Shneidman compares a suicide attempter's mental state to that of someone who has been intoxicated or faded with a psychoactive drug - the person is overcome by overwhelming emotions that alter self-concept negatively (Rodziński et al., 2017).

Psych-ache and the unpleasant feelings that accompany it arise from unmet, dissatisfied, or thwarted emotional needs, which are divided into two categories: modal needs and vital needs. Modal needs are the needs that define an individual's unique personal qualities within their daily environment. Vital needs are the needs that an one would literally die for, and a lack of these needs cannot be tolerated by the individual (Flamenbaum, 2009).

According to Flamebaum (2009), Shneidman also identified six elements to the progression to suicide. The first element are life stressors and emotional traumas that result to change and failure to the individual. The second element is the impact of the individual's genetic makeup and their current, and constant daily environment. The third element is the individual's view of daily life pressures in a negative and pessimistic light. The fourth element is the individual's understanding of pain as intolerable and unbearable. The fifth element is the individual's belief that the only way to get rid of their torment is by losing consciousness. The final element involves the ultimate discomfort that is more than one's tolerance for enduring mental pain. The pain exceeds the individual's pain threshold.

Therefore, according to Shneidman, what all suicides have in common is the search for a solution to this pain; and the common goal of suicide is to stop the painful stream of consciousness (Flamebaum, 2009).

2.7 Emile Durkheim's Concepts on Suicide

Throughout history, philosophers and intellectuals have sought to comprehend the variables that contribute to suicide. The psychological understandings of the period are typically reflected in these ideas. Some studies have included an interpersonal dimension to suicide to be explored-Emile Durkheim's idea of suicide is an example (Frey & Cerel, 2013). Suicide, according to Durkheim, is the outcome of society's control over the individual. This suicidal state develops as a result of social integration. Social integration is the process by which individuals think they belong and are accepted by society. Social integration also governs the standards that regulate how people communicate (Frey & Cerel, 2013). He stated that social and cultural variables need to be considered in the understanding of suicide (Goldman-Mellor et al., 2014).

Based on statistics, Durkheim stated that social cohesiveness and societal effect on people' beliefs, goals, limits, individual attitude, and overly high expectations had the biggest influence on suicide (Durkheim, 2005). As cited in Rodziński et al. (2017), Durkheim's observations led him to select four categories of suicide: egoistic, altruistic, anomic, and fatalistic. Egoistic is caused by an individual's lack of social cohesiveness with his or her social community as well as a loss of a sense of belonging. Altruism is caused by excessive social solidarity, leading to group interests overriding individual goals, as well as a willingness to put one's life in the interest of the social group, such as those in need. Anomic is a period of social unrest. It is caused by the collapse and ambiguity of social norms and rules. It is also caused by society's lack of regulatory control over the morals and expectations of the individual. Fatalistic is due to unnecessary constraints, restrictions, and intrusive controls on individuals from the outside.

2.8 Thomas Joiner's Concepts on Suicide

Thomas Joiner presented the Interpersonal Theory of Suicide (IPTS). This theory specifically recognizes that interpersonal structure plays a role in suicide risk. The IPTS combines several risk factors for suicide to provide verifiable estimates of who will develop suicidal thoughts and who will attempt suicide. Therefore, this theory is expected to improve our understanding of how different suicide risk factors interact and that prevention and intervention should focus on (Van Orden et al., 2010).

According to Ribeiro et al. (2014), the IPTS suggests that humans are biologically prepared to fear suicide. This is because committing suicide exposes the individual to stimuli and signals associated with threats to the survival of the body. Thinking about suicide naturally causes fear. In order to plan and prepare for suicide, one must despise this fear, which according to theory is not an action that most people can take. In order to develop this ability and overcome phobias, theory suggests that individuals must be repeatedly exposed to and pay attention to instincts, pain, and potentially fatal stimuli (Ribeiro et al., 2014).

The IPTS proposes that the capability for suicide must be combined with two interpersonal factors: thwarted belongingness and perceived burdensomeness. Thwarted belongingness can be explained as a complex cognitive-emotional state mediated by both interpersonal and interpersonal influences, including familial conflicts, little social support, misinterpreting others' behaviour as rejection (Van Orden et al.,2010). On the other hand, perceived burdensomeness refers to the perception that one's existence is a burden on friends, family, and community. It can be divided into two categories: self-hatred and obligation. For example, self-hatred might appear as 'I despise myself.' Liability can manifest itself as 'my death is worth more to others than my life' (Van Orden et al., 2010).

Perceived burdensomeness, like thwarted belongingness, is a complex cognitive condition influenced by risk factors such as homelessness, unemployment, illness, inferiority complex and being undesirable (Van Orden et al., 2010).

Although it is hypothesized that feeling burdensome or isolated may evoke passive suicidal ideation, it is only their involvement, combined with the belief that they are stable and unchanging that leads to suicidal desire (Van Orden et al., 2010). The ITPS terms this desire as the acquired capability for suicide.

The acquired capability for suicide is defined as the ability to suppress one's natural need for self-preservation and indulge in lethal self-injury (Joiner, 2009). The capability for suicide is thought to be attributed to a decreased fear of death as a result of prolonged exposure and habituation to physically painful and fear-inducing situations, as well as an increased tolerance for physical pain (Ribeiro & Joiner, 2009).

Consistent with IPTS, studies have indicated that fear of death and tolerance to high pain play an important role in suicidal behavior (Ribeiro et al., 2014). Therefore, individuals who have high levels of all three constructs; thwarted belongingness, perceived burdensomeness, and acquired capability, are said to be at most risk for lethal suicidal behaviour, as they possess both the desire for and capability to attempt suicide.

Shneidman, Durkheim, and Joiner highlight the role of the social connection and self-concept as risk factors for suicide ideation and attempts. Shneidman highlights the individual's thwarted thoughts on belonging, Durkheim highlights the individual's social deficiency and Joiner highlights the individual's thwarted belonging and perceived burdensomeness.

2.9 Related Research

You, Van Orden, and Conner (2011) studied the relationship between various indices of social connection and the life history of suicidal ideation and suicide attempts among individuals. According to the prediction, all social connection indices; interpersonal conflict, low social support, low sense of belonging and living alone are associated with a higher probability of suicide attempts and a history of suicidal thought. Interpersonal conflict and a sense of belonging are important predictors of the history of suicidal ideation. Sense of belonging, perceived social support, and living alone are important predictors of suicide attempts.

Hooven et al. (2012) conducted a study of 759 young adults who were potential high school dropouts when they were young and in school. Researchers examined the adolescent risk factors that predict the state of young adults to understand why suicide risk is continuous for some and discontinuous for others. The research of this study concluded that young adult suicide risk can be predicted by several indicators of social disconnection, family bonds, and time alone. According to Hoover et al. (2012), young people who reported higher family free time and time together had a discontinuous state of suicide risk in adulthood.

Marcus et al. (2012) investigated the experience of young people and their health problems. Excerpts from the blog were analyzed using a combination of grounded theory and qualitative consensus research methods. Qualitative analysis of blog accounts revealed two main categories: I cannot do anything and, I am completely alone. ‘I am powerless’ was classified as an intrapersonal concept, and ‘I am completely alone’ was classified as an interpersonal concept. In general, young adult bloggers showed obvious feelings of helplessness due to mental health issues, but they also feel a deep sense of loneliness, alienation, and lack of contact with others.

Wilxcox et al. (2014) investigated the factors that cause first-year college students to consider suicide. Over the course of four years, data was obtained prospectively. Low social support, childhood or adolescent domestic violence exposure, maternal depression, and significant self-reported depressive symptoms were all found to be risk factors for persistent suicide ideation.

Rose (2015) used Durkheim's suicide theory to conduct a study of Canadian veterans in Afghanistan. The study investigated the experiences of Canadian veterans serving in Afghanistan, focusing on the social dynamics brought on by difficult transitions, especially the risk of suicidal ideation. According to this study when there is a sense of moral purpose gained through community integration and control, some participants may psychologically return to 'home', to a space where they felt they belonged. It was suggested by the study that institutional support can help bridge the cultural gap between military and civilian life, which can help alleviate abnormal social conditions that lead to feelings of loss.

Hatcher and Stubbersfield (2013) systematically reviewed research on the association between belonging and suicide. They investigated this research based on an electronic database to conduct research that included assessing suicide and feelings of belonging. The results of the study found an association between belonging and suicidal tendencies, but almost all studies were conducted in non-clinical populations, and the association was weak. According to Hatcher and Stubberfield (2013), the association between low belonging and suicide is weak.

To investigate the elements that lead to suicidal ideation in young people, Gutiérrez and colleagues (2001) constructed a general pathway model based on current studies on suicide risk. The questionnaire package was completed by 673 undergraduate students. Based on this sample, black culture research has highlighted the importance of group cohesion and ties with families, churches, and other social institutions, such as friendship networks, as protective factors against suicide.

Suicidal thoughts and attempts were measured retrospectively by You and colleagues (2011). They made no analysis of the relationship between social connections and current suicidal tendencies with the belief that some measurements of social connections with current suicidal tendencies. No other sources of heterogeneity of suicide attempts are available. They found belonging, which is a form of social connection assumed by IPTS as the most consistent variable supporting the relationship between suicidal ideation and suicide attempts. They further expressed belonging as a key factor in suicidal desire (You et al., 2011).

Lack of social support was found to be a significant risk factor for suicidal ideation in a study by Van Orden et al. (2008). Evidence showing college students who are members of a sorority or fraternity are less likely to express suicidal ideation supports the hypothesis that a sense of belonging helps prevent suicide (Brener et al., 1999). This is also possible, according to Van Orden et al. (2008), because changes in suicide ideation recorded over the semester can be linked to changes in the social mix of the university campus and its members.

Witte et al. (2012), within the framework of the interpersonal theory of suicide, investigated two personality characteristics, which may explain the recognized gender differences in suicide. In the two samples of college students, the acquired capability of suicide from men was significantly higher than that of women. Therefore, personality can be a psychological mechanism that explains gender differences in suicidal behavior.

Van Oden et al. (2008), explored the gender differences in suicide attempts. The study concluded that attempted suicide mainly occurred in women, while completed suicide occurred mainly in men. The risk factors for attempted suicide and completion of suicide include family environment, mental and addiction disorders, and precipitating events.

Joiner et al. (2002) analysed suicide notes from suicide attempters and completers in two studies to see if there were any differences in the predictors of completed suicide. Suicide completers' notes were deemed to be more burdensomeness than suicide attempters' notes, according to their findings.

Suicide attempt status and current suicidal symptoms were found to be significantly associated to burdensomeness and hopelessness in both adult and adolescent populations. After adjusting for hopelessness, the association between perceived burdensomeness and suicide attempt remained substantial. These outcomes suggest that perceived burdensomeness is a strong predictor of serious suicidal desire, comparable to despair, which is one of the most accurate predictors of suicide (Joiner & Van Orden, 2008).

IPTS was tested in three investigations by Vander Oden et al. (2008). Suicide cannot be committed unless a person has both the desire and the ability to do so, according to the interpersonal psychology theory of suicidal conduct. In the first investigation, the interaction of thwarted belonging and perceived burden predicted current suicidal ideation. As expected, thwarted sense of belonging and perceived burden was significantly and positively correlated. As predicted, feelings of belonging and burden were significantly related to suicidal ideation. In the second investigation, a higher level of acquired capability for suicide was found in people who had attempted suicide before. The results also showed that the experience of pain and provocative experiences significantly predicts the score obtained for acquired capability. In the third investigation, the relationship between acquired ability and perceived burden predicted the probability of suicidal behaviour as determined by the clinician.

The psych-ache theory of suicidality was examined by Flamenbaum (2009). In the first model, which adjusted for baseline levels of hopelessness and suicide ideation, psych-ache was utilized as a prospective indicator of suicide ideation. The prediction that psych-ache would predict future improvements in suicide ideation was rejected, since neither psych-ache nor hopelessness showed any significant longitudinal relationships with suicide ideation.

CHAPTER 3

METHODOLOGY

This chapter outlines the research methodology that was used to investigate social support and belonging as contributing factors to suicide attempts among young adults at the Raleigh Fiktin Memorial Hospital (RFM), eSwatini. This chapter includes the research design, population and sample, materials and measurement of variables, data collection procedure, and data analysis procedure.

3.1 Research Design

The research design for this study is quantitative. A case study approach and correlational model was used. According to Crowe et al. (2011), when an in-depth understanding of an issue, event, or phenomenon of interest is required in its natural real-life setting, the case study approach is particularly effective. Correlational studies are multi-subject, quantitative research in which participants are not randomised to treatment groups (Thompson et al., 2005). Correlational evidence can be used to guide causal inferences in at least two ways. The first method is based on statistics, and it entails statistically assessing competing alternative causal hypotheses. The second way is logic-based, and it uses logic and theory to rule out all feasible alternative explanations in order to make a single credible causal inference (Thompson et al., 2005).

3.2 Population and Samples

The population in this study are patients referred to the Raleigh Fikitin Memorial Hospital social welfare department after having attempted suicide. Non-probability sampling will be used in this study. Non-probability sampling approaches differ from probability sampling techniques in that samples are selected based on the researcher's subjective judgment rather than random selection (Bryman & Bell, 2011). The researcher will use a non-probability sampling method called purposeful sampling. Purposive sampling refers to a collection of sampling techniques that depend on the researcher's judgment in deciding which units to study (Reddy & Ramasamy, 2016).

On an average monthly basis, 40 patients from various wings of the hospital are referred to the RFM social welfare department for psycho-social counselling. The researcher will identify patients that meet the research criteria between the months of December 2020 to May 2021. The predicted population between the data collection time frame is 200. From that population a sample of 132 patients who have been admitted in the hospital for suicide attempt between the ages of 18-25 will be the ideal sample to be selected for the study, with a margin error of 5% and a confidence level of 95%.

A total of 66 patients however, responded to the questionnaire. Among 66 participants, 18 were male (27%), and 48 were female (73%). Descriptive statistics, regarding age were 50 (76%) for the participants between the ages of 21-23 and were 16 (24%) for participants 24 and above. For marital status, 65 (98%) participants were single and 1 (2%) was married. With regards to education, 9 (14%) participants were in high school and 57 (86%) were in tertiary. Employment status statistics for the participants were 29 (44%) for students, 18 (27%) for employed, and 19 (29%) for unemployed. Regarding living situation statistics, 9 (13.4%) participants lived alone, 28 (41.8%) lived with parents or guardians, 10 (14.9%) lived with relatives, and 19 (28.4%) lived with friends. Data was gathered and analyzed from eSwatini residents. The residential area statistics for participants were 33 (50%) lived in Manzini, 15 (22.7%) lived in Matsapha, 9 (13.6%) lived in Mbabane, and 9 (13.6%) lived in Ncabaneni.

Table 1.

Demographic information about the sample according to gender, age, marital status, education, employment, living situation, and residential area

	Demographic information	**N**	**%**
Gender	Male	18	27
	Female	48	73
Age	21 to 23	50	76
	24 and above	16	24
Marital status	Single	65	98
	Married	1	2
Education	High school	9	14
	Tertiary	57	86
Employment	Student	29	44
	Employed	18	27
	Unemployed	19	29
	Alone	9	13.4
	With Parents/ Guardians	28	41.8
	With Relatives / Extended Family	10	14.9
	With Friends	19	28.4
Residential Area	Manzini	33	50.0
	Matsapha	15	22.7
	Mbabane	9	13.6
	Ncabaneni	9	13.6
Total		66	100

3.3 Materials and Measurement of Variables

During the data collection procedure, participants were asked several demographic or personal questions, such as their gender, age, current living situation, and employment status. Overall, the scales used in the study include:

3.3.1 Demographic Scale

This scale was developed by the researcher and included questions regarding the demographic background of participants. The demographic data collected includes gender, age, marital status, residential area, current living situation, level of education, employment status, history of previous suicidal attempt, history of previous psychological diagnosis, psychotherapy in the past six months, and family history of suicide.

3.3.2 ENRICHD Social Support Instrument

The ENRICHD Social Support Instrument is 7-item measure of social support that is used to assess social support in this study. It was developed by Pamela H Mitchell (Mitchell et al., 2003). Participants are asked to rate on a 5-point likert scale ranging from 1 to 5, with 1 equalling none of the time and 5 equalling all the time. The scale was shown to be a valid and reliable measure of social support because it taps into four distinguishing characteristics of social support: emotional, instrumental, informational, and appraisal. Cronbach's alpha 0.87 indicates that this scale has strong internal reliability.

3.3.3 Interpersonal Needs Questionnaire (INQ)

To measure belonging, this study uses the Interpersonal Needs Questionnaire which is a 15-item measure of perceived burdensomeness and thwarted belongingness. It was developed by Kimberly A Van Orden, Kelly C Cukrowics, Tracy K Witte and Thomas E Joiner (Van Orden, Cukrowicz, Witte, & Joiner, 2012). Participants are asked to rate on a 7-item likert scale 1=not at all true for me to 7=very true for me.

The INQ includes 8-items to tap burdensomeness which can be described as feeling like a burden or load to others and 7-items to assess belongingness which can be described as feeling connected to others. Both scales usually show good internal reliability and have demonstrated construct validity. The perceived burdensomeness scale has a Cronbach's alpha 0.87 and the thwarted belongingness scale has a Cronbach's alpha 0.84.

3.3.4 Acquired Capability for Suicide Scale-Fearlessness about Death (ACCS-FAD)

The Acquired Capability for Suicide Scale- Fearlessness about Death is used in this study to determine suicide capability. Ribeiro JD, Witte TK, Van Orden KA, Selby EA, Gordon KH, Bender TW, Joiner T created a seven-item questionnaire (Ribeiro et al., 2014). The ACSS-FAD is an update of previous ACSS versions developed within the context of interpersonal suicide theory. Its seven self-reported statements look at the capability for suicide's fearlessness-about-death trait. On a five-item likert scale, participants are asked to rate themselves on a scale of 1 to 5, with 1 equalling not at all like me and 5 equalling very much like me, corresponding to a value of 0-4. Internal consistency reliability of this scale was shown to be adequate in numerous samples of undergraduate students; Cronbach's alpha.77–.85, an inpatient sample Cronbach's alpha 0.81, and a general population sample Cronbach's alpha 0.76 (Ribeiro et al., 2014).

3.4 Data Collection Procedure

This study must adhere to ethical considerations. Data collection will commence once the Near East University Ethical Committee has approved the proposed study. Once permission is granted for the study to begin, the Raleigh Fiktin Memorial Hospital also must grant permission. Ethical standards must be upheld as the data in this study will be collected from a vulnerable group; it will be collected from hospital patients. The participants' individual rights will be protected by adhering to these following three principles: respect for persons, beneficence, and justice (Diekema, 2006).

3.5 Data Analysis Procedure

Quantitative techniques will be used to analyse the data collected. The findings of this research method are derived using statistical and mathematical methods. Quantitative data will conclude on a problem's purpose and grasp how prevalent it is by looking for outcomes that can be projected to a broader population while attempting to quantify it (Sukamolson, 2007). The Statistical Package for Social Sciences software will be used to analyse the data (SPSS Version 26.0).

Firstly, to begin analysis, descriptive statistics of participants were obtained, and normality of data was examined using skewness and kurtosis indicators. The researcher will further examine the relationship between social support, interpersonal needs, and the capability for suicide using the regression and correlation test. The researcher will also conduct a t test for all three scales according to gender, according to employment status, according to history of previous suicide attempt, and according to history of psychological diagnosis to observe the correlation regarding suicide relations. The researcher will lastly use ANOVA to analyse the data.

Detailed data properties are illustrated in the table below:

Table 2.

Data Properties

						Skewness		Kurtosis	
Variable	**N**	**Minimum**	**Maximm**	**Mean**	**Std Dev**	**Statistics**	**Std. Error**	**Statistics**	**Std. Error**
Social Support	66	13.00	21.00	17.5758	2.45614	-.576	.295	-.411	.582
Interpersonal Needs	66	22.00	32.00	26.7121	3.16600	.192	.295	-1.033	.582
ACCS	66	1.71	2.86	2.2468	.25127	.361	.295	-.163	.528

Table 2 represents the descriptive statistics for variables included in the study. From the 66 participants, it is observed that the statistic of the skewness falls between +2 and -2. Therefore, the data in this distribution is normally distributed.

CHAPTER 4

RESULTS

This chapter contains the analysis results of the data collected. It expresses the result and consequences between social support, interpersonal needs, and the acquired capability for suicide.

Table 3.

Acquired capability for suicide frequency

Acquired Capability for suicide	Frequency	%
1.71	2	3.0
1.86	2	3.0
2.00	12	17.9
2.14	17	25.4
2.29	15	22.4
2.43	6	9.0
2.57	6	9.0
2.71	5	7.5
2.86	1	1.5

Total	66	100

Table 3 shows the scores of the participants on acquired capability for suicide over and possible 4.

Table 4.

Correlation between age, acquired capability for suicide, social support, and interpersonal needs

		ACCS	Age of participant	Social support	Perceived burdensomeness	Thwarted belongingness
ACCS	R	1	-.155	.065	0.043	0.006
	P		.215	.602	0.731	0.959
Age	R		1	-0.76	-0.082	-0.59
of participants	P			.546	0.514	0.637
Social support	R			1	-0665	-0.592
	P				0.000	0.000**
Perceived burdensomeness	R				1	0.886
	P					0.000**
Thwarted belongingness	R					1
	P					

P<0.05* p≤0.001**

The results of the table above show that there is no significance by age and interpersonal needs, social support or acquired capability for suicide. There is also no correlation between acquired capability for suicide and social support, perceived burdensomeness, and thwarted belongingness. There is a negative correlation between social support and perceived burdensomeness and thwarted belongingness.

Table 5.

Comparison of the total and sub-scales of social support, interpersonal needs, and the acquired suicide capability according to gender

	Male			**Female**				
	N	**Mean**	**Std Dev**	**N**	**Mean**	**Std Dev**	**T**	**P**
Social Support	18	18.50	2.09	48	17.23	2.51	1.910	.061
Perceived burdensomeness	18	13.78	5.30	48	16.15	5.38	-1.598	0.115
Thwarted belongingness	18	12.17	2.83	48	10.85	2.84	1.672	0.099
ACCS	18	2.27	.25	48	2.24	.25	.454	.651

$P<0.05^{*}$ $p\leq0.001^{**}$

The independent sample test shows us that there is no significant difference between social support according to gender, ($p>0.05$). The mean for males is 18.50 and the mean for females is 17.22, while the standard deviation for males is 2.093 and the standard deviation for females is 2.511.

There is no significant different between interpersonal needs and gender, (p>0.05). The mean for males is 25.944 and the mean for males is 27.00. There is also no significant difference between capability for suicide and gender, (p>0.05).

Table 6.

Comparison of the total and sub-scales of social support, interpersonal needs, and the acquired suicide capability according to marital status

	Single			**Married**				
	N	**Mean**	**Std Dev**	**N**	**Mean**	**Std Dev**	**T**	**P**
Social Support	65	17.6462	2.4072	1	13.0000	0.000	1.910	.061
Perceived burdensomeness	65	15.43	5.44	1	20.00	0.000	-0.834	0.407
Thwarted belongness	65	11.25	2.89	1	9.00	0.000	0.772	0.443
ACCS	65	2.2484	.25289	1	2.1429	0.000	.454	.651

P<0.05* p≤0.001**

The results show that there is no significant difference between perceived burdensomeness and thwarted belongingness according to marital status. There is no significant relationship between capability for suicide according to marital status.

Table 7.

Comparison of the total score and sub-scales of social support, interpersonal needs, and the acquired suicide capability according to employment status

Variables	Employment Status	N	Mean	Std Dev	F	Df	P
Social Support	Student	29	19.6897	.96745	51.327	3	.000
	Employed	18	16.5000	.51450			
	Unemployed	19	15.3684	2.56495			
Perceived burdensomeness	Student	29	10.6897	.47082	79.808	3	0.000
	Employed	18	21.5000	4.63046			
	Unemployed	19	17.1579	3.07794			
Thwarted belongingness	Student	29	13.7241	1.25062	49.151	3	0.000
	Employed	18	9.0000	3.08697			
	Unemployed	19	9.4737	.51299			
ACCS	Student	29	2.2512	.26079	.235	3	.791
	Employed	18	2.2143	.24130			
	Unemployed	19	2.27.07	.25597			

P<0.05* p≤0.001**

The above ANOVA table shows multiple variables analyzed across one factor; the factor is employment. There is significant difference between social support according to employment status in this study, (p=0.000). There is also a significant difference between perceived burdensomeness, thwarted belongingness according to employment status, (p=0.000). There is no significant difference between the capability for suicide according to employment status, (p>0.05).

Post hoc analysis with Tukey shows that there are significant differences between all three groups on the subscales of perceived burdensomeness, (p=0.000). For thwarted belongingness, the significant difference is between students and both employed and unemployed people, (p=0.000).

Table 8.

Comparison of the total score and sub-scales of social support, interpersonal needs, and the acquired suicide capability according to living situation

Variables	Living Situation	N	Mean	Std Dev	F	Df	P
Social Support	Alone	9	16.0000	0.0000	76.677	3	.000
	With Parents / Guardians	28	18.7500	1.75594			
	With Relatives / Extended Family	10	13.0000	0.00000			

	With Friends	19	19.0000	0.00			
Perceived burdensomeness	Alone	9	17.00	0.00	13.016	3	0.000
	With Parents / Guardians	28	16.79	6.58			
	With Relatives / Extended Family	10	20.00	0.00			
	With Friends	19	10.53	0.51			
Thwarted belongingness	Alone	9	12.00	0.00	11.524	3	0.000
	With Parents / Guardians	28	10.14	3.35			
	With Relatives / Extended Family	10	9.00	0.00			
	With Friends	19	13.58	1.54			
ACCS	Alone	9	2.1587	.23084	.857	3	.468

With Parents / Guardians	28	2.2959	.24259
With Relatives / Extended Family	10	2.2571	.25017
With Friends	19	2.2468	.25127

P<0.05* p≤0.001**

The above ANOVA table shows multiple variables analyzed across one factor; the factor is living situation. There is significant difference between social support according to living situation in this study, (p=0.000). There is also significant difference in thwarted belongingness and perceived burdensomeness according to current living situation, (p=0.00). There is no significance between the capability for suicide according to living situation, (p>0.05).

Post hoc analysis with Tukey shows that there are significant differences in social support and its subscales. For social support, participants who live alone score lower, (p=0.00). There is a significant difference between people who live with relatives or extended family. Then participants living with parents and guardians follow in score.

On the scale of belongingness and its subscales participants who live with friends score lower, (p=0.00). Those who live with relatives then follow in score. They are followed by those that live with parents and guardians and lastly those who live alone. On the scale for burdensomeness, participants who live with friends score significantly lower than the other three subscales.

Table 9.

Comparison of the total score and the sub-scales of social support, interpersonal needs, and the acquired suicide capability according to residential area

Variables	Residential area	N	Mean	Std Dev	F	Df	P
Social Support	Manzini	33	18.6154	2.18092	17.545	3	0.000
	Matsapha	15	17.8571	1.06904			
	Mbabane	9	13.0000	0.00000			
	Ncabaneni	9	19.0000	0.00000			
Thwarted belongingness	Manzini	33	11.46	2.46	29.925	3	0.000
	Matsapha	15	14.13	2.07			
	Mbabane	9	13.00	0.00			
	Ncabaneni	9	9.00	0.00			
Perceived burdensomeness	Manzini	33	14.12	3.50	8.671	3	0.000
	Matsapha	15	18.53	8.26			
	Mbabane	9	20.00	0.00			

	Ncabaneni	9	11.00	0.00			
ACCS	Manzini	33	2.2527	.25524	.062	3	.979
	Matsapha	15	2.2245	.23119			
	Mbabane	9	2.2571	.30971			
	Ncabaneni	9	2.2381	.29623			

P<0.05* p≤0.001**

The above ANOVA table shows multiple variables analyzed across one factor; the factor is residential area. There is significant difference between social support and residential area in this study, (p=0.000). There is no significance between interpersonal needs and residential area, (p>0.05). There is also no significance between the capability for suicide and residential area.

Post hoc analysis with Tukey reveals that the participants from Manzini and Ncabaneni score significantly lower scores on perceived burdensomeness than those from Matsapha and Mbabane. On the scale of thwarted belongingness, the participants from Ncabaneni score significantly lower than all the other areas, followed by Manzini with scores significantly lower than Matsapha and Mbabane. The results also revealed that participants from Mbabane reported receiving significantly less social support than the other three areas.

Table 10.

Comparison of the total score and sub-scales of social support, interpersonal needs, and acquired suicide capability according to history of suicidal attempts

	Yes			No				
	N	**Mean**	**Std Dev**	**N**	**Mean**	**Std Dev**	**T**	**P**
Social Support	9	17.00	0.00	57	17.6667	2.63448	-.754	.453
Perceived burdensomeness	9	26.00	0.00	57	13.84	3.69	9.81	0.000
Thwarted belongingness	9	6.00	0.00	57	12.04	2.14	-8.414	0.000
ACCS	9	2.2698	.25198	57	2.2431	.25321	.295	.769

P<0.05* p≤0.001**

The independent sample t test shows that there is no significant difference between social support according to history of previous suicidal attempts, (p>0.05). The mean score for participants between social support and a history of suicidal attempt 17.00 and the mean score for those that do not have a history is 17.66. There is an observed significant difference between perceived burdensomeness and thwarted belongingness according to history of previous suicidal attempt, (p=0.000). The mean score is 32.00 for history of previous suicidal attempt and 25.87 for those with no suicidal attempt history with regards to interpersonal needs. There is no significant difference observed between the capability for suicide according to previous suicidal attempts.

Table 11.

Comparison of the total score and sub-scales of social support, interpersonal needs, and acquired suicide capability according to history of psychological diagnosis

	Yes			No				
	N	**Mean**	**Std Dev**	**N**	**Mean**	**Std Dev**	**T**	**P**
Social Support	9	17.0000	.00000	57	17.6667	2.63448	-.754	.453
Perceived burdensomeness	9	26.00	0.00	57	13.84	3.69	9.813	0.000
Thwarted belongingness	9	6.00	0.00	57	12.04	2.14	-8.414	0.000
ACCS	9	2.2698	.25198	57	2.2431	.25321	.295	.769

$P<0.05$* $p\leq0.001$**

The independent sample t test shows that there is no significant difference between social support according to history of psychological diagnosis, ($p>0.05$). The mean score for participants with a history of psychological diagnosis is 17.00 and the mean score for those that do not have a history is 17.66. There is an observed significant difference between perceived burdensomeness and thwarted belongingness according to history of previous psychological diagnosis, ($p=0.000$). The mean score is 32.00 for history of psychological diagnosis and 25.87 for those with no history of psychological diagnosis. However, there is no significant difference observed in the means for capability of suicide according to history of psychological diagnosis.

CHAPTER 5

DISCUSSION

This study examined the relationship between social support, interpersonal needs and capability for suicide attempts among young adults at Raleigh Fiktin Memorial Hospital, eSwatini. The findings of the study revealed that there is no significant relationship between social support and interpersonal needs and capability for suicide. The findings of this study contradict those of a study by Davidson et al. (2010) which found that each variable independently predicted suicidal thought. However, that study consisted in a mostly Caucasian sample whereas this study took place in an African population and consisted of a black population. According to Davidson et al. (2010), Joiner suggested that thwarted belongingness and perceived burdensomeness must be heightened for an individual to desire suicide, whereas more acquired capacity to enact suicide is required for an individual to physically carry out a suicide attempt. It is possible, then, that people with only high degrees of acquired capability do not have suicidal ideation because they do not want to die. According to Davidson et al. (2010) this association should be researched more in the future. Western studies have reported the maximum prevalence of parasuicides. Most patients among suicidal ideators, attempters and completers belonged to 26 to 35 years' age group followed by those in 16-25 year and 36–45-year age group (Bhatia, Aggarwal, and Aggarwal, 2010), However, this study was limited to the 18–25-year-old population which could have an impact on the findings of the study.

This suggests that there is a probability that a study with a larger sample and unrestricted age group may yield different results.

The findings also showed that there is a negative correlation between social support and perceived burdensomeness and thwarted belongingness. Other research that looked at the co-occurrence of perceived burdensomeness and thwarted belongingness as mediators of a given predictor and suicide ideation found that perceived burdensomeness, but not thwarted belongingness, was a significant mediator. Van Orden and colleagues (2008) discovered that thwarted belongingness did not predict suicidal symptoms until paired with perceived burdensomeness. Future research should investigate why this is the case. The effect of a lack of social support or connectivity on suicide ideation reveals that these variables may be a proximal risk factor for suicide and have their effect on suicide ideation through perceived burdensomeness (Holligsworth et al., 2018).

The findings further show that there is no significant difference between interpersonal needs according to gender; they further show that there is also no significant difference between capability for suicide according to gender. According to these results, this implies that gender is a weak predictor of suicidal behaviour at RFM, eSwatini. These findings agree with the CDC (2009), and Mosciki (1994) who state that the insignificant difference between gender and the identified variables implies that gender may not be a strong predictor for suicide intent. Regarding broader gender trends, research results consistently show that women are more likely than men to attempt suicide, but men are more likely than women to commit suicide entirely. In all age groups, the suicide rate of men is higher than that of women. On average, men choose more lethal ways like weapons, whilst women prefer less lethal techniques like poisoning, jumping, drug overdose, and suffocation (CDC, 2010). Freedenthal et al. (2011) discovered an unanticipated inconsistency between men and women in their findings.

The findings of this study further revealed that there is significant difference between social support according to marital status with regards to suicidal behaviour. This could also be attributed to the fact that there was only one married individual who participated in the study. It also revealed that there is no significant difference between perceived burdensomeness and thwarted belongingness according to marital status. There was also no significant relationship between capability for suicide according to marital status. This too could also be attributed to the fact that there was only one married individual who participated in the study. Despite the before-mentioned statements, there is the assumption that being engaged in interpersonal relationships is a buffer for suicide risk. Suicide risk is affected by the presence and quality of social bonds.

In adulthood, one's partner is the most prevalent source of these relationships. As a result, there is a well-established link between marital status and suicide risk, with married people having a decreased risk (Øien-Ødegaard, Hauge & Reneflot, 2021). According to Øien-Ødegaard, Hauge & Reneflot (2021) married men and women have a lower suicide risk than unmarried men and women. Divorced and separated people, regardless of gender, have much higher suicide risk than unmarried people. The fact that divorced and separated people are more likely to commit suicide suggests that suicide is linked to reduced social connections. According to Øien-Ødegaard, Hauge & Reneflot (2021), two studies investigating marital status and education level pointed out that marital status is a more important suicide risk factor than education inequality. Kravdal et al. found that non-married people have a higher mortality risk than married people, and that educational changes only account for around 5% of the difference. Lorant et al. analyzed data from eight European nations and found that being married protects against socioeconomic inequalities in suicide. Therefore, according to these findings, being married is linked to a lower risk of suicide, even when educational achievement is taken into consideration.

The findings of the study also revealed that there is significant difference between social support according to employment status within the sample. There was also a significant difference between perceived burdensomeness and thwarted belongingness according to employment status. This expresses that employment status has an effect in suicidal behaviour in relation to social support and interpersonal needs. Van Orden, et al. (2011) found no association in several studies examining the relationship between unemployment and suicide rates at the population level but tended to find associations in studies examining smaller and more homogeneous populations. This study meets that same criterion because it was homogeneous.

The results of the study revealed that there are significant differences between participants who are students, employed and unemployed on the sub-scales of perceived burdensomeness. For thwarted belongingness, the significant difference is between students and both employed and unemployed people. Young adults must transition from school to work ambition, from parental guidance to personal responsibility, from living with their parents to establishing their own family, from the child health care system to the adult health care system (Walker-Harding et al., 2017). The context of the greater world, which is continually changing also influences these challenges and milestones.

More recent evidence suggests that lack of social interaction and participation in religious activities which promote a sense of belonging increases the overall risk of suicide and the effects of mood disorders and occupational status (Duberstein et al., 2004). It is also clear that not only the quantity but also the quality of social connection is crucial to young adult suicide. Trout's (1980) definition of social isolation incorporates both the physical and emotional aspects of social isolation. In individuals with extremely dependent needs such as chronic illnesses, homelessness, unemployment and so forth the perception of being a burden on self or others in the present or future was viewed as a trigger that preceded expression of desire for hastened death (Marty, 2012).

The findings of the study revealed that there is significant difference between social support according to living situation across the study's sample. It was also revealed that there is significant difference between thwarted belongingness and perceived burdensomeness according to current living situation. However, it was revealed that there is no significance between the capability for suicide according to living situation. For social support, participants who live alone scored lower. There is a significant difference between people who live with relatives or extended family. Then participants living with parents and guardians followed in score. On the scale of belongingness and its subscales participants who live with friends scored lower. Those who live with relatives then followed in score. They are followed by those that live with parents and guardians and lastly those who live alone. On the scale for burdensomeness, participants who live with friends score significantly lower than the other three subscales.

According to Frey and Cerel (2015), many studies on family and suicide have focused on the composition of families living with individuals. The studies have shown that living alone increases a person's risk of suicide. Human beings have the need to belong. Frey and Cerel (2015), found that people who die from suicide or suspected self-harm are more likely to live alone than people who die from unnatural causes that have nothing to do with self-harm. Social isolation was arguably the strongest and most dependable predictor of deadly suicidal thoughts, suicide, and suicidal activity among populations of diverse ages, nationalities, and clinical severity (Van Orden et al., 2011). Loneliness, social isolation, living alone and lacking social support, living in an incomplete family, losing a spouse due to death or divorce, and being incarcerated are all linked to lethal suicide conduct, according to empirical studies. Marriage, children, more friends and relatives, on the other hand, are linked to a lower likelihood of fatal suicide conduct (Van Orden et al., 2011).

The findings of this study further revealed that there is significant difference between social support according to residential area within the sample. This implies residential area may have an impact to the degree of social support received with regards to suicidal behaviour. Participants from Manzini and Ncabaneni scored significantly lower scores on perceived burdensomeness than those from Matsapha and Mbabane. This implies that participants from these regions had low levels of burdensomeness.

On the scale of thwarted belongingness, the participants from Ncabaneni scored significantly lower than all the other areas, followed by Manzini with scores significantly lower than Matsapha and Mbabane. Participants from Ncabaneni experience significantly less thwarted belongingness because this is a rural community and maintains a communal way of life as opposed to individualistic life in urban areas. This communal setting may also account for the low perceived burdensomeness scores of these participants (Giuseppe et al., 2007).

The results also revealed that participants from Mbabane reported receiving significantly less social support than the other three areas. Mbabane is the capital city of eSwatini. The results could be the result of urbanization in the city. Urbanization is associated with the disintegration of the family as a unit. Historically Africans maintain close relations with the extended family which serves as an extended line of social support. However, in urban areas this support is lost since the extended families would no longer reside near each other (Giuseppe et al., 2007). Manzini is the commercial center and the second largest city in eSwatini. The results from the Manzini participants show that there are ways of mediating the effects of urbanization on the integration of the family and society so young adults can feel that they belong and are not a burden.

In the past 20 years, eSwatini has experienced a great deal of immigration, and the city and suburbs of greater Manzini, including Matsapha which is an industrial zone and now has a population of close to 100,000 (Tevera et al., 2012). This may be the reason it lacks support for young adults.

Rapid urbanization in Matsapha has resulted in the establishment of many unplanned settlements with low-quality housing, inadequate sanitation, unpleasant living conditions, high levels of poverty, and a lack of work prospects due to rural-urban migration and natural population expansion (Tevera et al., 2012). This may result to young adults feeling displaced as there is a lack of activity focused on their welfare.

According to O'Reilly et al. (2008) suicide rates vary widely in different regions, but it is unclear whether this is due to differences in population composition or background factors at the regional level. Previous literature has shown that the incidence of social problems, mental disorders and suicidal behavior is higher in city centers, and the suicide rate is higher in poor or socially dispersed areas. O'Reilly and colleagues (2008) further state that over time, the suicide rates increase more in areas with the highest levels of poverty or social division. It should be noted that eSwatini's health-care system that is already overburdened with chronic personnel shortages, restricted national budget allocations, medicine shortages, congestion in health-care institutions, and insufficient high-care facilities and equipment (Shongwe and Huang, 2021).

The findings of the study revealed that there is a significant difference between perceived burdensomeness and thwarted belongingness according to history of previous suicidal attempt. One of the strongest predictors of death by suicide is the history of suicide attempts in the past (Van Orden et al., 2010). Lakeman and Fitzgerald (2014) conducted a systematic assessment existing literature to see how individuals dealt with suicidal ideation, particularly in terms of recovering a desire to live. They discovered that participants struggled with suicidal ideation and frequently mentioned feelings of isolation and misery. A more recent study emphasized the delicate balance individuals had to strike between the excruciating pain of ongoing suicidal ideation and the optimism for the future after surviving a suicide attempt (Berglund et al., 2016).

In a similar study, just 10 of the 50 patients reported feeling happy or relieved soon after surviving a suicide attempt. The most common negative emotions expressed were sadness, depression, disappointment, emptiness, anger, embarrassment, and shame. While many participants' negative emotions had changed to feelings of happiness, gratitude, and hope by the time they participated in the study, over 30% of individuals still had unfavorable thoughts about their survival (Maple et al., 2019).

The findings of the study also revealed that there is no significant difference observed between the capability for suicide according to history of previous suicidal attempts. This may reflect the effectiveness of the intervention program offered at RFM. Furthermore, following a suicide attempt some suicide attempters may experience relief or happiness for surviving the attempt which may account for the moderate score on capacity for suicide. In a study by Maple et al. (2019) only about 30% of the suicide attempters had negative feelings about surviving (Shamsaei et al., 2020).

The findings of this study further revealed that there is a significant difference between perceived burdensomeness and thwarted belongingness according to history of psychological diagnosis. Mood disorders are a long-standing and dangerous illness. It was originally recognized and reported by ancient Greek physicians more than 2000 years ago, according to an ancient finding (Hippocrates, 460-377 BC).

Suicide is a common sign of mental illness that has a high death rate all around the world. Hippocrates discovered a sign of 'melancholia', now known as 'depression,' and linked the ailment to human 'brain malfunction' during his time. Despite the passage of time, these statements have remained unchallenged. This observation will continue to be the focus of future scientific and medical research according to Lu et al. (2020). From ancient times to the present, scientists have been trying to figure out if there is a link between suicide and mental illness. Despite a lengthy history of suicide and mental disease study, diagnoses are particularly restricted; the present focus of research is on suicide attempts and suicide repeaters (Lu et al., 2020).

Lastly, the findings of the study revealed that there is no significant difference between capability for suicide according to history of psychological diagnosis. This could be attributed to the lack of a robust mental health care culture in eSwatini. Usually, individuals seek mental health care assistance only once having been prescribed by a physician.

CHAPTER 6

CONCLUSION & RECOMMENDATIONS

This chapter summarizes and restates the main points of the study and its findings. It also includes the recommendations and suggestions for further research.

6.1 Conclusion

To conclude, this study investigated the contributory risk factors of suicide attempts among young adults at Raleigh Fiktin Memorial Hospital, eSwatini. The findings of the study revealed that there is no significance by age and interpersonal needs, social support or acquired capability for suicide. There is also no correlation between acquired capability for suicide and social support, perceived burdensomeness, and thwarted belongingness. The findings also revealed that there is a negative correlation between social support and perceived burdensomeness and thwarted belongingness.

They further revealed that there is also no significant difference between capability for suicide according to gender. The findings of the study also revealed that there was significant difference between social support according employment status within the sample. There was also a significant difference between perceived burdensomeness and thwarted belongingness according to employment status. Employment is generally considered a risk factor for suicidal ideation and behavior.

The findings of the study revealed that there was significant difference between social support according to living situation across the study's sample. It was also revealed that there was significant difference in thwarted belongingness and perceived burdensomeness to current living situation. Previous literature has shown that living alone increases a person's risk of suicide. Interpersonal relationships are often linked to a lower likelihood of fatal suicide conduct.

The findings of this study further revealed that there was significant difference between social support according to residential area among the sample. The results could be the result of urbanization in the city. Urbanization is associated with the disintegration of the family as a unit therefore, resulting in loss of connection.

The findings of the study revealed that there is no significant difference between capability for suicide according to history of psychological diagnosis. This could be attributed to the lack of a robust mental health care culture in eSwatini. Usually, individuals seek mental health care assistance only once having been prescribed by a physician. The findings of the study also revealed that there is no significant difference observed between the capability for suicide according to history of previous suicidal attempts.

6.2 Recommendations

Future research could start off by applying the study in the whole of eSwatini in order to get a larger representative sample. The effect of belonging and perceived burden on suicidal behaviour could be applied to an older age group to identify the significance of age with regards to the trend in suicidal behaviour. Researchers are recommended to explore beyond social factors in order gain more insight regarding the phenomenon. This will also create the development of adequate preventive measures. Future studies are recommended to be longitudinal in order to get more accurate data pertaining this phenomenon. The findings from this study could be used to improve literature on eSwatini with regards to mental health.

6.2.1 Recommendations for Further Research

This study used psycho-social concepts to define and research on suicide. In this field, precision and outliers need to be investigated on a regular basis in order to avoid ambiguity about the social risk factors to suicide. Though research is always evolving, precision will prevent researchers from investigating concepts that have been thoroughly exhausted.

REFERENCES

Abrams, D., & Hogg, M. A. (1988). Comments on the motivational status of self-esteem in social identity and intergroup discrimination. *European journal of social psychology, 18(4)*, 317-334.

Allen, K. (2019). Making sense of belonging. *Inpsych 2019, 41*(3). Retrieved from https://www.psychology.org.au/

Almansour, A. M., & Siziya, S. (2017). Suicidal ideation and associated factors among school going adoloscents in Swaziland. *Afri Health Sci, 17(4)*, 1172-1117. doi:10.4314/ahs17i4.26

American Psychiatric Association (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American journal of psychiatry, 160(11*), 1-60.

Amitai, M., & Apter, A. (2012). Social aspects of suicidal behavior and prevention in early life: a review. *International journal of environmental research and public health, 9(3)*, 985-994.

Arria, A. M., O'Grady, K. E., Caldeira, K. M., Vincent, K. B., Wilcox, H. C., & Wish, E. D. (2009). Suicide ideation among college students: A multivariate analysis. *Archives of suicide research, 13(3)*, 230-246.

Barzrafshan, M., Sharif, F., Molazem, Z., & Mani, A. (2016). Exploring the risk factors contributing to suicide attempt among adoloscents: A qualitative study. *Iranian Journal of Nursing and Midwifery Research, 21(1)*, 93-99.

Beck, A. T., & Rush, A. J. (1978). *Cognitive approaches to depression and suicide*.

Bhatia, M. S., Aggarwal, N. K., & Aggarwal, B. B. L. (2000). Psychosocial profile of suicide ideators, attempters and completers in India. *International journal of social psychiatry*, *46*(3), 155-163.

Bilsen, J. (2018). Suicide and Youth Risk Factors. *Front Psychiatry, 9,* 540. doi:10.33389/fpst.2018.00540

Buunk, B. P., Van der Zee, K., & VanYperen, N. W. (2001). Neuroticism and social comparison orientation as moderators of affective responses to social comparison at work. *Journal of personality, 69(5*), 745-762.

Cromartie, J., & Bucholtz, S. (2008). *Defining the "rural" in rural America* (No. 1490-2016- 127511, pp. 28-35).

Crosby, A. E., Ortega, L., & Melanson, C. (2011). Self-directed violence surveillance: Uniform definitions and recommended data elements, Version 1.0. Atlanta (GA): *Centers for Disease Control and Prevention, National Center for Injury Prevention and Contro*l. Retrieved from https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pd

Crowe, S., Cresswell, K., Robertson. (2011). The case study approach. *BMC Med Res Methodol 11*, 100. doi: 10.1186/1471-2288-11-100

Davidson, C. L., Wingate, L. R., Slish, M. L., & Rasmussen, K. A. (2010). The great black hope: Hope and its relation to suicide risk among African Americans. *Suicide and Life-Threatening Behavior*, *40*(2), 170-180.

Diekema, D. S. (2006). Conducting ethical research in pediatrics: a brief historical overview and review of pediatric regulations. *The Journal of pediatrics, 149(1)*, S3-S11.

Dori, G. A., & Overholser, J. C. (1999). Depression, hopelessness, and self-esteem: *Accounting for suicidality in adolescent psychiatric inpatients. Suicide and Life-Threatening Behavior, 29(4)*, 309-318.

Durkheim, E. (1897). *Suicide: Alcan Sociology Study*. Paris, France.

Durkheim, E. (2005). *Suicide: A study in sociology*. Routledge.

Eisenberger, N. I., Lieberman, M. D., & Williams, K. D. (2003). Does rejection hurt? *An fMRI study of social exclusion. Science, 302(5643*), 290-292.

ESwatini Nazarene Health Institution (ENHI). (2019). *Highest population coverage (> 40%) in eSwatini.* Retrieved from https://enhicare.com/pages/about.php

Festinger, L. (1954). A theory of social comparison processes. *Human relations, 7(2),* 117-140.

Flamenbaum, R. (2009). Testing Shneidman's theory of suicide: Psychache as a prospective predictor of suicidality and comparison with hopelessness *(Doctoral dissertation)* Queen's University.

Giuseppe, Gabrielli & Maffioli, Dionisia & Sacco, Piero. (2007). The Impact of Urbanization on The Traditional Family Systems in Sub-Saharan Africa

Goldman-Mellor, S. J., Caspi, A., Harrington, H., Hogan, S., Nada-Raja, S., Poulton, R., & Moffitt, T. E. (2014). Suicide attempt in young people: a signal for long-term health care and social needs. *JAMA psychiatry, 71(2),* 119-127.

Gonzalez, A. (2014). Interpersonal Needs and Suicide: Strengthening Measurement in an Offender Population. *Dissertations. 288*. Retrieved from https://aquila.usm.edu/dissertations/288

M. Gutierrez, Paul J. Rodriguez, Patricia Garcia, P. (2001). Suicide risk factors for young adults: Testing a model across ethnicities. *Death Studies, 25(4),* 319-340.

Gutman, S. A. (2005). Understanding suicide: What therapists should know. *Occupational Therapy in Mental Health, 21(2)*, 55-77.

Hagerty, B. M., Lynch-Sauer, J., Patusky, K. L., Bouwsema, M., & Collier, P. (1992). Sense of belonging: A vital mental health concept. *Archives of Psychiatric Nursing, 6(3)*, 172–177. doi:10.1016/0883-9417(92)90028-H

Hatcher, S., & Stubbersfield, O. (2013). Sense of belonging and suicide: a systematic review. *The Canadian Journal of Psychiatry, 58(7)*, 432-436.

Hollingsworth, D. W., Slish, M. L., Wingate, L. R., Davidson, C. L., Rasmussen, K. A.,O'Keefe, V. M., & Grant, D. M. (2018). The indirect effect of perceived burdensomeness on the relationship between indices of social support and suicide ideation in college students. *Journal of American college health*, *66*(1), 9-16.

Hooven, C., Snedker, K. A., & Thompson, E. A. (2012). Suicide risk at young adulthood: Continuities and discontinuities from adolescence. *Youth & Society, 44(4),* 524-547.

Joiner Jr, T. E., & Van Orden, K. A. (2008). The interpersonal–psychological theory of suicidal behavior indicates specific and crucial psychotherapeutic targets. International Journal of Cognitive *Therapy, 1(1),* 80-89.

Joiner, T. (2009). *The interpersonal-psychological theory of suicidal behavior: Current empirical status*. Psychological Science Agenda. Retrieved from http://www.apa.org/science/about/psa/2009/06/sci-brief

Joiner, T. E. (2005). *Why people die by suicide:* Harvard University press. Cambridge, MA, 10.

Joiner, T. E., Pettit, J. W., Walker, R. L., Voelz, Z. R., Cruz, J., Rudd, M. D., & Lester, D. (2002). Perceived burdensomeness and suicidality: Two studies on the suicide notes of those attempting and those completing suicide. *Journal of Social and Clinical Psychology, 21(5),* 531-545.

Jordan, J. R., & McIntosh, J. L. (2011). *Suicide bereavement: Why study survivors of suicide loss. Grief after suicide:* Understanding the consequences and caring for the survivors

Kapila, S., & Lyon, F. (2006). *Expedition Field Techniques: People Oriented Research. Geography Outdoors:* The Centre Supporting Field Research, Exploration and Outdoor Learning, (ISBN 978-0-907649-67-0).

King, K. A., Strunk, C. M., & Sorter, M. T. (2011). Preliminary effectiveness of surviving the Teens Suicide Prevention and Depression Awareness Program on adolescents' suicidality and self-efficacy in performing help-seeking behaviors. *Journal of school health, 81(9)*, 581-590.

Kleiman, E. M., & Riskind, J. H. (2013). *Utilized social support and self-esteem mediate the relationship between perceived social support and suicide ideation.* Crisis.

Klonsky, E. D., May, A. M., & Saffer, B. Y. (2016). Suicide, Suicide Attempts, and Suicidal Ideation. *The Annual Review of Clinical Psychology, 12,* 307-330. doi: 10.1146/annurev.clinpsy-0218015-093204

Leenaars, A. A. (2004). *Psychotherapy with suicidal people: A person-centred approach*. John Wiley & Sons.

Leenars,A. (2010). *Edwin S. Shneidman on Suicide.* Retrieved from http://www.suicidology-online.com/pdf/SOL-2010-1-5-18.pdf

Lu, D. Y., Wu, H. Y., Cao, S., & Che, J. Y. (2020). Historical analysis of suicide. *Journal of Translational Genetics and Genomics, 4(3)*, 203-209.

MacMillan, D. W., & Chavis, D. M. (1986). Sense of community: Prospects for a community psychology. *J Community Psychol, 14,* 6-23.

Mann, J. J. (2003). Neurobiology of suicidal behaviour. *Nature Reviews Neuroscience, 4(10)*, 819-828.

Marcus, M. A., Westra, H. A., Eastwood, J. D., Barnes, K. L., & Mobilizing Minds Research Group. (2012). What are young adults saying about mental health? An analysis of Internet blogs. *Journal of medical Internet research, 14(1),* e17.

Marty, M. A. (2012). *Older adults and the desire for suicide: The role of perceived burdensomeness and thwarted belongingness*. University of Colorado at Colorado Springs.

McIntosh, W. L., Spies, E., Stone, D. M., Lokey, C. N., Trudeau, A. R. T., & Bartholow, B. (2016). Suicide rates by occupational group—17 states, 2012. *Morbidity and mortality weekly report, 65(25*), 641-645.

Miao, H., Li, Z., Yang, Y., & Guo, C. (2018). Social Comparison Orientation and Social Adaptation Among Young Chinese Adolescents: The Mediating Role of Academic Self-Concept. *Frontiers in psychology, 9,* 1067.

Milner, A., Page, A., Morrell, S., Hobbs, C., Carter, G., & Dudley, M. et al. (2015*). Social connections and suicidal behaviour in young Australian adults: Evidence from a case–control study of persons aged 18–34 years in NSW, Australia*. Retrieved from https://www.sciencedirect.com/science/article/pii/S2352827315000026?via%3Dihub

Mitchell, P. H., Powell, L., Blumenthal, J., Norten, J., Ironson, G., Pitula, C. R.., Berkman, L. F. (2003). A short social support measure for patients recovering from myocardial infarction: the ENRICHD Social Support Inventory. *Journal of Cardiopulmonary Rehabilitation and Prevention, 23(6)*, 398-403.

Morales-Vives, F., Dueñas, J. M., Vigil-Colet, A., & Camarero-Figuerola, M. (2020). Psychological variables related to adaptation to the COVID-19 lockdown in Spain. *Frontiers in Psychology, 11,* 2438.

Mościcki, E. K. (1994). Gender differences in completed and attempted suicides. *Annals of epidemiology, 4(2),* 152-158.

Nock, M. K. (Ed.). (2014). *The Oxford handbook of suicide and self-injury.* Oxford University Press.

Nock, M., Borges, G., Bromet, E., Cha, C., Kessler, R., & Lee, S. (2008). Suicide and Suicidal Behavior. *Epidemiologic Reviews, 30(1),* 133-154. doi: 10.1093/epirev/mxn002

O'Connor, R. C. (2011). Towards an integrated motivational–volitional model of suicidal behaviour. *International handbook of suicide prevention: Research, policy and practice, 1,* 181-98.

Øien-Ødegaard, C., Hauge, L., & Reneflot, A. (2021). Marital status, educational attainment, and suicide risk: a Norwegian register-based population study. *Population Health Metrics*, *19*(1). doi: 10.1186/s12963-021-00263-2

Pengpid, S., & Peltzer, K. (2020). The Prevalence and Correlates of Suicidal Ideation, Plans and Suicide Attempts among 15- to 69-Year-Old Persons in eSwatini. *Behavioral Sciences, 10(11),* 172. doi: 10.3390/bs10110172

Pigoga, J. L., Joiner, A. P., Chowa, P., Luong, J., Mhlanga, M., Reynolds, T. A., & Wallis, L. A. (2020). Evaluating capacity at three government referral hospital emergency units in the kingdom of eSwatini using the WHO Hospital Emergency Unit Assessment Tool. *BMC emergency medicine, 20,* 1-7.

Reddy, L. S., & Ramasamy, D. (2016). *Justifying the judgmental sampling matrix organization in outsourcing industry*. Vidushi.

Ribeiro, J., & Joiner, T. (2009). The interpersonal-psychological theory of suicidal behavior:current status and future directions. *Journal Of Clinical Psychology, 65(12),* 1291- 1299. doi: 10.1002/jclp.20621

Ribeiro, J., Witte, T., Van Orden, K., Selby, E., Gordon, K., Bender, T., & Joiner, T. (2014). Fearlessness about death: The psychometric properties and construct validity of the revision to the Acquired Capability for Suicide Scale. *Psychological Assessment, 26(1),* 115-126. doi: 10.1037/a0034858

Rodziński, P., Rutkowski, K., & Ostachowska, A. (2017). Progression of suicidal ideation to suicidal behavior from a perspective of selected suicidological models. *Psychiatria Polska, 51(3),* 515-530. doi: 10.12740/pp/63984

Rogers, C. (1951). *A Theory of Therapy, personality and interpersonal relationships as developed in the Client-centered framework*. In (eds.) S. Koch, Psychology: A Study of a Science. Vol. 3. New York: McGraw Hill.

Rose, S. (2015). Applying Durkheim's theory of suicide: A study of altruism and anomie among Canadian veterans of Afghanistan (*Doctoral dissertation).* Queen's University.

Roubal, E. (2018). *UNEMPLOYMENT AND SUICIDE IN THE FRAMEWORK OF THE INTERPERSONAL THEORY OF SUICIDE*. Retrieved from https://core.ac.uk/display/236470445

Rumbidzai, C. (2015). Discussion on high suicide rate in Swaziland [*Blog pos*t]. Retrieved from https://rumbidzaic.blogspot.com/2015/08/discussion-on-high-suicide-rate-in.html

Schwarzer, R., & Leppin, A. (1991). Social support and health: A theoretical and empirical overview. *Journal of social and personal relationships, 8(1)*, 99-127.

Schwarzer, R., Knoll, N., & Rieckmann, N. (2004). Social support. *Health psychology,* 158, 181.

Shahnazarian, D., Hagemann, J., Aburto, M., & Rose, S. (2017). *Informed Consent in Human Subjects Research. University of Southern California.* Office for the Protection of Research Subjects, California.

Shamsaei, F., Yaghmaei, S., & Haghighi, M. (2020). Exploring the lived experiences of the suicide attempt survivors: a phenomenological approach. *International journal of qualitative studies on health and well-being, 15*(1), 1745478.

Shneidman, E. S. (1987). *A psychological approach to suicide.* In American Psychological Association Convention, Aug 1986, Washington, DC, US; This chapter is based upon one of the 1986 Master Lectures that were presented at the convention. American Psychological Association.

Shongwe, M., & Huang, S. (2021). Suicidal Ideation and Predictors of Psychological Distress during the COVID-19 Pandemic in eSwatini: A Population-Based Household Telephone Survey. *International Journal of Environmental Research and Public Health*, *18*(13), 6700. doi: 10.3390/ijerph18136700

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social psychology quarterly*, 224-237.

Sukamolson, S. (2007). *Fundamentals of quantitative research*. Language Institute Chulalongkorn University, 1, 2-3.

Sukati, N. A. (1996). Primary health care in Swaziland: an exploration of women's opinions (*Doctoral dissertation).* University of California, San Francisco.

Tanvir, S., Habib, S., Bhatti, K. (2013). Self-Concept And Suicidal Ideation Among Patients with Mood Disorder. *International Journal Of Liberal Arts And Social Science, 1(4)*, 357.

Tevera, D., Simelane, N., Graciana, P., & Abul, S. (2012). Retrieved from https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1014&context=afsun

Thompson, B., Diamond, K. E., McWilliam, R., Snyder, P., & Snyder, S. W. (2005). Evaluating the quality of evidence from correlational research for evidence-based practice. *Exceptional Children, 71(2),* 181-194.

Trepte, S., & Loy, L. S. (2017). Social identity theory and self-categorization theory. *The international encyclopedia of media effects,* 1-13.

Trout, D. L. (1980). The role of social isolation in suicide. *Suicide and Life-Threatening Behavior, 10(1*), 10-23.

Ursano, R. J., Kessler, R. C., Naifeh, J. A., Mash, H. B. H., Nock, M. K., Aliaga, P. A., Stein, M. B. (2018). Risk factors associated with attempted suicide among US Army soldiers without a history of mental health diagnosis. *JAMA psychiatry*, *75*(10), 1022-1032.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological assessment, 24(1)*, 197.

Van Orden, K. A., Witte, T. K., Gordon, K. H., Bender, T. W., & Joiner Jr, T. E. (2008). Suicidal desire and the capability for suicide: Tests of the interpersonal-psychological theory of suicidal behavior among adults. *Journal of consulting and clinical psychology, 76(1)*, 72.

Van Orden, K., Witte, T., Cukrowicz, K., Braithwaite, S., Selby, E., & Joiner, T. (2010). The interpersonal theory of suicide. *Psychological Review, 117(2)*, 575-600. doi: 10.1037/a0018697

Verrocchio, M., Carrozzino, D., Marchetti, D., Andreasson, K., Fulcheri, M., & Bech, P. (2016). Mental Pain and Suicide: A Systematic Review of the Literature. *Frontiers In Psychiatry, 7*. doi: 10.3389/fpsyt.2016.00108

Walker-Harding, L., Christie, D., Joffe, A., Lau, J., & Neinstein, L. (2017). Young Adult Health and Well-Being: A Position Statement of the Society for Adolescent Health and Medicine. *Journal Of Adolescent Health, 60(6)*, 758-759. doi: 10.1016/j.jadohealth.2017.03.021

Wilcox, H. C., Arria, A. M., Caldeira, K. M., Vincent, K. B., Pinchevsky, G. M., & O'Grady, K. E. (2010). Prevalence and predictors of persistent suicide ideation, plans, and attempts during college. *Journal of affective disorders, 127(1-3)*, 287-294.

Williams, P., Barclay, L., & Schmied, V. (2004). Defining social support in context: a necessary step in improving research, intervention, and practice. *Qualitative health research, 14(7)*, 942-960.

Witte, T. K., Gordon, K. H., Smith, P. N., & Van Orden, K. A. (2012). Stoicism and sensation seeking: Male vulnerabilities for the acquired capability for suicide. *Journal of research in personality, 46(4)*, 384-392.

World Health Organization. (2011). *Mental health atlas-2011 country profiles*. Department of Mental Health and Substance Abuse, WHO.

World Health Organization. (2012). Public health action for the prevention of suicide: a framework.

World Health Organization. (2014). *Preventing suicide: A global imperative.* World Health Organization.

Yakunina, E. S., Rogers, J. R., Waehler, C. A., & Werth, J. L., Jr. (2010). College students' intentions to seek help for suicidal ideation: Accounting for the help-negation effect. *Suicide and Life-Threatening Behavior, 40,* 438–450.

You, S., Van Orden, K., & Conner, K. (2011). Social connections and suicidal thoughts and behavior. *Psychology Of Addictive Behaviors, 25(1)*, 180-184. doi: 10.1037/a0020936

APPENDIX 1

ENRICHD Social Support Instrument

SOCIAL SUPPORT For each question, CIRCLE the number that BEST describes your current situation.						
	QUESTION	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
1.	Is there someone available to you whom you can count on to listen to you when you need to talk?	**1**	**2**	**3**	**4**	**5**
2.	Is there someone available to give you good advice about a problem?	**1**	**2**	**3**	**4**	**5**
3.	Is there someone available to you who show you love and affection?	**1**	**2**	**3**	**4**	**5**

APPENDIX 2

Interpersonal Needs Questionnaire

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

		Not at all true for me			Somewhat true for me			Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7

APPENDIX 3

Acquired Capability for Suicide Scale-Fearlessness about Death

ACSS-FAD

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

		0 Not at all like me	1	2	3	4 Very much like me
1	The fact that I am going to die does not affect me.	0	1	2	3	4
2	The pain involved in dying frightens me.	0	1	2	3	4
3	I am very much afraid to die.	0	1	2	3	4

APPENDIX 4

RE: ENRICHD Social Support Instrument Permission

PM **Pamela H. Mitchell <pmitch@uw.edu>**
02:29

To: Nokufika Mkhatshwa

Dear Nokufika Mkhatshwa:

Thank you for your inquiry about using the ESSI social support instrument. This instrument was developed on an NIH grant and is therefore in the public domain. This means you do not have to obtain any further permission to use it. It is published in the American Journal of Cardiology, 2001;88:316-332 and in Mitchell PH, Powell L, Blumenthal J, Norten J, Ironson G, Pitula CR, Froelicher ES, Czajkowski S, Youngblood M, Huber M, Berkman LF. A short social support measure for patients recovering from myocardial infarction: the ENRICHD Social Support Inventory.J Cardiopulm Rehabil. 2003 Nov-Dec;23(6):398-403. There is no fee or further permission needed to use the instrument, but, please credit ENRICHD Investigators accordingly in any work, reports, manuscripts, scientific meetings where the ESSI is involved/used.

The instrument is an appendix to both these publications and the scoring is embedded in the paper. WORD indicates it is at the Fleish-Kincaid 8th grade reading level. It can be administered verbally (with explanation) to participants if that reading level is a problem.

Sincerely,

Pamela H. Mitchell, PhD, FAHA, FAAN
Professor Emeritus, Biobehavioral Nursing and Health Informatics
Box 357266, University of Washington, Seattle WA 98195

From: Nokufika Mkhatshwa <mkhatshwa.fika@gmail.com>
Sent: Wednesday, February 10, 2021 3:25 PM

APPENDIX 5

Re: ACSS-FAD & INQ-15 Permission

TJ

Thomas Joiner <joiner@psy.fsu.edu>
01:14

To: Nokufika Mkhatshwa

yes that would be fine, good luck with the work. Best, Thomas.

On 2/10/2021 6:12 PM, Nokufika Mkhatshwa wrote:
>
> Good day Dr Joiner,
>
> My name is Nokufika Mkhatshwa; I am a 25 year old female native of the
> Kingdom of Eswatini (previously Swaziland) and currently pursuing a
> Master of Arts in General Psychology at Near East University (located
> in North Cyprus).
>
> I am currently conducting research on the typical risk factors that
> lead to suicide attempts among young adults at the age of 18-25: A
> case study of Raleigh Fiktin Memorial Hospital, Eswatini. My research
> aims to draw from studies of Joiner, Shneidman as well as Durkheim
> which emphasise the role of social connection with relation to suicide
> attempts among young adults; it aims to extend the findings within the
> context of the Kingdom of Eswatini at Raleigh Fiktin Memorial Hospital.
>
> I would like to use the ACSS-FAD & INQ-15 as measures within the
> study. Please give me permission to use these measures.
>
> Your cooperation would be highly appreciated.
>
> Regards,

APPENDIX 6

Bibliography

Nokufika Mpumelelo Mkhatshwa was born on the 28th of May 1995, in the Kingdom of eSwatini. She pursued her Bachelor of Arts degree, majoring in Psychology and Political Science at Pearson Institute of Higher Education (PIHE), South Africa. She commenced her Master's degree at Near East University in February 2019, in the department of General Psychology. She is zealous for community development and children's welfare. She has volunteered in the Ministry of Public Service, eSwatini. She has also interned in two hospitals in eSwatini; both hospitals are centered around offering community comprehensive health care.

APPENDIX 7

Ethics Committee Approval

24.03.2021

Dear Nokufika Mpumelelo Mkhatshwa

Your application titled **"Investigating typical risk factors that lead to suicide attempts among young adults at the age of 18-25: A case study of Raleigh Fiktin Memorial Hospital, eSwatini"** with the application number YDÜ/SB/2021/952 has been evaluated by the Scientific Research Ethics Committee and granted approval. You can start your research on the condition that you will abide by the information provided in your application form.

Assoc. Prof. Dr. Direnç Kanol

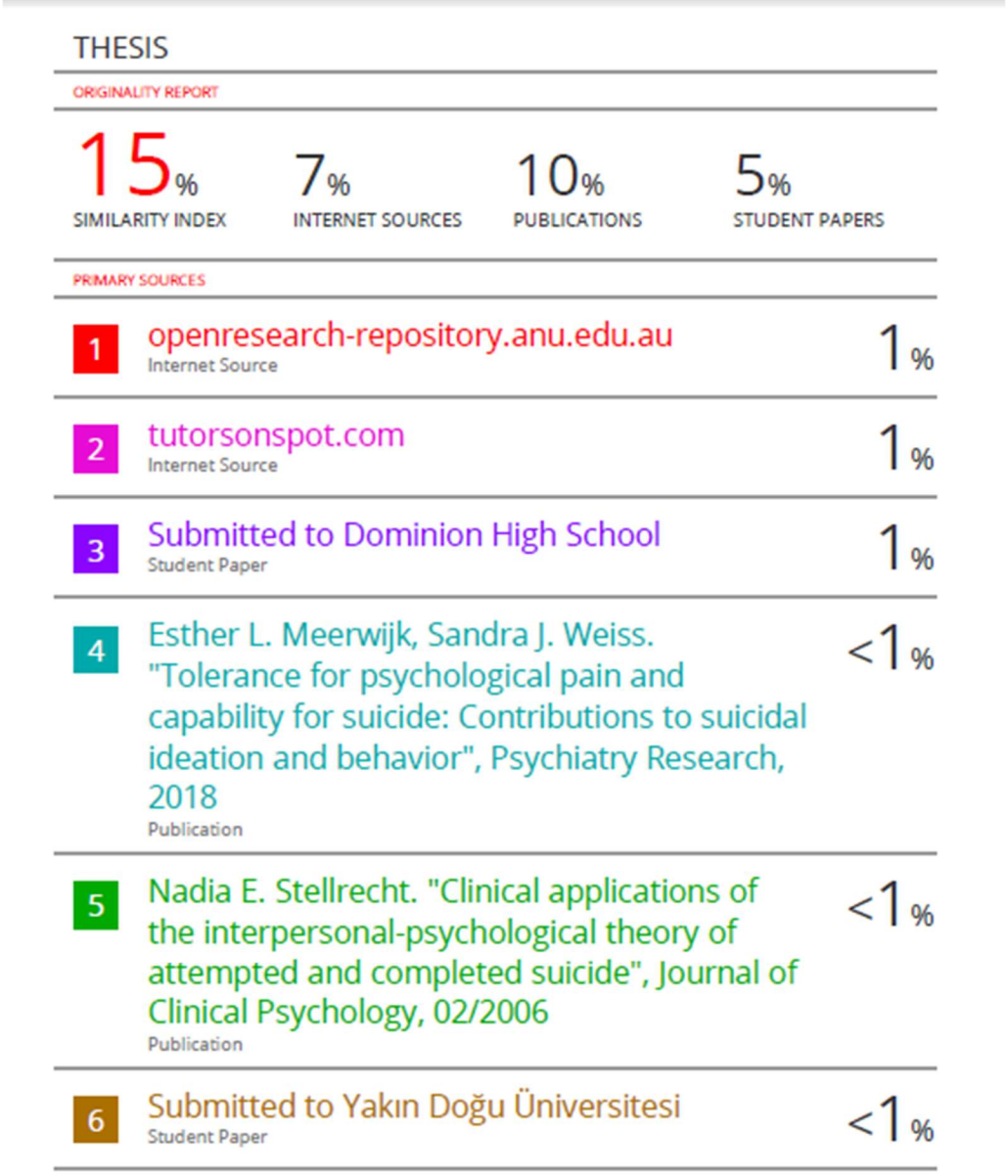
Rapporteur of the Scientific Research Ethics Committee

Direnc Kanol

Note: If you need to provide an official letter to an institution with the signature of the Head of NEU Scientific Research Ethics Committee, please apply to the secretariat of the ethics committee by showing this document.

APPENDIX 8

PLAGIARISM REPORT



THESIS

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4	Esther L. Meerwijk, Sandra J. Weiss. "Tolerance for psychological pain and capability for suicide: Contributions to suicidal ideation and behavior", Psychiatry Research, 2018 Publication	<1%
5	Nadia E. Stellrecht. "Clinical applications of the interpersonal-psychological theory of attempted and completed suicide", Journal of Clinical Psychology, 02/2006 Publication	<1%
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