Correlates of suicidality in South African high school learners: A cross-sectional study

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A minor dissertation submitted in partial fulfilment of the requirements for the award of the degree of Master of Arts Psychological Research

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University of Cape Town

2025

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Acknowledgment

A special thank you to my supervisor, Professor Catherine Ward, for her unwavering support and for encouraging me to keep pushing forward. Your guidance has been invaluable, and your reminders to "put my skates on and write" kept me on track. I also thank the University of Cape Town Research Committee for the grant to Prof. Ward, which has funded my fieldwork, and the South African Department of Science and Innovation, which provided funding to Prof. Ward who was therefore able to give me a scholarship to complete my degree. Marilyn Lake also provided invaluable support with statistical analyses.

I would also like to extend my gratitude to the Gauteng Department of Education and two schools involved in this project. I sincerely appreciate the teachers and staff for their dedication and assistance in ensuring that data collection was possible and met my deadline seamlessly and in a timely manner.

Additionally, I would like to thank SADAG for making mental health matter and for offering their invaluable services to support any distressed learners who may have needed to speak to a counsellor after completing the survey. Your commitment to mental health is deeply appreciated.

Lastly, to my loved ones, thank you for your constant encouragement, for wiping away my tears, and for holding my hand throughout this journey. Your support has meant the world to me.

Abstract

Adolescent suicidality is a significant global concern, with numerous factors potentially contributing to its prevalence. However, the specific correlates of suicidality in South Africa remain inadequately understood.

This study used a cross-sectional survey, which was administered to 161 learners from two schools in Gauteng, South Africa, to examine suicidal ideation and its potential correlates. The survey explored factors including low future expectations, depression, anxiety, strained mother-adolescent relationships, teacher and peer relationships, experiences of abuse, bullying, cyberbullying, and living in unsafe neighbourhoods.

Univariate analyses revealed significant correlations between suicidality and several variables, including depression, strained relationships with both parents, low expectations for the future, household conflict, strained teacher and peer relationships, bullying, cyberbullying, substance abuse, and limited social support. The strongest correlations ($r > 0.40$) were observed between suicidality and depression, anxiety, relationships with mothers and peers, and experiences of bullying.

Multivariate linear regression analysis indicated that maternal relationships and depression were the most critical predictors of suicidality among the grade 10 and 11 learners in this study.

These findings highlight the urgent need for accessible mental health interventions, particularly within schools, along with broader efforts to provide support through digital platforms and organizations such as the South African Depression and Anxiety Group, which offers free resources.

Chapter 1: Introduction and Literature Review

According to the World Health Organization (WHO, 2024), suicide is the third leading cause of death globally among 15–29-year-olds. *Suicide* refers specifically to the act of intentionally ending one's own life, whereas *suicidality* is a broader term encompassing the spectrum of thoughts, behaviours, and intentions related to suicide, including suicidal ideation and attempts (Klonsky et al., 2016; O'Connor & Nock, 2014). Understanding this distinction is essential, as not all individuals experiencing suicidality will go on to die by suicide, highlighting the importance of early intervention and nuanced assessment (WHO, 2021).

In 2022, the Centers for Disease Control and Prevention (CDC) reported that the suicide rate was 13.4 per 100.000 population for the age group 15-24 years in the United States (CDC, 2022). Mental health issues are among the most prevalent factors contributing to adolescents being at heightened risk for suicide (Thornton et al., 2019). In addition to mental health problems, a variety of societal and cultural factors may further exacerbate suicidality among adolescents.

Adolescent suicide remains a critical and persistent global public health issue, with recent data highlighting concerning rates of suicidal ideation, planning, and attempts among youth. According to the *Youth Risk Behaviour Survey Data Summary & Trends Report: 2013–2023*, in 2023, 20% of high school students in the United States seriously considered attempting suicide, 16% made a suicide plan, and 9% attempted suicide at least once during the year (CDC, 2024).

More recent cross-sectional studies have reinforced these findings and further identified associated psychosocial risk factors in specific South African contexts. For example, Khuzwayo et al. (2020) investigated suicide planning and attempts among Grade 10 learners in rural KwaZulu-Natal and found that 12.6% had planned suicide and 14.8% had attempted suicide in the previous year, with 12.4% requiring medical treatment after an attempt. Their study also highlighted risk factors, including bullying via social media, exposure to violence, and alcohol use, differing by gender (Khuzwayo et al., 2020). These data emphasize the complex socio-environmental influences on suicidality among South African adolescents and the need for targeted prevention efforts.

Adolescence is a critical transitional period characterized by considerable biological, psychological, and social changes. According to Khuzwayo et al. (2018), this phase involves the development of independence and the ability to navigate key developmental tasks, which can present challenges. Adolescents are faced with the task of learning to manage their autonomy and taking responsibility for their actions, which can be difficult for some individuals (Khuzwayo et al., 2018).

Understanding the challenges faced by adolescents is crucial, as broader factors influencing their mental health can contribute to suicidal ideation or behaviour. Adolescent

suicidality has profound long-term consequences for individuals, families, communities, and educational systems.

Several factors have been identified as potential correlates of adolescent suicidality. Individual risk factors include age (14–24 years), common mental disorders such as anxiety and depression, gender, a history of suicide attempts, and substance misuse (Thornton et al., 2019). Social relationships play a crucial role, as strained or unhealthy connections with family, friends, or educators can heighten the risk of suicidal ideation and attempts (Groholt & Ekeberg, 2009; Wild, Flisher et al., 2004). Supportive relationships, on the other hand, promote better mental health and resilience. Although social ties can act as either protective or risk factors depending on their nature and context, recent evidence suggests that social support can buffer the impact of stressful life events and reduce the risk of suicidal ideation and behavior among adolescents (Bakken et al., 2024; Mackin et al., 2017).

Adolescence is also a critical period for identity development and social belonging, making experiences like bullying particularly harmful. Bullying, whether direct (e.g., verbal or physical abuse) or indirect (e.g., social exclusion, spreading rumours), has been linked to long-term negative mental health outcomes (Arseneault et al., 2010). Additionally, academic stress can contribute to emotional distress, with concerns about performance, future uncertainty, and career prospects exacerbating anxiety and depression (Benner & Mistry, 2020; Khan et al., 2014).

Environmental factors further shape adolescent mental health. Exposure to high levels of crime, substance abuse, and economic deprivation has been associated with increased psychological distress and suicidality (Pillay, Y., 2022; Seedat et al., 2009). Adolescents living in disadvantaged communities often face heightened stress due to limited access to education, healthcare, and employment opportunities, further exacerbating mental health risks (Visagie et al., 2024).

Lastly, the COVID-19 pandemic may have intensified these challenges, amplifying feelings of isolation, anxiety, and family stress. Reduced social support and rising domestic violence during lockdowns likely contributed to increased mental health struggles and suicidality (Guessoum et al., 2020; Humphreys et al., 2020). Adolescent suicidality is influenced by a complex interplay of factors encompassing individual vulnerabilities, social relationships, academic pressures, and broader environmental conditions. The literature consistently highlights that mental health disorders, strained relationships, bullying, and socio-economic deprivation significantly elevate the risk of suicidal ideation and attempts. Although the COVID-19 pandemic has ended, its lasting psychological and social effects on adolescents remain underexplored. In light of the pandemic's disruptions, including isolation, family stress, and academic uncertainty, it is essential to assess how these factors continue to shape adolescent mental health.

Despite extensive research on adolescent suicidality, post-pandemic studies in South Africa that examine current rates and contributing factors are scarce.

Study aims and objectives

The aim of this study was to examine how a range of psychosocial and environmental factors influenced adolescent mental health, and how these mental health outcomes related to adolescent suicidality. The study investigated both direct and indirect relationships between adverse experiences and suicidality, considering mental health as a potential mediator.

This study addressed that gap through a quantitative correlational analysis of adolescent suicidality in 2024, focusing on two schools in Gauteng. Schools serve as practical settings for both research and intervention, offering critical insights into suicidality while informing effective prevention strategies. By identifying the most relevant risk factors in a post-pandemic context, this study enriches the evolving discourse on adolescent mental health and supports the development of targeted interventions.

The objectives of this study were to:

1. Assess the relationships between future expectations, environmental stressors, interpersonal strain, and adolescent mental health outcomes (depression and anxiety).
2. Examine how depression and anxiety were associated with suicidality among adolescents.
3. Explore whether the effects of interpersonal, academic, and environmental stressors on suicidality were mediated through depression and/or anxiety.
4. Identify which psychosocial and contextual risk factors were the strongest predictors of suicidality among adolescents.

Chapter 2: Method

Quantitative research methods is essential for investigating complex phenomena, such as adolescent suicidality, since they are helpful for examining the relationships between multiple variables and testing specific hypotheses. These methods provide a robust framework for deriving objective, reliable, and generalizable results, which are crucial in addressing sensitive topics like suicidality (Creswell, J.W & Creswell, J.D, 2017). In the context of this study, quantitative approaches allowed for the systematic analysis of factors such as mental health conditions, social support, and behavioural risks, to explore their potential associations with adolescent suicidality. By utilizing measurable data, quantitative techniques enabled the application of rigorous statistical analyses, thus facilitating meaningful inferences that could contribute to theoretical models of adolescent well-being and inform clinical practice (Chapman, 2017). This section outlines the specific quantitative methods used in the current research, including data collection procedures, sampling procedures, analytical techniques that were used to interpret findings, and ethical considerations that were adhered to throughout the research process.

Study Design

The study employed a cross-sectional design, aiming to investigate adolescent mental health and well-being by identifying the correlates associated with adolescent suicidality.

Setting

The study was conducted across two secondary schools in Johannesburg. To maintain anonymity and confidentiality, the schools will be referred to as School One and School Two throughout the paper. The researcher received ethics approval from the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town, HREC REF: 425/ 2024 (Appendix A). On April 3rd, 2024, the researcher-initiated contact by sending introductory emails to both schools, providing a brief overview of the research objectives and interests.

After receiving approval from the Gauteng Education Department and the schools (Appendix C), the researcher visited the schools and invited the learners to take part in the study and to answer any questions that learners, teachers and principals had regarding the study. The researcher also reached out to the South African Anxiety and Depression Group (SADAG) to request assistance in providing support to distressed parents and learners following the completion of the survey. This request was subsequently approved by SADAG (Appendix D).

To facilitate recruitment, consent forms were distributed to the schools for teachers to hand out to learners (which were to be signed by their parents or guardians) (see Appendix E), and the researcher maintained weekly communication with teachers to monitor the progress and return rate of the consent forms. This recruitment phase was prolonged due to delays in the return of the forms by the learners, as many failed to meet the agreed-upon deadline.

The return rate of the consent forms was lower than anticipated and it was required that data be collected before the learners began with their final exams. Data was collected at School One on August 1st, 2024, and at School Two on August 2nd, 2024. At both schools, learners provided their assent to participate in the study (Appendix F) and completed their surveys (Appendix G) under test conditions in the school halls. The learners were then given suicide prevention brochures from SADAG (Appendix H).

Measures

This study assessed a comprehensive set of variables to explore the complex relationships between adolescent mental health, academic and future expectations, strained relationships, lack of support from peers, parents, and teachers, and suicidal ideation.

A questionnaire was developed in English and the schools that were included in the study both used English as a medium of instruction, therefore the learners were able to answer the survey without translation of the questionnaire.

Certain items across multiple measures were reverse scored to ensure that all scores aligned in the same direction typically with higher scores indicating greater levels of psychological distress, weaker interpersonal relationships, or lower perceptions of safety. All reverse scoring was applied during data preparation prior to analysis to ensure conceptual and statistical consistency across all measures.

For this study, several scales (the anxiety scale, depression scale, substance abuse scale, problems related to alcohol and substance use scale, substances scale, relationships with teacher's scale, neighbourhood safety scale, and the exposure to violence scale) were drawn from The Social and Health Assessment (SAHA) (Ruchkin et al., 2008). The SAHA was developed in the USA, and it has been used successfully in countries such as the USA, Belgium, and Russia (Ruchkin et al., 2008), as well as in South Africa (Ward et al., 2007).

According to Ruchkin et al. (2008), the SAHA was originally tested on the 6th, 8th and 10th- grade population of an urban public school system in the USA.

The additional scales about peer relationships and parent-adolescent relationships included in the questionnaires were items from the Optimus Study South Africa (Artz et al., 2016), and from the Inventory of Parent and Peer Attachment (IPPA) (Armsden & Greenberg, 1983).

Suicidality

Three items from the SAHA were used to assess suicidal ideation as well as deliberate self-harming behaviour which may have been presented by adolescents. Participants were asked if they had ever seriously thought about harming themselves that could result in death, if they had ever tried to put an end to their life, and if during any of their attempts did, they truly wanted to die themselves (Ruchkin et al., 2008).

Mental Health

Depression. This was assessed using fifteen items on depressive symptoms from the Centre for Epidemiological Studies-Depression Scale (CES-D) (Radloff, 1977), as used in the SAHA (Ruchkin et al., 2008). This scale included questions about how learners were feeling over the last thirty days (e.g., "I felt that my life had been a failure", "I felt lonely", "I didn't like myself"). Each item was based on a binary scale, which was either "true" or "false". The Cronbach's alpha from the US study was .80 in the SAHA study (Ruchkin et al., 2008).

Further support for the CES-D's validity in South African populations is provided by Baron et al., (2017), who validated the 10-item version (CES-D-10) among Zulu, Afrikaans, and Xhosa-speaking samples. They reported depression prevalence rates of 6.6%, 18.0%, and 6.9% in the Zulu, Afrikaans, and Xhosa groups, respectively. The CES-D-10 showed acceptable internal consistency across language groups (Cronbach's alpha was .69–.89) and demonstrated adequate concurrent validity.

In this study, positively worded items on the depression subscale (e.g., "I felt hopeful about the future," "I enjoyed doing things," "I felt that people liked me," "It was easy for me to make decisions," and "I felt confident") were reverse scored, as they reflect well-being rather than depressive symptomatology.

Anxiety. 22 items from the SAHA scale, originally adapted from the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978), were used to assess participants' anxiety symptoms. Example items addressing psychological symptoms included; "I worry about other people liking me", and "I stay away from things that make me nervous". The questions were on a three-point scale ("not true, somewhat true, and true Internal consistency for the full-scale RCMAS in a South African sample Cronbach's alpha was .81, indicating good reliability. Subscale reliabilities were lower: physiological anxiety (Cronbach's alpha was .58), concentration (Cronbach's alpha was .59), and worry/oversensitivity (Cronbach's alpha was .68) (Boyes & Cluver, 2013). Example items include "I worry about other people liking me" and "I stay away from things that make me nervous." Items were rated on a three-point scale ("not true," "somewhat true," "true"). For comparison, the original U.S. validation study reported a Cronbach's alpha of .87 for the full scale (Reynolds & Richmond, 1978).Seven additional items assessed somatic anxiety (the bodily, physiological processes which are associated with anxiety) and were included in the

SAHA (Ruchkin et al., 2008.

These items were included in the overall anxiety measure. These items were also derived from the Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978) and included items such as "my heart beats fast", "I feel tense or uptight". These questions were assessed on a three point-scale ("not true" 1, "somewhat true" 2, and "true" 3). The Cronbach's alpha in the US study was .78 (Ruchkin et al., 2008).

In the anxiet**y** subscale, items reflecting prosocial behaviour, self-regulation, or positive peer perception were reverse scored to ensure alignment with the scale's focus on internalising symptoms. These included statements such as *"I try to be nice to other people. I care about their feelings," "I usually share with others," "I usually do what I am told," "I am helpful if someone is hurt, upset or feeling ill," "I have one good friend or more," "Other people my age generally like me," "I am kind to younger children," "I often offer to help others,"* and *"I think before I do things. I finish the work I'm doing. My attention is good."*

Substance abuse. One item from the Monitoring the Future Scale (Johnston et al., 2000) was used to assess alcohol use. Responses were provided on a four-point scale ranging from "never" to "often." Additional items about drug use (cannabis and other substances) were drawn from the SAHA and adapted from the School Health Study (Jessor et al., 1998). These items also used a four-point scale. Cronbach's alpha for this scale has been reported as .80 in SAHA studies conducted in Belgium and .90 in the U.S. (Ruchkin et al., 2008), with a South African study by Govender et al. (2013) reporting a similarly strong internal consistency of Cronbach's alpha of .815

Three additional items assessed whether the learners were experiencing problems caused by alcohol use (Ruchkin et al., 2008). Items were answered on a four-point Likert-like scale ranging from "0" times to "six" times. The Cronbach's alpha for this scale in the US study was .74 (Ruchkin et al., 2008). A further 5 items, also drawn from the SAHA, assessed problems caused by other substances (Ruchkin et al., 2008). These items were rated on a three-point scale (ranging from "never to "often"), and Cronbach's alpha was .72 in the US.

Academic performance

This academic performance scale was taken from a study of US adolescents (Hawkins et al. (1992). It was important to use this scale in order to assess whether academic performance correlated with mental health and suicidality. One question from this scale was used to assess the academic performance of learners *e.g. "How would you say you do in school?".* This question was given on a 5-point Likert-like scale ranging from well above average (1), somewhat above average (2), average (3), somewhat below average (4) and well below average (5).Although it is not possible to calculate a Cronbach's alpha for a single-item measure, this question was nonetheless important for understanding how learners perceived their academic performance, and how such perceptions might influence their mental health, suicidality, and

expectations for the future.

Future expectations

Seven items from the Expectations of Goal Attainment Scale (Jessor et al., 1998) were used, as adapted by Ruchkin et al. (2008). These items have previously been included in the South African Health and Well-being Study (SAHA), but no South African reliability coefficients have been published to date. While the original US-based study reported acceptable internal consistency (Cronbach's alpha was 0.79), the lack of a local validation sample is noted as a limitation

Bullying

Nine items from the Social and Health Assessment (SAHA), which were adapted from the Multidimensional Peer-Victimization Scale (MPVS) developed by Mynard and Joseph (2000), were used to assess peer victimization (Ruchkin et al., 2008). Responses were recorded on a four-point scale ranging from "not at all" to "four or more times." In the original U.S.-based study, the scale demonstrated good internal consistency, with a Cronbach's alpha of .82 (Ruchkin et al., 2008). In addition to these items, four cyberbullying questions from the Optimus Study (Artz et al., 2016) were also included, using the same response format.

While elements of the MPVS have therefore been indirectly incorporated into South African studies via the SAHA, to date, the original or revised MPVS has not been directly used or validated in any peer-reviewed South African adolescent samples. In contrast, limited use of the MPVS has been reported in Nigeria. For example, Nwafor (2024) conducted a Confirmatory Factor Analysis (CFA) of the Revised Peer Experience Questionnaire (RPEQ) and noted that few Nigerian studies have focused on peer victimization, often employing varied instruments—including the MPVS (Nwafor, 2024). This suggests a broader regional gap in standardized measurement of peer victimization. The absence of direct MPVS validation in South Africa highlights the need for culturally appropriate adaptation and psychometric testing of such multidimensional tools in local contexts.

Relationships

The Inventory of Parent and Peer Attachment (IPPA) was developed in 1983, to assess the adolescent perceptions of the negative and positive affective/ cognition dimensions of relations with parents and close friends (Armsden & Greenberg, 1983). In an Italian study, Cronbach's alpha of peer attachment was found to be 0.92 (Armsden & Greenberg, 1983).

Relationship with peers. Twenty items from the Inventory of Parent and Peer Attachment (IPPA)(Armsden & Greenberg, 1983) were used to assess the relationships and social support between adolescents and their peers. Questions were answered on a five-point scale ranged from "almost never" (1) to "always true (5)". The Cronbach's alpha for this scale in Italy was .92.

For the peer relationships measure, multiple items were also reverse scored, including *"My friends can tell when I'm upset about something," "When we discuss things, my friends care about my point of view," "My friends understand me," "My friends encourage me to talk about my difficulties," "My friends accept me as I am," "I feel the need to be in touch with my friends more often," "I feel my friends are good friends," "My friends are fairly easy to talk to," "My friends care about how I am feeling," "I can count on my friends when I need to get something off my chest,"* and *"I trust my friends,"* all of which indicate higher levels of peer support if left unadjusted.

Relationship with parents. In South Africa, several studies have explored the reliability of measures assessing adolescent relationships with parents. For instance, Dowdall et al. (2017) reported a Cronbach's alpha of .77 for the Parental Attachment and Relationship Scale (PARS) (Ward et al., 2007), which consists of 11 items evaluating the nature of adolescent relationships with their parents. Additionally, four items from the Optimus Study (Artz et al., 2016) were used to determine whether both parents of a participant were still alive, serving as a prerequisite to further questions about parent-adolescent relationships. Five items from the parental scale developed by Ruchkin et al. (2008) assessed perceptions of parental warmth and support, with a Cronbach's alpha of .80 reported in the original U.S. study.

Most recently, Carter, van der Watt, and Esterhuyse (2023) reported reliability coefficients for maternal and paternal attachment in a South African sample as .74 and .79, respectively, adding further local validation to the use of parent attachment measures.In the relationships with parents measure, items such as *"Makes me feel better after talking over my worries with him/her," "Enjoys doing things with me," "Gives me a lot of care and attention,"* and *"Believes in showing his/her love for me"* were reverse scored, as they reflect high-quality parent–child relationships, which would otherwise contradict the intended direction of the scale

Relationship with teachers. Four items from the SAHA (Ruchkin et al., 2008), originally derived from the seven-item Negative School Environment scale adapted from Kasen et al. (2004), were used to assess the relationship between adolescents and their teacher.

These ranged from "not true" (1). "neutral" (2), and "true" (3). The Cronbach's alpha in the US study was .71 (Hawkins el at., 1992), in Belgium, it was .74 (Ruchkin et al., 2008), and in Russia, it was .72 (Ruchkin et al., 2008). The Cronbach's alpha reported by Barnes et al. (2014) for the adapted Negative School Environment scale in the South African context was .73.

Support from Teachers

Seven items from the *Perceived Teacher's Support in School* scale, developed by the SAHA (Ruchkin et al., 2008), were used. The scale is a 4-point measure ranging from 'Definitely not true' to 'Definitely true.' In the US study, Cronbach's alpha was .71, indicating acceptable reliability.

Neighbourhood Safety

Five items from the SAHA (Ruchkin et al., 2008) were used to assess how the participants felt about their neighbourhoods, in relation to the issues of safety. These were answered on a "yes" or "no" scale. The Cronbach's alpha from the US study was .82 (Ruchkin et al., 2008). In a South African context, the reliability test produced a very high internal consistency for a similar measure of neighbourhood safety concerns, with an average Cronbach's alpha of .73 (Ndamase, 2024).

Finally, in the neighbourhood safety subscale, the items *"I like my neighbourhood"* and *"I feel safe in my neighbourhood"* were reverse scored to ensure that higher scores reflected lower perceived neighbourhood safety.

Exposure to Violence

At home. Seven items from the SAHA (Ruchkin et al., 2008) were used to assess if the participant has experienced abuse/ violence at home, or if they have seen someone being physically hit by their parents or guardians. The Cronbach's alpha for this scale in a study in the US was .89 (Ruchkin et al., 2008). In a South African context, Pillay, Pillay, and Sibanda (2024) developed an indirect exposure to violence index combining witnessed and heard-about violence. They reported Cronbach's alphas adapted from Richters and Saltzman, with lifetime witnessing violence at .89 and past year witnessing violence at .89, indicating strong reliability for exposure to violence measures within South African samples.

At school. In addition**,** one item from the SAHA (Ruchkin et al., 2008) was used to assess if the participant has experienced abuse at school by their teacher. This scale falls under the negative school environment.

Within the teacher relationships subscale, positively framed items such as "*I like most of my teachers this year", "I like school", and "I feel safe at my school"* were reverse scored to ensure consistency with the intended construction of lower perceived school support.

Participants

The inclusion criteria for this study were: adolescents in grades 10 and 11, aged between 15 and 19 years. According to the Social Surveys and Centre for Applied Legal Studies (2010), it is not uncommon in South Africa for learners to be three or more years older than the typical age for their grade level. This discrepancy can be attributed to factors such as delayed school entry or the repetition of one or more grades. These learners who were above the age of 18 were adults and able to give consent for themselves.

The researcher left parental consent forms at the schools and asked the teachers to distribute them to learners to take home with them and return the forms signed by their parents if they agreed to their children taking part in this study.

Procedure

The data collection took place over two weeks, from August 1st to August 15th, 2024. After the data collection dates were set, the researcher visited the schools to distribute both assent forms and the survey (see Appendix I) on the same day. Data collection was conducted during school hours at both participating schools. Prior to the distribution of surveys, the researcher visited each school to invite learners to participate in the study and provided them with consent forms to take home for parental or guardian approval. Only learners who returned signed parental consent forms were eligible to participate. These learners were then invited to the designated data collection area, where they reviewed and signed an assent form before completing the survey. Learners who did not return both signed consent and assent forms were not eligible to take part in the study.

At School One, the survey was administered during the Life Orientation period in the school hall. At School Two, data collection took place in the morning before the start of the school's sports day activities, a day on which no formal classes were scheduled.

Learners who were absent on the initial day of data collection but had returned signed consent forms were accommodated on the following day during break time. These learners completed the survey in an available, empty classroom.

Before any surveys were distributed, the researcher explained the purpose of the study and verbally guided learners through the assent form, summarising its key points to ensure understanding. Learners were then given time to read the assent form independently and were encouraged to ask questions if they required clarification about any part of the form or the survey itself.

Learners were informed that they could skip any items they did not feel comfortable answering. The survey also included a "prefer not to answer" option for some items. It was emphasized that participation was voluntary and that there would be no consequences for skipping questions or not completing the survey.

The survey took approximately 40 minutes for each learner to complete. Upon completion, the assent forms and surveys were submitted to the researcher. The researcher reviewed each survey to assess completeness. Surveys that were left entirely blank or contained responses to only one section were excluded from data entry and analysis. Only fully completed surveys and those missing responses in no more than one or two sections were included in the final dataset.

The researcher reviewed each eligible survey before entering the data into SPSS for statistical analysis, ensuring that no identifying information was recorded. The data entry process was completed over a two-week period. After all responses were captured, the researcher revisited the codebook to confirm the accuracy of variable labelling and

categorisation. Where necessary, certain survey items were reverse scored to maintain consistency across the dataset for analysis purposes.

Ethical considerations

This study was approved by the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town. Ethical considerations (REF: 425/ 2024; see Appendix B) were of paramount importance throughout the study to ensure that participants' rights and well-being were safeguarded. As explained above, parents or guardians were invited to provide informed consent for their child younger than 18 years to be approached to participate in the study (see Appendix J), while the adolescent participants themselves were asked to provide informed assent at the beginning of the survey (see Appendix K). This dual consent process ensured that both parents and adolescents were fully aware of the study's nature and objectives (Lakeman & FitzGerald, 2009). Adolescents who refused their assent were not permitted to proceed with the survey, respecting their autonomy and right to withdraw without any consequences (Fowler, 2013).

To address potential concerns or queries, participants and their parents were provided with contact information for the researcher and supervisor. This ensured transparency and facilitated communication throughout the study (Fowler, 2013). Additionally, in line with ethical guidelines, contact details for the Department of Psychology Research Ethics Committee and the Human Research Ethics Committee were provided in the event of complaints, concerns regarding participant treatment, or violations of participants' rights (Fowler, 2013).

Although suicide is a difficult and sensitive subject matter, authors such as Gould et al. (2018) argued that there is no negative impact on high school learners responding to research questions regarding suicide and therefore it is important for such research to be conducted on mental health and youth suicide prevention. Given the sensitive nature of some survey questions, particularly those relating to emotional well-being and suicidality, ethical precautions were taken to safeguard participants' mental health. As the surveys were completed anonymously to protect learner privacy, it was not possible to identify individuals who may have indicated suicidal thoughts or emotional distress.

In preparation for data collection, school psychologists or counsellors were informed about the inclusion of sensitive items and the potential for some learners to experience emotional distress. Although individual responses could not be linked to specific learners, school-based support staff were advised that the overall findings might reflect elevated mental health risks. They were encouraged to ensure support systems were in place and to remain available to assist learners should the survey results indicate a broader need for intervention.

To support learners more immediately, all participants received contact details for the South African Depression and Anxiety Group (SADAG) and Childline, both offering toll-free, confidential support. SADAG also agreed to provide extended telephonic assistance to any learner who reached out in distress related to the study (see Appendix D). A suicide prevention brochure was distributed to all participants and left with school staff for broader distribution to all learners, including those who did not participate (see Appendix E).

Although direct follow-up with individuals was not possible due to the anonymous nature of the survey, learners were actively encouraged both verbally and in writing to seek help from trusted adults at school or to make use of the helplines provided. This approach aimed to balance the ethical responsibility of maintaining confidentiality with the obligation to promote access to mental health support (Israel, 2015; Lakeman & FitzGerald, 2009).

Data analysis

The data was evaluated for its suitability for regression analysis, based on theoretical considerations regarding the underlying distribution, and this evaluation was supported by verification of the assumptions of the linear regression model. Multiple regression analysis was used to examine the relationship between adolescent suicidality and various psychosocial factors (Field, 2018). This statistical method allowed for the simultaneous assessment of multiple predictors, clarifying the strength and direction of their associations with suicidal ideation. Prior to analysis, frequency checks were conducted to ensure accurate data entry. A correlation matrix was then constructed to explore interrelationships among the variables and their associations with suicidality. Finally, regression analysis was conducted to identify the most significant predictors of suicidal ideation, providing insights to inform targeted intervention strategies. A significant level of 0.005 (Cronbach's alpha being 0.05) was applied for all statistical tests.

Chapter 3: Results

This chapter presents the results of the statistical analyses conducted to test the hypotheses outlined in Chapter 1. The study employed a quantitative correlational design to evaluate the direct and indirect effects of various psychosocial and contextual stressors, including strained interpersonal relationships, bullying (traditional and cyber), low future expectations, substance use, and unsafe neighbourhood environments on adolescent mental health (depression and anxiety) and suicidality.

Descriptive statistics were conducted to summarize the instrument scores, including calculations of the mean and standard deviation for each scale. For these analyses, responses marked as "I choose not to answer" were treated as missing data. When computing the scale totals, missing item-level responses were treated as zero, and these totals were calculated by summing the available item responses within each scale.

Participant characteristics

There were 229 learners from School One, of whom 111 (69%) returned their signed consent forms, also a week before data collection. In contrast, there were 369 learners at School Two of whom 50 (31%), returned signed consent forms which were collected by their teachers a week prior to data collection.

Table 1 describes the sample demographics. The age distribution showed that, as expected, most learners were 16 or 17 years of age, with the largest proportion of participants being 16 years old (n=60, 37%), followed by 17 years (n=50, 31%), and the smallest group being 19-year-olds (n=3, 1.9%).

Most participants (n=93) were in grade 10 (58%), while 68 learners (42%) were in grade 11. The sample had 93 females (58%), followed by 48 males (30%), with three (1.9%) identifying as transgender, two (1.2%) as non-binary (1.2%), four as gender neutral (2.5%) and 11 (6.8%) other participants categorized themselves under other gender categories (6.8%).

Table 1

Participant Characteristics

Characteristics	n (%)
School	
School One	111 (69.0%)
School Two	50 (31.0%)
Age	
15 years	39 (24.0%)
16 years	60 (37.0%)
17 years	50 (31.0%)
18 years	9 (5.6%)
19 years	3 (1.9%)
Grade	
Grade 10	93 (58.0%)
Grade 11	68 (42.0%)
Gender	
Male	48 (30.0%)
Female	93 (58.0%)
Transgender	3 (1.9%)
Non-binary	2 (1.2%)
Gender neutral	4 (2.5%)
Other	11 (6.8%)

Note. N= 161. The percentages may not total 100% due to rounding.

Reliability

In this section, the reliability of the various scales used in the study was examined through Cronbach's alpha coefficients, which assesses internal consistency (Bland & Altman, 1986). A Cronbach's alpha value of 0.70 or higher is typically considered an indication of good reliability (Kennedy, 2022), though values in the range of 0.60 to 0.69 may be acceptable in exploratory research (Kennedy, 2022). Values below 0.60 usually suggest that a

scale may be an inadequate internal consistency, necessitating refinement or reconsideration of items.

Table 2 presents the Cronbach's alpha coefficients for each of the scales used in the current study. Most scales demonstrated acceptable to strong internal consistency, with alpha values ranging from 0.74 to 0.90. The Strained Relationship with Teachers scale yielded a lower alpha of **0.67**, which falls just below the conventional threshold. Despite this, the value is considered marginally acceptable in exploratory analyses (Field, 2018), and the scale was retained for subsequent analyses.

Table 2

Cronbach's Alpha Coefficients for Scales Used in the Questionnaire.

Scale	Cronbach's alpha (α)
Future Expectations	0.75
Depression	0.83
Anxiety	0.74
Suicidality	0.78
Strained relationship with maternal figure	0.77
Strained relationship with a paternal figure	0.82
Arguments in the household	0.82
Strained relationship with teachers	0.67
Substance use	0.74
Bullying experience	0.80
Cyberbullying experience	0.75
Strained relationship with friends	0.90
Living in an unsafe neighbourhood	0.81

Note. Cronbach's alpha values ≥ 0.70 indicate acceptable internal consistency. The alpha for the teacher relationship scale (α = 0.67) was slightly below the conventional threshold but retained for exploratory purposes.

Suicidal ideation questions posed to participants

Table 3 presents responses to the question regarding suicidal ideation that may have been experienced by the participants over the past 12 months. The data presented that nearly half of the participants (43%) reported having seriously considered self-harm with the potential for fatal outcomes within the past 12 months. This indicates a substantial portion of the study population has experienced suicidal ideation.

A third of the sample (26%) reported having made a suicide attempt during the same period. This finding suggests that while suicidal ideation is more prevalent than actual suicide attempts, a substantial number of individuals are contemplating ending their lives.

Furthermore, among those who had attempted suicide, 30% reported that they genuinely desired to die, whereas 70% did not.

Table 3

Suicidal Ideation Questions Posed to Participants

Question	Yes	No	Missing
"During the past 12 months, did you ever seriously think about harming yourself in a way that may result in your death"?	65 (43%)	86 (57%)	10
"During the past 12 months, did you ever try to put an end to your life"?	39 (26%)	110 (74%)	12
"During any of your attempts, did you really want to die"?	43 (30%)	101 (70%)	17

Descriptive Statistics

The standard deviations, as well as the actual and possible ranges for the variables included in this study, are presented in Table 4. These composite-level data descriptives provide an overview of the distribution and variability of the variables, offering context

for the interpretation of subsequent analyses.

Suicidality findings

Suicidality data showed a mean of 0.95 out of a possible range of 0-3.0 and a median of 0.0, reflecting that while suicidality was not uncommon in this sample, generally learners did not experience more than one symptom of suicidality. However, actual scores ranged from 0.0 to 3.0, covering the full range of possible scores. 43% (n=65) of the participants reported having experienced thinking about harming themselves.

Descriptive statistics for suicidality-related variables indicate the following: Depression scores ranged from 0.0 to 15.0 (out of a possible 19), with a mean of 8.0 and a standard deviation (SD) of 3.8, suggesting moderate variability. The interquartile range (IQR) of 6.0 to 12.0 indicates that many learners experienced mild to moderate depressive symptoms. None of the participants reported maximum depressive symptoms.

Anxiety findings

For anxiety, scores ranged from 0.0 to 18.0 (possible range of 18.0), with a mean of

8.8 and a median of 9.0, reflecting a relatively symmetric distribution. The SD of 4.1 suggests moderate variability, with most learners experiencing mild to moderate anxiety, as indicated by an IQR of 6.0 to 12.0.

Parent-child relationships findings

Regarding parent-child relationships, adolescents reported moderately positive relationships with mothers (mean = 12.4, SD = 6.2) and fathers (mean = 13.0, SD = 8.0). The wide variability in these relationships (IQR: 7.0–17.0 for mothers, 6.0–17.0 for fathers) suggested diverse experiences, with some adolescents reporting strong bonds while others experienced weaker or strained dynamics, which can impact suicidality risk.

Arguments findings

Arguments in the household were generally infrequent (mean = 2.1, median = 2.0, SD = 2.0), with most adolescents having experienced minor disagreements. However, the IQR of 0.0 to 3.0 and a range of 0.00 to 7.0 indicate that some adolescents faced more familial conflict, potentially exacerbating emotional distress and suicidal ideation.

Teacher-adolescent relationships

The teacher-learner relationship, with a mean of 4.2 and SD of 2.3, suggested generally neutral to positive connections. The IQR of 2.0 to 6.0 indicates that while most

adolescents report moderate teacher support, some may face less positive or even negative experiences. These relationships may serve as a buffer against mental health challenges (Umberson & Karas Montez, 2010).

Table 4

Descriptive Statistics for Psychosocial and Suicidality Variables 22

	Mean	Median	Std. Dev.	Actual range	Possible range	Interquartile range
Marks (0 missing)	2.8	3.0	1.3	1-6	6	2.0-3.0
Age (0 missing)	2.2	2.0	0.9	1-5	5	2.0-3.0
Future expectation (2 missing)	6.0	6.0	4.0	.0-19.0	19.0	3.0-9.0
Depression (1 missing)	8.0	8.0	3.8	.0-15.0	15.0	4.3-11.0
Anxiety (1 missing)	8.8	9.0	4.1	.0-18.0	18.0	6.0-12.0
Suicidality (7 missing)	0.95	.0	1.1	.0-3.0	3.0	0.0-2.0
Strained relationship with maternal figure (4 missing)	12.4	11.0	6.2	3.0-27.0	27.0	7.0-17.0
Strained relationship with paternal figure (17 missing)	13	12.0	8.0	.0-33.0	33.0	6.0-17.0
Arguments in the household (3 missing)	2.1	2.0	2.0	.0-7.0	7.0	0.0-3.0
Strained relationship with teachers (3 missing)	4.2	4.0	2.3	.0-9.0	9.0	2.0-6.0
Substance use (3 missing)	1.4	1.0	1.6	.0-6.0	6.0	0.0-2.3
Bullying experience (4 missing)	9.0	8.0	6.0	.0-26.0	26.0	4.0-13.0
Cyberbullying experience (4 missing)	2.2	2.0	1.8	.0-6.0	6.0	0.0-4.0

Note. Values presented are the mean, median, standard deviation, actual range (minimum to maximum), possible range, and interquartile range for each variable.

Correlation Matrix

Table 5 displays the correlation matrix in the form of a heat map. Several risk factors were significantly associated with suicidality. High correlations, as defined by Cohen and Wills' categories (1985), were observed between suicidality and depression (r = 0.56), anxiety (r = 0.47), and strained relationships, such as with the mother (r = 0.36) and father (r = 0.25). According to Cohen's guidelines, correlations of r = 0.5 and above are considered "high" (Cohen & Wills, 1985). Other variables correlating with suicidality include future expectations (r = 0.18), household arguments (r = 0.27), strained teacher relationships (r= 0.32), bullying (r= 0.35), cyberbullying (r = 0.36), substance use (r = 0.24), and limited social support from friends (r = 0.24). A weak but statistically significant correlation was noted with living in unsafe neighbourhoods (r = 0.14). These factors underscore the complex interplay of individual, relational, and environmental influences on suicidality, highlighting the multifaceted nature of its risk.

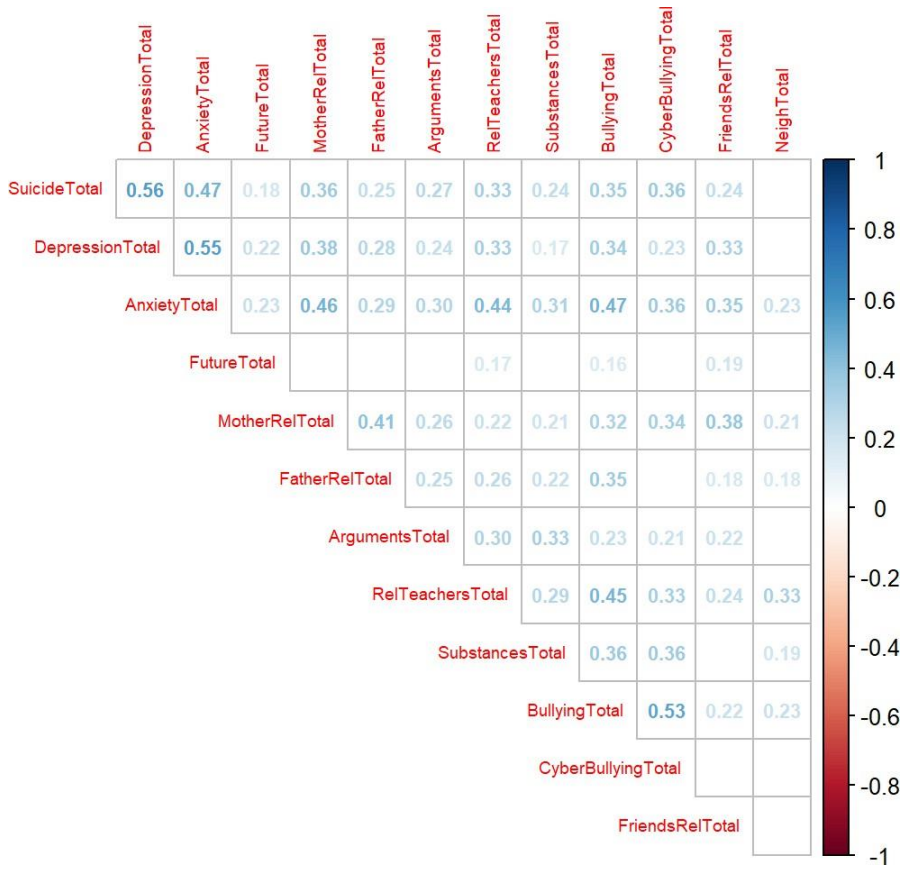
In addition, depression was strongly correlated with anxiety (r = 0.55). Depression shows moderate associations with strained relationships, such as those with the mother (r = 0.38), father (r = 0.28), and teachers (r = 0.36). The correlation between familial and social dynamics were associated with depression, which contributes to the risk of suicidal ideation.

Anxiety also shared many of the same relational stressors, with significant correlations to strained relationships with the mother (r = 0.46), teachers (r = 0.46), and experiences of bullying (r = 0.47). Moreover, the stressors of bullying and cyberbullying (r = 0.36), further correlated with factors such as household arguments (r = 0.30). Substance use (r =0.31) and limited social support from friends (r = 0.35) were additional stressors that influenced both depression and anxiety, highlighting the role of external factors in exacerbating mental health conditions. The relationship between these variables suggests that a combination of personal distress and environmental challenges contributes to the elevated risk of suicidality.

Potential multicollinearity among the predictor variables was evaluated using univariate correlation coefficients. As presented in Table 5, all correlations were below 0.60, which is well under the commonly accepted threshold of 0.80 used to indicate problematic multicollinearity (Daoud, 2017). This suggests that the variables included in the regression model were not highly collinear. Additionally, there were no indications of inflated standard errors or unstable coefficient estimates in the final regression output, further supporting the conclusion that multicollinearity did not pose a significant issue in this analysis.

Table 5

Correlation Matrix/ Heat Map



Multiple Regression Model

A multivariable linear regression analysis was conducted in R to examine the association between suicidality and a range of mental health and psychosocial risk factors. The full model included suicidality as the dependent variable and incorporated the following independent variables: anxiety, depression, future expectations, relationships with mother and father, frequency of arguments, relationships with teachers and friends, substance use, experiences of bullying and cyberbullying, and neighbourhood environment. Depression and anxiety were included as distinct observed variables in the models.

Table 6 displays the multiple regression model examining predictors of adolescent suicidality. The analysis revealed that, after controlling for other variables, higher scores of depression ($p < 0.001$) and poor relationships with mothers ($p = 0.05$) were significantly associated with increased suicidality. The model accounted for 17.6% of the variance in suicidality ($R^2 = 0.176$), indicating that while these factors explain a meaningful portion of suicidality risk, or other unmeasured variable likely to contribute to the outcome.

Table 6

Multiple Regression Predicting Suicidality

Variable	Estimate	SE	statistic	*p*-value	CI
(Intercept)	-0.78	0.23	-3.42	0.00	[-1.23, -0.33]
Anxiety	0.03	0.03	1.07	0.29	[-0.02, 0.08]
Depression	0.11	0.02	4.67	0.00	[0.07, 0.16]
Future	-0.01	0.02	-0.67	0.50	[-0.05, 0.03]
Relationship with mother	0.03	0.02	1.96	0.05	[0.00, 0.06]
Relationship with father	0.00	0.01	-0.25	0.80	[-0.02, 0.02]
Arguments	0.04	0.04	1.06	0.29	[-0.04, 0.12]
Relationship with teachers	0.04	0.04	1.06	0.29	[-0.04, 0.12]
Relationship with friends	-0.01	0.01	-1.29	0.20	[-0.02, 0.00]
Substances	0.03	0.05	0.62	0.54	[-0.07, 0.14]
Bullying	0.00	0.02	0.06	0.96	[-0.03, 0.03]
Cyberbullying	0.08	0.05	1.57	0.12	[-0.02, 0.19]
Neighbourhoods	-0.01	0.04	-0.35	0.73	[-0.10, 0.07]

Note. $N = 161$. SE = Standard Error; CI = Confidence Interval. Significant predictors ($p < .05$) are Depression and Relationship with Mother. The model accounted for 17.6% of the variance in suicidality ($R^2 = .176$).

Chapter 4: Discussion

Adolescent suicidality remains a global public health concern, with suicide ranking as a leading cause of death among South African adolescents. This crisis has profound implications, not only for the affected individuals and families, but also for society at large. Addressing suicidality in South Africa is particularly challenging due to socio-economic disparities, cultural dynamics, and psychological stressors that influence adolescents' mental health. Data from the South African Depression and Anxiety Group (SADAG, 2020) highlighted an intensification in suicide rates, underscoring the urgent need for targeted prevention and intervention strategies.

This chapter explores these issues in greater depth, comparing the study's findings with existing literature to provide a broader context for the results. It examines the interplay between individual, familial, and societal factors, emphasizing the importance of early interventions. Using the mental health intervention spectrum and risk reduction model (Haggerty & Mrazek,1994), the chapter assesses the role of school-based mental health support, the significance of early intervention, and strategies for fostering supportive environments within educational settings.

This study revealed significant levels of suicidality among adolescents, with 43% of participants reporting serious consideration of self-harm with potentially fatal outcomes within the past year, and 26% indicating a suicide attempt during the same period.

Importantly, 70% of those who attempted suicide did not have a genuine intent to die, suggesting that acute emotional distress, rather than a definitive desire for death, played a significant role. These findings align with global trends showing rising adolescent suicidality, particularly post-pandemic (Park et al., 2023).

Several key factors were identified as strong correlates of suicidality, including mental health disorders (depression and anxiety) and strained mother-child relationships. Depression exhibited a strong positive correlation with suicidality ($r = 0.56$), consistent with prior research identifying depression as a primary risk factor (Nock et al., 2006). Anxiety also correlated with suicidality ($r = 0.47$), with its effects compounded by relational stressors, such as bullying and negative interactions with mothers and teachers. Strained relationships with mothers showed a moderate correlation with suicidality ($r = 0.36$), emphasizing the crucial role of familial support in adolescent mental health.

These findings reinforce existing literature that highlights the complex interaction between mental health disorders and suicidality. Depression and anxiety not only increase the likelihood of suicidal ideation but also amplify the effects of environmental and relational

stressors (Khatami& Khodabakhshi-Koolaee, 2021). This interplay has been observed across diverse socio-cultural contexts, reinforcing the need for preventive measures tailored to vulnerable youth populations (Karim, 2016).

Beyond mental health and familial factors, other risk variables significantly contributed to suicidality. Substance use showed a moderate correlation with suicidality ($r = 0.24$) and anxiety ($r = 0.31$), supporting the notion that adolescents often use substances to self-medicate distress, which in turn exacerbates their vulnerability to mental health issues (Carney & Myers, 2012). Negative perceptions about future prospects were also associated with suicidality ($r = 0.18$), consistent with research indicating that pessimistic views about education and career opportunities can worsen mental health struggles (Benner & Mistry, 2020).

Teacher-student relationships were another important factor, with strained interactions correlating with suicidality ($r = 0.32$), depression ($r = 0.36$), and anxiety ($r = 0.46$). These negative interactions may contribute to emotional distress, increasing adolescents' vulnerability to suicidal ideation. Additionally, bullying and cyberbullying showed strong correlations with suicidality ($r = 0.35$ and $r = 0.36$, respectively), reinforcing the detrimental impact of peer victimization on adolescent mental health. These results align with global studies demonstrating higher rates of psychological distress and suicidal behaviours in victimized adolescents (Le et al., 2017). Lastly, living in unsafe neighbourhoods was also linked to suicidality ($r = 0.14$), underscoring the role of environmental stressors in adolescent mental health outcomes (Seedat et al., 2009).

High rates of suicidality

This study confirmed significant levels of suicidality among adolescents, with 43% reporting serious consideration of self-harm and 26% attempting suicide in the past year.

However, 70% of those who attempted suicide did not intend to die, highlighting that acute emotional distress, rather than a clear desire for death, often drives suicidal behaviours. At first glance, this may resemble the characteristics of non-suicidal self-injury (NSSI), which involves deliberate self-harm without the intention to die. However, the behaviours referenced here are classified as suicidal due to the lethality of the methods used, the context of acute psychological crisis, and the presence of suicidal ideation—even when intent to die is ambivalent (Joiner, 2005; Klonsky et al., 2014). This distinction is critical, as NSSI typically serves different functions, such as affect regulation or self-punishment, and is generally not associated with a wish to die (Nock, 2010). This complexity underscores the need for interventions that not only prevent suicide attempts but also address the underlying emotional distress that often precipitates such acts.

The study's suicidality data revealed a mean score of 0.95, indicating relatively low levels of suicidality on average. However, the median score of 0.0 suggested that most participants reported minimal or no symptoms, reflecting considerable variability in suicidality levels. This discrepancy emphasizes the need for targeted interventions that cater to the diverse intensities of suicidality experienced by adolescents.

Previous research consistently links mental health disorders, childhood maltreatment, bullying, and cyberbullying to suicidal ideation (Joiner, 2005). These findings align with the current study, reinforcing the importance of addressing these risk factors in suicide prevention. Furthermore, studies such as Park et al. (2023) show an increase in self-harm incidents following the COVID-19 pandemic, mirroring global trends and highlighting the need for robust mental health support for adolescents.

Two main correlates

This study found two key correlates that strongly contribute to adolescent suicidality: depression and strained relationships with mothers. These findings emphasize that both mental health issues and family dynamics are critical in understanding the risk of suicidal ideation among adolescents.

The primary mental health factors explored in this study were depression and anxiety, which were found to have strong associations with suicidal ideation. Depression, in particular, emerged as a notable predictor of suicidality.

Depression and Suicidality

The study revealed that depression scores were moderately variable among participants, with most adolescents reporting mild to moderate symptoms (mean = 8.0, SD = 3.8). This suggested that while depressive symptoms were common, they were not overwhelmingly severe across the sample. However, a strong positive correlation was found between depression and suicidality ($r = 0.56$), indicating that higher scores of depression were closely linked to increased suicidal ideation. This aligns with previous research (Nock et al., 2006) highlighting depression as a key risk factor for suicidality among adolescents.

Additionally, depression was moderately correlated with strained relationships with key figures, particularly mothers ($r = 0.38$), fathers ($r = 0.28$), and teachers ($r = 0.36$). These correlations suggest that familial and social stressors may intensify depressive symptoms and contribute to the development of suicidal thoughts. This supports the theory that the stress of interpersonal conflicts and lack of support networks can exacerbate feelings of depression and heighten the risk of suicidal ideation (Cohen & Wills, 1985).

Khatami and Khodabakhshi-Koolaee (2021) noted that mental health disorders such as anxiety, substance use, and depression are frequently linked to suicidal behaviour. In line with this, Karim (2016) highlighted that mental health conditions are prevalent among adolescents, yet many go untreated or undiagnosed. In South Africa, nearly one-third of the population will experience mental health issues at some point in their lives (North et al.2020). In our study, depression remained strongly associated with suicidality, underscoring the critical role of depression in suicidal ideation.

Strained relationship with parents

The study also identified strained relationships with mothers as a key correlate of suicidality. On average, adolescents reported moderately positive relationships with both their mothers and fathers, though the quality of these relationships varied widely across participants. Some adolescents experienced strong, supportive bonds with their parents, while others faced more challenging dynamics.

Strained mother-child relationships were closely associated with suicidality ($p = 0.05$), with a moderate correlation ($r = 0.36$) suggesting that poor maternal relationships were linked to higher scores of suicidal ideation. This finding highlights the vital role of the

mother-child bond in adolescent mental health. When this relationship is strained, adolescents are more likely to experience emotional distress, increasing their vulnerability to suicidal thoughts. On the other hand, the correlation between strained father-child relationships and suicidality was weaker ($r = 0.25$), suggesting that although father-child relationships are important, maternal relationships may have a stronger influence on adolescent mental health, particularly in terms of suicidality.

The association between strained mother-child relationships and increased suicidality in adolescents can be meaningfully interpreted through attachment theory. Recent research confirms that insecure maternal attachment is significantly associated with elevated suicide risk in adolescents (Leben Novak et al., 2023). This is likely due to a compromised sense of emotional safety, which impairs an adolescent's ability to seek help or express vulnerability during psychological crises. Insecure attachment can manifest emotional dysregulation, withdrawal, or a chronic sense of rejection, all of which heighten vulnerability to suicidal ideation. In the current study, the moderate correlation between poor maternal relationships and suicidality underscores this risk, reinforcing the foundational role of maternal emotional availability in safeguarding adolescent mental health.

Strained maternal relationships may contribute to a profound sense of social disconnection and emotional isolation key elements of thwarted belongingness. Several recent studies have supported this mechanism in adolescent populations, showing that attachment anxiety toward mothers can

intensify feelings of rejection and burdensomeness, which in turn mediate suicidal ideation (McBride et al., 2021). Moreover, high family conflict in emotionally intense or collectivist cultural contexts may further amplify these feelings (Zayas et al., 2023), particularly when maternal expectations are internalized by adolescents as unattainable or critical.

Adolescents who do not receive consistent emotional validation or support from their mothers may develop maladaptive coping mechanisms such as emotional suppression, impulsivity, or externalizing behaviours, which are linked to higher suicidality risk (Adrian et al., 2023). This is particularly concerning in contexts of high family conflict, where the home environment fails to serve as a secure base. A recent meta-analysis (Gómez-Baya et al., 2024) highlights family dysfunction and emotional invalidation as robust predictors of self-injurious behaviors among adolescents.

While father absence and household arguments can also impact adolescent mental health and suicidality, these factors should be unpacked further. Fatherlessness is a widespread issue in South Africa, largely due to socio-economic challenges, unemployment, and changing societal norms around masculinity. Mkhwanazi et al. (2024) argue that fathers play a crucial role in shaping adolescents' values, cultural practices, and identity. The absence of a father figure often leads to academic difficulties, financial hardships, and mental health struggles (Mkhwanazi et al., 2024).

In South Africa, nearly two-thirds of children grow up without a father, and the country has one of the highest rates of fatherlessness globally. Statistics South Africa (2024) reported that in 2023, only 39% of households were nuclear families, while 19% of children lived without either biological parent, or 45.4% lived with their mothers. Furthermore, 12.3% of children were orphaned. These statistics underscore the challenges faced by children raised without both parents, especially in contexts where familial support is essential for mental well-being.

Household arguments and exposure to violence

Regarding household arguments, most adolescents reported relatively low levels of conflict, with a mean of 2.1 (SD = 2.0). However, there was considerable variability in the frequency of conflicts, ranging from mild disagreements to more intense familial disputes. This range suggests that while some adolescents faced occasional mild conflicts, others experienced more frequent and potentially distressing familial strife.

Although the data did not show a direct correlation between the frequency of family arguments and suicidality, it is important to acknowledge that frequent or intense familial conflicts may contribute to emotional distress. Even minor but frequent disagreements can create feelings of instability, rejection, and frustration, which may exacerbate underlying mental health issues. For

adolescents already struggling with depression or anxiety, these conflicts could intensify their feelings of isolation or hopelessness, ultimately increasing their risk of suicidal ideation (Pu et al., 2025).

Furthermore, exposure to violence also has implications for adolescent mental health. Research indicates that children exposed to intimate partner violence (IPV) or other forms of family violence face heightened risks of depression, suicidal ideation, and suicide attempts (Mason-Jones et al., 2016). In South Africa, high rates of gender-based violence, including femicide and domestic violence, contribute to this cycle of trauma, further highlighting the importance of addressing family dynamics when developing interventions aimed at reducing suicidality in adolescents.

Multicollinearity Among Predictors

Although depression and strained maternal relationships were strongly correlated with suicidality in this study, it was important to consider the broader network of contributing factors, even if their correlations with suicidality are weaker. Several variables examined were substantially interrelated, suggesting that suicidality emerges from a confluence of emotional, relational, and behavioural stressors.

Anxiety, for example, showed a moderate correlation with suicidality ($r = 0.47$), though its impact was secondary to depression. Elevated anxiety, particularly in the context of relational stressors like strained relationships with mothers and teachers, can exacerbate mental health challenges. This underscores the need for interventions that address not just internal symptoms of anxiety but also the relational dynamics at play. These findings align with research that highlights the role of social stressors, such as bullying and family conflict, in exacerbating anxiety (Hatzenbuehler et al., 2009).

Similarly, future expectations had a moderate correlation with suicidality ($r = 0.18$), with negative outlooks about the future leading to an increased risk of suicidal ideation.

Adolescents facing uncertainty about their academic and career paths, especially in socioeconomically disadvantaged contexts like South Africa, may struggle with mental health. This highlights the importance of fostering a more hopeful view of the future by improving opportunities and support for at-risk adolescents (Louw & Louw, 2022).

Substance use, while not strongly correlated with suicidality ($r = 0.24$) or anxiety ($r = 0.31$), still plays a significant role in adolescent mental health. Substance use can impair judgment, increase impulsivity, and exacerbate pre-existing mental health issues. In areas with high rates of substance misuse, such as South Africa, the compounded effect of substance use on mental health can elevate suicidality risk (Creswell, KG. et al., 2020).

Both bullying (r = 0.35) and cyberbullying (r = 0.36) demonstrated notable associations with suicidality, with cyberbullying showing a slightly stronger link. These forms of peer aggression often co-occur with anxiety, highlighting how social stressors contribute to adolescent mental health challenges. Adolescents experiencing both bullying and familial conflict were particularly vulnerable to emotional distress, emphasizing the need for comprehensive approaches to mental health support that address multiple environments (Chang et al., 2013).

Finally, strained teacher-learner relationships showed moderate correlations with suicidality (r = 0.32), depression (r = 0.36), and anxiety (r = 0.46). Negative interactions with teachers, especially within disciplinary contexts such as corporal punishment, can exacerbate stress and emotional difficulties. These findings contribute to a broader understanding of how school environments impact adolescent well-being and highlight the importance of supportive educational settings (Quail & Ward, 2023).

Addressing Suicidality in Schools: A Multi-Layered Approach

Teachers and schools play a crucial role in addressing suicidality, not just through the delivery of targeted treatments and preventive programs, but also by identifying early signs of mental health distress in students. Given that teachers interact with students regularly, they are often the first to notice changes in behaviour, mood, or academic performance that may indicate underlying mental health issues. This positions them as key figures in early detection and intervention.

To help teachers recognize these signs, schools can implement training programs that equip educators with the necessary skills. Teachers should be trained to identify warning signs of suicidal ideation, such as withdrawal from social interactions, a sudden decline in academic achievement, self-harm, or verbal cues like expressions of hopelessness and feelings of worthlessness (Cunningham et al., 2021; Wasserman et al., 2015). This heightened awareness enables teachers to take prompt action by offering support, providing a safe space for students to talk, and referring them to appropriate mental health professionals, such as school counsellors, social workers or psychologists, for further evaluation and intervention (King & Fazel, 2019).

In the context of South Africa's mental health system, where school psychologists are scarce and mental health services are unevenly distributed, schools have become critical sites for identifying and addressing adolescent mental distress. Non-governmental organisations such as Community Keepers have helped bridge this gap by offering counselling and psychosocial services directly within school environments (Community Keepers, 2023). However, more sustainable, scalable responses are needed, particularly for addressing complex issues like adolescent suicidality.

Universal, school-based interventions have emerged as promising approaches. For example, *Four Steps to My Future* (4STMF) is a structured programme that helps learners develop self-awareness, coping strategies, and pathways for accessing support (Coetzee et al., 2024). Likewise, *Project HASHTAG* integrates whole-school initiatives with classroom-based psychosocial skills training to improve mental health literacy, reduce stigma, and foster safer school environments (Tomlinson et al., 2024). These models are particularly relevant given that depression and strained family relationships, especially with caregivers, were identified in this study as key factors contributing to adolescent suicidality.

In many South African homes, socioeconomic realities result in adolescents spending more time with teachers than with parents, making the school a central space for psychosocial intervention (Cluver et al., 2020). Yet, many teachers feel unprepared for this role, citing a lack of training and confidence in responding to learners' emotional needs (du Plessis, 2022). Laurenzi et al. (2020) further highlight that few psychosocial interventions in low-resource contexts directly address suicidality, despite its growing prevalence.

Projects such as HASHTAG (Lopez Garcia et al., 2023) offer an important corrective by supporting teachers not by expecting them to act as counsellors, but by equipping them to foster emotionally safe environments while trained facilitators handle direct intervention. This layered approach illustrates the importance of multi-level, contextually grounded strategies for suicide prevention in schools that support both learners and the adults who surround them. It also reinforces the argument that addressing adolescent suicidality requires not only identifying risk factors but building resilient systems around adolescents, particularly within the school setting.

Addressing suicidality in schools requires a multi-layered approach, combining targeted treatments for at-risk students with universal preventive measures. Evidence-based therapies such as cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) have shown to be effective in reducing self-harm behaviours and improving emotional regulation (Hofmann et al., 2012). Accessible mental health services, including school psychologists and crisis support teams, should be provided in schools so as to offer immediate assistance to students in need (King & Fazel, 2019).

In addition, teachers working closely with school psychologists can also introduce students to treatment options like CBT and DBT, which have been proven effective in managing emotional distress and suicidal ideation (Hofmann et al., 2012). School psychologists can conduct initial assessments and collaborate with teachers to identify students who may benefit from these therapies, creating a direct pathway for students to access professional mental health care. This collaborative

approach ensures that students receive timely interventions, helping them better manage their mental health in the school setting.

The role of school psychologists is essential in addressing suicidality. In addition to crisis intervention, they are instrumental in providing culturally sensitive care and supporting the development of school-wide mental health policies that prioritize the emotional well- being of students (Pérusse et al., 2009). As advocates for mental health, school psychologists work to raise awareness about mental health issues, ensuring the integration of mental health services within the school's infrastructure.

Moreover, schools can foster a supportive environment through peer-led initiatives or mental health education programs that promote open communication and reduce the stigma surrounding mental health struggles. Initiatives like SADAG's "Buddy System" can encourage students to reach out for help, creating a school culture of empathy and support (Khan et al., 2014).

The UK National Institute for Health and Care Excellence (2022) emphasizes the importance of having clear policies and procedures in place for identifying and responding to suicidal ideation and self-harm behaviours. These policies should guide school staff on how to detect warning signs, respond appropriately, and ensure proper referral pathways for students. Comprehensive school-wide initiatives can effectively address suicidality by combining the efforts of teachers, school staff, and mental health professionals such as social workers and school nurses to create a supportive and safe environment for all students.

Mental Health Prevention Model and Its Role in School Interventions

The *Risk Reduction Model*, introduced by Mrazek and Haggerty (1994), emphasizes reducing risk factors and enhancing protective factors to prevent mental health disorders, including suicidality, in adolescents. By identifying and addressing modifiable risk factors and strengthening protective factors, this model can help lower the likelihood of adolescents developing mental health issues, including suicidal ideation. In the school context, this model can guide the development of targeted interventions that focus on early detection, intervention, and creating a positive environment to support mental well-being for all students.

Universal prevention programs for mental health

Universal prevention programs target mental health issues for all adolescents, irrespective of whether they have previously exhibited suicidal behaviours. These programs focus on reducing general risk and promoting mental well-being within the broader adolescent population. The ultimate goal is to build mental health literacy, resilience, and early intervention skills to prevent the onset of suicidal thoughts and behaviours.

One of the most effective ways to prevent suicidality is by addressing the stigma associated with mental health. Programs that raise awareness, de-stigmatize seeking help, and promote open conversations about mental health can help create a supportive school environment. By challenging societal misconceptions, these programs encourage adolescents to seek help when needed.

In addition, mindfulness programs in schools play a crucial role in helping students develop emotional regulation skills, reducing the effects of stress, anxiety, and depression. Interventions that teach techniques like deep breathing, progressive muscle relaxation, and mindfulness exercises have proven effective in managing emotional distress (Barrett et al., 2001). These practices help adolescents better manage their emotions and foster resilience when facing life's challenges.

Furthermore, a key intervention strategy is psychoeducation in involves teaching adolescents about mental health, recognizing early warning signs, and promoting positive coping strategies. LifeLine Crisis Support similarly offers counselling and mental health resources in schools, assisting students in managing emotional challenges in real time. Comprehensive initiatives like South Africa's *Caring Schools* aim to create environments where students can safely discuss mental health issues and build coping skills, especially targeting vulnerable populations (Aggarwal et al., 2015).

While this study proposes that teachers play a key role in identifying and supporting learners at risk of suicidality, it is crucial to acknowledge the challenges that may hinder their ability to provide direct mental health support. South African research has shown that many teachers feel unprepared or reluctant to assume mental health responsibilities, often believing that such support should be the domain of trained counsellors or mental health professionals (du Plessis, 2022). Learners, too, have expressed concerns about seeking help from teachers, particularly around issues of confidentiality, trust, and stigma. These findings suggest that although teachers are well-positioned to observe and refer learners in distress, their involvement in mental health interventions must be carefully structured to reflect their capacity, training, and the preferences of learners.

In light of these challenges, universal, school-based mental health programmes such as *Four Steps To My Future* (4STMF) offer a promising approach. Coetzee et al. (2024) evaluated the feasibility, acceptability, and exploratory outcomes of 4STMF,a structured, eight-session mental health promotion programme delivered by trained non-specialists to Grade 5 learners in South African primary schools. The programme was well-received by learners and teachers and demonstrated improvements in learners' emotion regulation and, in some cases, self-esteem. Crucially, while it is delivered by trained facilitators, 4STMF is embedded within the school timetable and encourages collaboration with teaching staff. This design recognises that teachers are often the most consistent adult presence in learners' lives, particularly in communities where caregivers may work long hours, commute long distances, or return home only on weekends.

By being present and observant, teachers are well-positioned to notice early warning signs of mental health distress, including suicidality. A programme like 4STMF provides a structured, proactive way for schools to address mental health without requiring teachers to act as counsellors. Instead, teachers can support the process by reinforcing key messages, creating emotionally safe classroom environments, and referring learners for additional help when necessary. In this way, 4STMF does not replace the teacher's role but rather complements it, bridging the gap between classroom presence and psychosocial support and helping to ensure that learners receive the care they need within a context that acknowledges the realities of South African family structures and resource limitations.

Digital platforms also offer significant opportunities for mental health support, particularly in rural or hard-to-reach areas. Tools like *SPARX*, a computer-based CBT platform, engage adolescents through interactive, gamified approaches while addressing mental health stigma (Merry, S., N. et al., 2012). In South Africa, mobile applications like *Headspace* and *Calm* provide self-guided mindfulness and relaxation exercises, offering accessible mental health support (Olton-Weber et al., 2020). Online counselling services, such as those provided by SADAG, allow adolescents to access confidential support and reduce barriers to seeking help (Hawton et al., 2012).

In addition to school-based initiatives, parenting programs play a vital role in supporting adolescent mental health. Programs like *Parenting for Lifelong Health* and *Triple P* (Positive Parenting Program) focus on strengthening parent-child relationships, enhancing communication, and reducing mental health issues at home (Sanders et al., 2014; Ward et al., 2019). These programs help create a supportive home environment that reinforces mental health resilience and provides additional layers of support for adolescents.

Furthermore, in South Africa, cultural beliefs about mental health can complicate the recognition of mental distress. For instance, mental illness may be attributed to witchcraft, or some believe that only individuals from unstable families face mental health issues (Pillay, Y., 2019). Psychoeducational programs are essential in challenging these misconceptions, helping parents and educators recognize early signs of distress, such as mood changes or social withdrawal (Luxton & Kyriakopoulos, 2022). By incorporating local context and addressing cultural barriers, these programs can foster greater understanding and support for adolescents' mental health.

Universal Interventions for Strained Mother-Child Relationships and Household Conflict

Parenting programs play a pivotal role in improving relationships between mothers and children, especially in preventing conflict and fostering emotional stability. These programs, which

can be integrated into school initiatives, offer parents tools to communicate effectively, resolve conflicts peacefully, and avoid harmful disciplinary methods. In doing so, they help create healthier home environments, which, in turn, support adolescent mental health.

For instance, *Sinovuyo Teen* in South Africa has proven effective in improving parenting practices and family well-being, reducing conflict and promoting emotional resilience (Cluver et al., 2018). Similarly, integrating evidence-based therapies like Attachment-based Family Therapy (ABFT) into school mental health services can strengthen the bond between parents and adolescents, offering both parties tools to improve emotional connection and manage conflict constructively (Brager-Larsen, 2015). By providing parenting education, schools can empower families to create supportive environments that foster mental well-being, reduce the likelihood of adolescent violence, and strengthen the overall family unit.

In addition, schools also play an important role in addressing wider societal issues like intimate partner violence (IPV), violence against women (VAW), and violence against children (VAC). Through education, students can learn to recognize the signs of unhealthy relationships, abusive behaviours, and how to seek help. These programs, integrated into the curriculum, create a foundation for understanding and preventing violence while offering learners tools to navigate potentially harmful situations.

Furthermore, creating safe spaces for students to report abuse without fear of retribution is crucial. Confidential reporting systems, such as hotlines or online platforms, can give adolescents an anonymous way to seek help. Programs focused on non-violent conflict resolution, violence prevention, and gender-based violence can significantly reduce the impact of household conflict on adolescent mental health.

A key strategy in addressing strained mother-child relationships and household conflict is the involvement of community organizations and local leaders. By partnering with organizations specializing in family welfare, schools can strengthen the support network available to adolescents. Community-based initiatives can train local leaders, including elders and healthcare professionals (social workers and school nurses), to recognize signs of violence or distress, which can help prevent escalation and ensure timely intervention (Fulu & Miedema, 2015).

Programs that link school-based efforts with local resources create a more comprehensive support system, ensuring that adolescents and families are supported both at school and at home. Through these partnerships, schools can also offer family therapy sessions and support groups, providing safe spaces for parents and children to address conflict constructively.

In sum, integrating school initiatives with broader community support systems plays a vital role in preventing family violence and strengthening the mother-child relationship. This multi-

layered approach promotes emotional resilience and reduces the potential for negative mental health outcomes among adolescents.

Correlation of Key Risk Factors and Universal Interventions

Global research highlights a complex interplay between mental health disorders such as depression, anxiety, substance use, bullying, family dysfunction, and peer relationships and suicide risk factors (Borges et al., 2010). In South Africa, these issues are further exacerbated by poverty, high unemployment, gender-based violence, and socio-political instability, all of which heighten adolescents' vulnerability to suicidal ideation (Shilubane et al., 2013). In under-resourced communities, stigma surrounding mental health, limited access to care, and low mental health literacy often prevent adolescents from seeking the help they need.

These risk factors while multifaceted are not isolated from one another; rather, they are deeply interconnected. Mental health challenges, like depression and anxiety, can fuel substance use, bullying behaviours, and strained relationships, while also being exacerbated by familial and peer dynamics. Given the compounded nature of these risk factors, targeted interventions are essential to address both the individual and environmental determinants of adolescent well-being.

Adolescent substance use is a multifaceted issue that requires integrated school-based interventions). Beyond classroom education, extracurricular activities like sports, arts, and leadership programs empower learners to resist peer pressure and offer alternative outlets for stress.

Schools can also collaborate with local authorities to advocate for stronger enforcement of laws to prevent underage drinking, especially in informal venues (Parry & Dewing, 2006). Environmental strategies such as creating substance-free zones and establishing clear consequences for violations reinforce the importance of maintaining healthy environments.

Engaging parents in substance use prevention efforts further strengthens these initiatives. Programs like *Teen Intervene* have demonstrated success in reducing substance misuse by improving communication and problem-solving skills within families (Spoth et al., 2001). Additionally, peer support programs foster a sense of belonging and empower students to share their experiences, while mentorship programs offer guidance and life skills to keep learners engaged (Catalano et al., 2004; Kelly et al., 2017).

To address issues like bullying, depression, and self-esteem, schools must adopt a comprehensive approach. Teachers are critical in identifying signs of bullying and intervening early. Changes in academic performance, social withdrawal, and mood swings often signal distress (Kowalski et al., 2014). By fostering an open communication culture, teachers can help learners report incidents safely, either anonymously or through trusted channels (Olweus et al., 2019).

Schools should implement clear anti-bullying policies and promote leadership programs that teach students valuable skills like conflict resolution and decision-making. These programs empower learners to navigate social situations, resist peer pressure, and contribute to reducing bullying (Gresham & Elliott, 2008; Watts & Zimmerman, 2002). Additionally, social and emotional learning (SEL) programs foster self-awareness and self-regulation, building emotional resilience and improving students' mental health (Yeager, 2017).

Extracurricular activities, such as sports or volunteering, also build confidence, leadership skills, and resilience, contributing to a positive outlook and reduced bullying. Peer mentoring programs, where older students act as role models, can provide support to at-risk learners and create a culture of empathy and care (Johnson & Johnson, 2002). Programs like KiVa, adapted from Finland, and the *Olweus Bullying Prevention Program* (OBPP) are effective models to reduce bullying by involving the whole school community. These programs address the needs of victims, perpetrators, and bystanders, promoting empathy and a positive school climate (Olweus et al., 2019; Salmivalli et al., 2013).

In schools, addressing strained teacher-learner relationships and promoting mental well-being require evidence-based interventions. Strategies like teacher-directed opportunities for response (OTR) encourage active engagement, while behaviour contracts and positive reinforcement reduce problematic behaviours (Gershenson et al., 2016; Quail, K.,& Ward, 2023). Non-violent discipline training for teachers and caregivers is essential to avoid corporal punishment, which can contribute to long-term mental health issues (Quail, K., & Ward, 2023).

Implementing programs focused on emotional regulation, such as the *Irie Classroom Toolbox*, can also enhance students' emotional growth (Baker-Henningham, 2015). Non-punitive approaches, like reflective time-outs, allow learners to regain control over their emotions, contributing to a more positive school environment (Simonsen & Sugai, 2019).

Unsafe Neighbourhoods: Addressing Mental Health and Socioeconomic Deprivation

In South Africa, adolescents living in unsafe, impoverished neighbourhoods often experience heightened mental health challenges, particularly due to exposure to violence, trauma, and lack of social support. Research by Humm et al. (2018) highlights the severe psychological impact of these stressors, with increased rates of depression and suicidal ideation among adolescents from disadvantaged communities. Studies have consistently shown a strong association between neighbourhood deprivation and mental health issues. For instance, Graham & Elliott (2008) found that adolescents living in areas marked by social and economic disadvantage are significantly more likely to experience psychological distress and suicidal behaviour.

The South African Indices of Multiple Deprivation (IMD) provide a useful tool to understand the complexities of these stressors, including poverty, lack of community resources, and exposure to violence (Graham & Elliott, 2008). Furthermore, Seedat et al. (2009) emphasize the critical role of neighbourhood characteristics in shaping adolescent mental health, with many young people facing high crime rates, substance abuse, and poor social cohesion. These factors contribute significantly to poor mental health outcomes, including depression and suicidality.

Moreover, exposure to violence in neighbourhoods with high crime rates often leads to substance abuse, deviant behaviour, and issues with emotional regulation, further compounding mental health challenges (Björkenstam et al., 2018; Jackson et al., 2019). In South Africa, communities with high crime rates and a lack of basic services, such as clean water, electricity, and sanitation, contribute to feelings of hopelessness and powerlessness, which are key precursors to depression and suicidal ideation (Dowdall et al., 2017).

The negative impact of unemployment in these areas further exacerbates the situation, with adolescents in deprived neighbourhoods often more likely to face delinquency, criminal activity, and poor mental health outcomes (Dowdall et al., 2017). For many, the cycle of poverty becomes difficult to break, leading to persistent feelings of hopelessness that are linked to depression and suicidality (Barkhuizen & Rothmann, 2008).

Universal interventions for adolescents in unsafe neighbourhoods

Given the multifaceted nature of deprivation in unsafe neighbourhoods, interventions need to focus on both immediate and long-term solutions, addressing individual vulnerabilities while fostering community-level resilience. Improving access to mental health services is a critical first step. In disadvantaged environments, making mental health resources accessible is essential. School-based counselling and community mental health services have been effective in providing early interventions and supporting adolescents (Rutter, 2006).

Moreover, addressing socio-economic challenges is key to breaking the cycle of disadvantages. Interventions aimed at alleviating poverty, such as funding for education, can provide adolescents with opportunities for upward mobility. Scholarships, transport subsidies, and school meal programs are examples of initiatives that can help alleviate some of the burdens faced by students in high-deprivation areas (Dowdall et al., 2017). Feeding schemes and food parcel initiatives can also address immediate nutritional needs, which have a direct effect on mental health.

Schools have a crucial role in connecting adolescents with necessary resources and offering support in unsafe neighbourhoods. Teachers can act as facilitators, helping students access community-based mental health services and supporting family engagement in mental health

programs (Rutter, 2006). By offering workshops on positive parenting and mental health awareness, schools can equip families with tools to support their children's emotional well-being (Seedat et al., 2009).

Schools are also uniquely positioned to foster a supportive environment through peer mentorship programs and social cohesion initiatives. By encouraging older learners to mentor younger students, schools can offer emotional support and guidance, reducing feelings of isolation (Shilubane et al., 2012). Teachers can facilitate these programs and ensure inclusivity, creating a space where all students feel safe to express themselves.

Moreover, open discussions about mental health in the classroom can help normalize conversations and encourage students to seek help when needed (Seedat et al., 2009).

Teachers can collaborate with school counselors or social workers to identify at-risk learners early and offer timely intervention strategies (Dowdall et al., 2017). By establishing a robust mental health support system within schools where teachers, counselors, social workers and other external professionals work together, schools can become safe spaces for adolescents who might otherwise lack access to mental health services (Barkhuizen & Rothmann, 2008).

Conclusion

This study highlighted the critical role of depression and strained mother-child relationships as the primary correlates of suicidality in adolescents. However, it was important not to overlook other significant factors, such as father absence, family conflict, exposure to violence, and broader societal issues like gender-based violence. Addressing these factors through comprehensive interventions that supported mental health and improved family dynamics, particularly those involving mothers, could significantly reduce the risk of adolescent suicidality.

In conclusion, while depression and strained maternal relationships were the most strongly correlated with suicidality in our study, the interconnectedness of other factors such as anxiety, substance use, bullying, teacher-learner dynamics, and future expectations needed to be addressed as part of a holistic approach to adolescent mental health. The study emphasized the need for multifaceted, targeted interventions within schools, which not only addressed immediate mental health concerns but also worked to mitigate stressors arising from family dynamics and peer conflicts.

A comprehensive approach would include strengthening family-school partnerships, provide accessible mental health support, and fostering safe, inclusive school environments. These findings underscored the importance of developing long-term, sustainable solutions, such as continuous professional development for educators and mental health professionals (social workers and school

nurses), as well as community-level initiatives that aimed to reduce societal stressors affecting adolescents.

Ultimately, a collaborative effort between educators, mental health professionals such as social workers, school nurses, psychologists, families, and communities is crucial in creating a safe and supportive environment for students. By integrating universal prevention models and proactive interventions into schools, we could have addressed suicidality and mental health challenges, promoting long-term mental well-being for all adolescents.

Limitations

An understanding of the challenges faced by adolescents, along with the various factors influencing their mental health and well-being, is crucial in addressing the growing concerns of suicide and suicidal ideation within this population. Identifying these challenges is essential for uncovering the underlying causes of increasing rates of suicide and suicidal thoughts among adolescents. However, several limitations should be acknowledged, as they may impact the interpretation and generalizability of the findings.

First, the cross-sectional design of the study limited the ability to draw causal conclusions about the relationships between depression, anxiety, and suicidality. While the study provides valuable insights into these associations, a longitudinal design would allow for a better understanding of the directionality of these relationships and the identification of potential causal pathways. Tracking the same individuals over time would also enable a more comprehensive assessment of how mental health issues evolve and whether early interventions can mitigate long-term risks of suicidality.

Additionally, the reliance on self-report measures introduces the potential for response biases. Adolescents may underreport or overreport their feelings of depression and anxiety due to social desirability or fear of stigma. This is particularly relevant in the context of sensitive topics such as suicidal ideation. Incorporating more objective measures, such as clinician assessments or peer reports, in future research could help mitigate these biases and provide a more accurate picture of adolescent mental health.

The small sample size, limited to only two schools, further restricts the generalizability of the findings. Adolescents from different schools or regions may face unique environmental and cultural influences that could impact their mental health outcomes. Expanding the sample size and including participants from a broader range of educational settings, especially those in more rural or under-resourced areas, would improve the representativeness of the study and ensure that the findings are more widely applicable to South Africa’s diverse adolescent population.

Moreover, the study did not account for important demographic factors such as race, socio-economic status (SES), and family structure, all of which play a significant role in shaping adolescents' experiences and mental health outcomes. For instance, socio-economic disparities are often linked to greater exposure to violence, limited access to mental health resources, and academic stress, all of which can contribute to heightened suicidality. Future studies should include these demographic variables to offer a more nuanced understanding of how these factors intersect mental health issues among adolescents. The exclusion of these variables in the current study limits its ability to fully explore the broader systemic factors that may affect mental health outcomes.

Another limitation was the lack of long-term follow-up, which hindered the ability to assess how suicidal ideation and mental health issues evolve. Longitudinal research would be essential to track the progression of mental health outcomes and determine the

long-term impact of interventions. A longer-term study could help identify critical periods in an adolescent's development when they are at the highest risk for suicidality, as well as how effective interventions are in addressing these risks over time.

In terms of intervention, school-based programs faced some challenges, particularly during school closures, which limited teacher support during holidays (Feiss et al., 2019).

Schools in low-income settings, often lacking access to school psychologists, face additional barriers in providing adequate mental health support to students. These constraints highlight the importance of strengthening the mental health infrastructure in schools, especially in under-resourced areas, to ensure that adolescents receive the support they need.

Finally, some scales used in the study had low internal consistency and were excluded from the analysis. This compromised the ability to fully explore certain variables that could have influenced suicidality, such as self-esteem or academic stress. Ensuring the reliability of measurement tools in future research is critical for obtaining valid and consistent results.

Implications for theory and research

The findings and limitations of this study carry significant implications for theoretical frameworks and future research on adolescent suicidality, particularly within the South African context.

Theoretical Implications

This study supports existing models linking adolescent suicidality to depressive symptoms and strained maternal relationships, echoing international findings. However, it underscores the importance of contextualizing these models within South Africa's unique socio-cultural and structural realities.

The study's limited sample, drawn from only two schools and lacking demographic detail regarding race, socio-economic background, cultural identity, and sexual orientation, restricted the ability to examine broader systemic influences. Structural factors such as historical inequality, community violence, and identity-based interpretations of mental health likely intersect with the variables studied but remain underexplored (Lund et al., 2018; Shilubane et al., 2012).

Mainstream theories often overlook these structural determinants. This research highlights the need for frameworks that integrate poverty, discrimination, and restricted mental health access as contributors to suicidality in South Africa (Díaz-Oliván et al., 2021). Though not the focus here, culturally specific constructs like *ubuntu* (humanity to others), emphasizing collective identity, compassion, and interconnectedness, may serve as protective factors and should be incorporated into future theoretical models (Boboyi, 2024).

Furthermore, the study points to a gap in literature where gender is frequently foregrounded over broader developmental experiences. By not disaggregating findings by gender, this research invites inquiry into suicidality beyond binary gender constructs, while still recognizing that gender-specific trajectories merit future attention.

Research Implications

Methodological constraints, including a small and geographically narrow sample and absence of demographic stratification, signal the need for more inclusive and representative research. Future studies should integrate variables such as race, cultural background, socio-economic status, and family structure to better reflect the intersectional nature of adolescent mental health in South Africa (Rossouw et al., 2024).

Longitudinal designs are essential to understanding how systemic challenges like educational disruption and community violence shape adolescent mental health over time (Moomal et al., 2009). Employing mixed methods, including clinical tools, qualitative interviews, and stakeholder input, may help mitigate underreporting due to stigma or cultural silencing around suicide (Lund et al., 2009).

While this study did not explore the impact of poverty or its psychosocial effects, future research should investigate how material deprivation, food insecurity, and housing instability contribute to emotional distress and suicidality. Similarly, although sexual and gender diversity were not focal points, there is an urgent need to examine the elevated risks faced by LGBTQI+ adolescents, who often confront dual stigmas and are frequently marginalized in mainstream interventions.

Digital influences, including social media use, cyberbullying, and online support, also warrant attention, given their growing relevance to adolescent well-being in an increasingly connected society.

Community-based participatory research (CBPR) offers a promising avenue for involving adolescents, caregivers, and educators in co-designing studies and interventions. Such approaches ensure cultural relevance and practical feasibility, particularly in resource-constrained settings.

A theoretical limitation that emerged in this study concerns the assumption embedded in many school-based mental health frameworks that teachers can serve as effective frontline supporters for learners experiencing suicidality or emotional distress. While the proximity of teachers to learners positions them as logical agents of support, this conceptual role often overlooks the severe structural and emotional challenges that educators face in the South African context. Research shows that a large proportion of teachers are experiencing burnout, emotional fatigue, and role overload (Buthelezi, 2025; Magubane, 2025), and many report limited preparation for managing the complex needs of learners in inclusive classrooms (Nthibeli & Griffiths, 2022). As such, models that assume teachers can be seamlessly integrated into psychosocial interventions without accounting for their well-being and training requirements risk overestimating the feasibility of implementation. Any intervention aiming to address adolescent suicidality must therefore critically examine and adapt its theoretical underpinnings to include both support for teachers and realistic expectations *of* them.

Lastly, school-based mental health programs remain critical, especially in light of unequal service provision across provinces. Research should assess how stigma, cultural beliefs, and infrastructural barriers affect the implementation and accessibility of these interventions and explore context-sensitive adaptations to support adolescents most at risk (Richter et al., 2022; Mkhize et al., 2024).

To conclude, these findings contribute not only to academic discourse but also offer insights to inform the development of contextually relevant mental health frameworks and inclusive, equity-focused suicide prevention strategies across policy and practice.

Future Considerations

Given the limitations of this study, there are several key considerations for future research aimed at enhancing the understanding of adolescent suicidality and mental health. Future studies should aim to include a larger and more diverse sample, incorporating participants from different geographical locations, socio-economic backgrounds, and school types. Including adolescents from a broader range of socio-economic settings would ensure that the findings are more generalizable and reflective of the challenges faced by South Africa’s diverse adolescent population. Moreover,

demographic variables such as race and socio-economic status should be integrated into research design to better understand how these factors influence mental health outcomes and suicidality.

The findings from this study suggest key associations between depression, anxiety, and suicidality, but causal relationships remain unclear. Future research should employ longitudinal designs to track adolescents over time and establish the directionality of these relationships. Understanding the progression of mental health challenges, and identifying early indicators of suicidality, would provide valuable insights into how interventions can be designed to reduce long-term risks. Longitudinal studies could also examine how mental health interventions implemented at different stages of adolescence influence outcomes over the course of several years.

This study highlighted the significant role of depression and anxiety in suicidality, but other factors, such as familial conflict, peer relationships, and bullying, also play crucial roles in shaping adolescent mental health. Future research should explore how these relational stressors interact with depression and anxiety to increase the risk of suicidality. Additionally, examining adolescents' coping mechanisms and resilience factors could provide important insights into protective factors that may buffer against suicidality. Strengthening coping skills and fostering resilience through targeted interventions could be a key strategy for prevention.

Given the issues with scale reliability in the current study, future research needs to focus on the development and pretesting of more reliable measurement tools. Accurate and valid tools for assessing suicidality and related mental health factors are crucial for capturing the complexity of adolescent mental health. Psychometrically robust measures will ensure that the data collected is both reliable and valid, enhancing the overall quality of the research.

Adolescent mental health issues are influenced by cultural and contextual factors, which means that research in South Africa could benefit from cross-cultural comparisons. Understanding how different cultural contexts impact mental health and how adolescents in various regions experience suicide risk will help inform culturally appropriate intervention strategies.

Furthermore, future research should investigate how societal attitudes toward mental health and the availability of mental health resources vary across regions and how these factors influence adolescent suicidality. Conclusively, evaluating the effectiveness of existing school-based mental health programs is critical. Future studies should assess how well these programs address suicidality and improve mental health outcomes for adolescents. By identifying successful interventions, researchers can inform policy and guide the development of more effective strategies to reduce suicidality. A multi-faceted approach that includes psychoeducation, peer support, and teacher training could be particularly effective in creating a comprehensive support system within schools.

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Appendices

22

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room 45 E-52-E-Floor- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-submissions uct.ac.za
Website: www.health.uct.ac.za home human-research-ethics

10 July 2024

HREC REF: 425/2024

Prof C Ward
Department of Psychology
Room 2.14 PD Hahn Building -FHS
Email: Catherine.ward uct.ac.za
Student: KGNMOL001@myuct.ac.za

Dear Prof Ward

PROJECT TITLE: A QUANTITATIVE CORRELATIONAL STUDY OF ADOLESCENT SUICIDALITY IN TWO GAUTENG SCHOOLS-
(MASTER OF ARTS IN PSYCHOLOGICAL RESEARCH-MISS MOLOKO KGANYAGO)

Thank you for your response letter dated 08 July 2024, addressing the issues raised by the Faculty of Health Sciences Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 July 2025.

Please submit a progress form, using the standardised Annual Report Form (FHS016) or FHS017 if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za fhs research humanethics forms)

The HREC acknowledge that the student: Miss Moloko Kganyago will also be involved in this study.

Please quote HREC REF 425/2024 in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

cs

Appendix B: Gauteng Education Department Approval letter

GAUTENG PROVINCE
Department: Education
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	18 June 2024
Validity of Research Approval:	08 February 2024– 30 September 2024 2024/151
Name of Researcher:	Kganyago MBM

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both principal and SGB) and the District/Head Office Senior Manager confirming that permission granted for the research to be conducted.

18/06/2024

The following conditions apply to the study. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

Appendix C: Approval letters from the schools

[REMOVED FOR CONFIDENTIALITY]

Appendix D: Support letter from SADAG

To Whom It May Concern:

MS M. KGANYAGO'S RESEARCH ON ADOLESCENT SUICIDALITY

We are delighted to hear that this research is taking place and look forward to being able to use the results to improve our service delivery.

We are aware that learners and their parents will be given our helpline number if they wish to seek further support.

Our work includes crisis stabilization, as well as a wide network of referral organisations. We are ideally placed to manage calls from parents or learners who would like assistance, and we stand ready to provide this assistance.

Yours faithfully

Appendix E: Parental consent form

PARENT CONSENT FORM

Dear Parent/Guardian

Invitation to your child to take part in a study of learners' wellbeing.

This study is about learners' mental health and wellbeing. Learners in Grades 10 and 11 will be invited to answer a survey.

We are asking your permission to invite your child to take part. Your child can choose to take part, or not to take part, there will be no problem either way.

No one will be able to tell who took part from the reports. There is a small risk that the questions may remind your child of difficult feelings. If this happens, they can contact:

The South African Depression and Anxiety Group (SADAG): 0800 567 567/ 0800 456 789 or they can send an SMS to 32312 for a call-back.

They can also call Childline 116 (Gauteng helpline) or go to www.childline.org

If you have any questions about this research, you may contact the following people:

Researcher, Moloko Kganyago, phone, email; Supervisor, Prof. Catherine Ward, phone, email.

If you have any questions or concerns about your child's rights as a research participant, you may contact:

The Department of Psychology Research Ethics Committee: Ms Mia Karriem: tel: [removed for confidentiality] or email: [removed for confidentiality]

The UCT Human Research Ethics Committee: tel [removed for confidentiality] or email: [removed for confidentiality]

If you are **WILLING** for your child to be invited to participate in this study, please let your school know by completing the section on the next page and sending the signed page back to the school. You may keep this page.

CONSENT FOR MY CHILD TO BE INVITED TO PARTICIPATE IN THE

By returning this form, I GIVE permission for my child (child's full name and

……
……

In Grade..... to be invited to take part in research about teen mental health.

……
……..

…….. ……
……

Signature of parent/legal

Appendix F: Assent form

Dear Learner

I am a Master's student in the Department of Psychology at the University of Cape Town (UCT).

We are inviting you to participate in a questionnaire to provide information to help develop new forms of mental health support for learners. The purpose of this study is to understand the mental health and wellbeing of adolescents.

We are interested in your views because you are in grade 10 or 11. This survey will take about an hour of your time to complete.

Please note that participation in the study is voluntary **(it is your choice)**. You can say you don't want to take part, or you can stop at any time or skip a question, without penalty.

Your school or your teachers, or your parents will not know what decision you make, and they will not see your answers.

Your participation in this study will be **anonymous** if you wish to withhold your name. Completed questionnaires will then be stored in locked filing cabinets, and electronic data in an encrypted file on a password-protected computer; and only the research team will be able to see it. Any reports about the study will only present averaged data from all the schools involved, and no one will be able to identify an individual learner from the reports.

If you agree to participate, please know that there are no direct benefits to participating in this study. You might however feel distressed by thinking about the difficulties in your life. Most people enjoy answering surveys like this one, but if you do feel distressed, you can contact SADAG, your schoolteacher, or ChildLine for support. Here are the toll-free numbers of these organizations:

South African Depression and Anxiety Group (SADAG): 0800 567 567/ 0800 456 78 9 OR you can send an SMS to 31393 and a counsellor will call you back.

Childline: 116. Alternatively, you can go to their website (www.childline.org.za) and click the chat option at the top; or send them a message on WhatsApp (using the 116 number) for an online counselling session, which is also free.

For any questions or concerns about the study, you can contact:

Moloko Kganyago, Phone:[removed for confidentiality] , email:[removed for confidentiality]

Professor Catherine Ward (supervisor): Phone:[removed for confidentiality] email:[removed for confidentiality]

If you have any questions about your rights as a research participant, you may contact the Department of Psychology Research Ethics Committee: Ms Mia Karriem: tel. [removed for confidentiality] or email [removed for confidentiality]

You can also contact the UCT Human Research Ethics Committee if you have a complaint or questions about your rights and welfare as the research subject. You may send an email [removed for confidentiality] or you can call this number:[removed for confidentiality] .

Your participation is greatly appreciated. Kind regards,

Moloko Kganyago

If you are **WILLING** to participate in this study, please write your name, surname as well as your grade in the spaces below. Once you have done this, please wait for the researcher to collect this paper before receiving the survey.

ASSENT TO PARTICIPATE IN THE

By signing this form, I (full name and surname) ..... in grade.. **AGREE** to participate in this study about teen mental health and well-being.

…… ……..

…… ……

…… ……

Signature of

Appendix G: Study survey

Please circle "yes" to proceed, or "no" to stop with the survey. **If you have circled "No", you may not continue completing the survey.**

Y

es

No

If you have circled "Yes", Thank you for choosing to answer the survey. For each question, choose the answer that best fits you. This is not a test: there are no right or wrong answers- just choose the answers that are closest to how you feel.

Please start by answering the following questions about yourself.

1. How old are you?_____
2. Do you identify as male, female, transgender, non-binary, gender neutral or other? (please circle your answer)
3. Which school are you at?_____
4. What grade are you in?_____
5. In general, how would you say you do in school? (Please tick "√" or place an "x" on the appropriate response below)

Well above average	**Somewhat above average**	**Average**	**Somewhat below average**	**Well below average**	**I choose to not answer**
1☐	2☐	3☐	4☐	5☐	6☐

Section 1

The next few questions are about how you see your future (or how you imagine your life after high school will be). Please indicate using the scale of very low (1), low (2), 50-50 (3), high (4), and very high (5) to indicate what the chances of the following questions coming true are using either a tick "√" or a cross "X" to your answer:

What are the chances that….

	Very low	Low	50-50	High	Very high	I choose to not answer
1.1 You will complete high school?	☐	☐	☐	☐	☐	☐
1.2 You will go to college/ university	☐	☐	☐	☐	☐	☐
1.3 You will have a job that pays well?	☐	☐	☐	☐	☐	☐
1.4 You will have a happy family life?	☐	☐	☐	☐	☐	☐
1.5 You will stay in good health most of the time?	☐	☐	☐	☐	☐	☐
1.6 You will find a job you enjoy?	☐	☐	☐	☐	☐	☐
1.7 You will succeed in doing what is important to you?	☐	☐	☐	☐	☐	☐

Section 2

The next questions are about how you have been feeling in the past 30 days. Please choose either "true" or "false" or "I choose to not answer". Please choose **ONE** answer **per question** that applies to how you have been feeling.

In the past 30 days:

	True	**False**	**I choose not to answer**
2.1 I did not feel like eating; my appetite was poor.	☐	☐	☐
2.2 I felt that I could not shake off my sad feelings even with help from family or friends.	☐	☐	☐
2.3 I felt hopeful about the future.	☐	☐	☐
2.4 I felt lonely.	☐	☐	☐
2.5 I enjoyed doing things.	☐	☐	☐
2.6 I felt like crying.	☐	☐	☐
2.7 I felt really down.	☐	☐	☐
2.8 I felt that people liked me.	☐	☐	☐
2.9 I felt that many bad things were my fault.	☐	☐	☐
2.10 I was tired.	☐	☐	☐
2.11 I have lost my interest in other people or things.	☐	☐	☐
2.12 It was easy for me to make decisions.	☐	☐	☐
2.13 I didn't like myself.	☐	☐	☐
2.14 I felt bothered by people and things.	☐	☐	☐
2.15 I felt confident.	☐	☐	☐

Section 3

In the past 30 days:

	rue	**Fals e**	**I choose t o not answer**
3.1 I try to be nice to other people. I care about their feelings		☐	☐
3.2 I am restless. I cannot stay still for a long time.		☐	☐
3.3 I get a lot of headaches, stomach-aches or sickness.		☐	☐
3.4 I usually share with others, for example devices, games and food.		☐	☐
3.5 I get very angry and often lose my temper.		☐	☐
3.6 I would rather be alone than with people my age.		☐	☐
3.7 I usually do what I am told.		☐	☐
3.8 I worry a lot.		☐	☐
3.9 I am helpful if someone is hurt, upset or feeling ill.		☐	☐
3.10 I am constantly fidgeting or squirming.		☐	☐
3.11 I have one good friend or more.		☐	☐
3.12 I fight a lot. I can make other people do what I want.		☐	☐
3.13 I am often unhappy, depressed or tearful.		☐	☐
3.14 Other people my age generally like me.		☐	☐
3.15 I am easily distracted. I find it difficult to concentrate		☐	☐
3.16 I am nervous in new situations. I easily lose confidence.		☐	☐
3.17 I am kind to younger children.		☐	☐
3.18 I am often accused of lying or cheating.		☐	☐
3.19 Other children or younger people pick on me or bully me		☐	☐
3.20 I often offer to help others (parents, teachers, children).		☐	☐

	rue	**Fals e**	**I choose t o not answer**
3.21 I think before I do things.		☐	☐
3.22 I take things that are not mine from home, school, or elsewhere.		☐	☐
3.24 I get along better with adults than with people my age.		☐	☐
3.25 I have many fears. I am easily scared.		☐	☐
3.26 I finish the work I'm doing. My attention is good.		☐	☐

Section 4

The next three questions are about whether you have felt like hurting yourself. Please answer as truthfully as you can. Please choose "yes" if you agree with the question and then choose "no" if you disagree or you can choose to not answer.

		es	N o	I choose to not answer
.1	During the past *12 months*, did you ever seriously think about harming yourself in a way that may result in your death?		☐	☐
.2	During the past *12 months*, did you ever try to put an end to your life?		☐	☐
.3	During any of your attempts, did you really want to die?		☐	☐

Section 5

The following questions are about your parents as well as the relationship you have with them. If you do not have biological parents, please think of the person who is like a mother or a father to you.

Please choose "yes" if you agree, and "no" if you disagree, and "if you choose to not answer" tick in the appropriate box.

	Yes	No	I choose to not answer
Is your biological mother alive?	☐	☐	☐
If YES, does your biological mother live in your household?	☐	☐	☐
Is your biological father alive?	☐	☐	☐
If YES, does your biological father live in your household?	☐	☐	☐

Please choose the answer that is true to you. If you do not have a biological mother, please think of the person who is like a mother to you.

You can only select one option for each question. Please place a "√" in the appropriate box.

My mother is a person who

	Never	Rarely	Sometimes	Often	Choose to not answer
5.1 Makes me feel better after talking over my worries with him/her.	☐	☐	☐	☐	☐
5.2 Is always trying to change how I feel or think about things.	☐	☐	☐	☐	☐
5.3 Changes the subject whenever I have something to say.	☐	☐	☐	☐	☐
5.4 Often interrupts me.	☐	☐	☐	☐	☐
5.5 Enjoys doing things with me	☐	☐	☐	☐	☐
5.6 Brings up past mistakes when she/he criticizes me.	☐	☐	☐	☐	☐
5.7 Gives me a lot of care and attention.	☐	☐	☐	☐	☐
5.8 Is less friendly with me if I do not see things his/her way.	☐	☐	☐	☐	☐
5.9 Will avoid looking at me when I have disappointed them.	☐	☐	☐	☐	☐

5.10 Believes in showing his/her love for me.	☐	☐	☐	☐	☐
5.11 If I have hurt his/her feelings, stops talking to me until I please him/her again.	☐	☐	☐	☐	☐

Please choose the answer that is true to you. If you do not have a biological father, please think of the person who is like a mother to you. You can only select one option for each question. Please place a "√" in the appropriate box:

My Father is a person who:

	Never	Rarely	Sometimes	Often	Choose to not answer
5.11 Makes me feel better after talking over my worries with him/her.	☐	☐	☐	☐	☐
5.12 Is always trying to change how I feel or think about things.	☐	☐	☐	☐	☐
5.13 Changes the subject whenever I have something to say.	☐	☐	☐	☐	☐
5.14 Often interrupts me.	☐	☐	☐	☐	☐
5.15 Enjoys doing things with me	☐	☐	☐	☐	☐
5.16 Brings up past mistakes when she/he criticizes me.	☐	☐	☐	☐	☐
5.17 Gives me a lot of care and attention.	☐	☐	☐	☐	☐
5.18 Is less friendly with me if I do not see things his/her way.	☐	☐	☐	☐	☐
5.19 Will avoid looking at me when I have disappointed them.	☐	☐	☐	☐	☐

5.20 Believes in showing his/her love for me.	☐	☐	☐	☐	☐
5.21 If I have hurt his/her feelings, stops talking to me until I please him/her again.	☐	☐	☐	☐	☐

Section 6

Some families have a lot of arguments. The next set of questions is about arguments you may have experienced or witnessed at home. Please either choose “yes” or “no” or “choose not to answer” by placing a “√” in the appropriate box.

	Yes	No	I choose not to answer
6.1 Have you ever seen a parent hit, beat, kick, or physically hurt you, your brothers, or sisters, (this does not include spanking on the bottom)?	☐	☐	☐

6.2 Did one of your parents threaten to hurt another parent and it seemed they might really get hurt?	☐	☐	☐
6.3 At any time in your life, did one of your parents, because of an argument, break, or ruin anything belonging to another parent, punch the wall, or throw something?	☐	☐	☐
6.4 At any time in your life, did one of your parents get pushed by another parent?	☐	☐	☐
6.5 At any time in your life, did one of your parents get hit or slapped by another parent?	☐	☐	☐
6.6 At any time in your life, did one of your parents get kicked, choked, or beat up by another parent?	☐	☐	☐
6.7 Now we want to ask you about fights between any grown-ups (adults) and teens, not just between your parents. At any time in your life, did any grown-up (adult) or teen who lives with you push, hit, or beat up someone else who lives with you, like a parent, brother, grandparent, or other relative?	☐	☐	☐

Section 7

Now we are going to think about school: Tick the most appropriate box about how you feel about school for each question.

	Not true	Neutral	True	I choose to not answer
7.1 I like most of my teachers this year	☐	☐	☐	☐
7.2 Teachers at my school hit the learners	☐	☐	☐	☐
7.3 I like school	☐	☐	☐	☐
7.4 I feel safe at my school	☐	☐	☐	☐
7.5 There is a lot of conflict between teachers and learners at my school	☐	☐	☐	☐

Section 8

The next set of questions is about substance abuse (alcohol or drugs). Please answer by choosing either “yes” or “no” or “choose to not answer”.

	Yes	No	I choose to not answer

8.1 Have you ever gotten into trouble while you were using drugs or alcohol?	☐	☐	☐
8.2 Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	☐	☐	☐
8.3 Do you ever use alcohol or drugs while you are by yourself (alone)?	☐	☐	☐
8.4 Do you ever forget things you did while using alcohol or drugs?	☐	☐	☐
8.5 Do your family or friends ever tell you that you should cut down on your drinking or drug use?	☐	☐	☐
8.6 Have you ever ridden in a car driven by someone (including yourself) who has high or had been using alcohol or drugs?	☐	☐	☐

Section 9

These next questions are about bullying at school (and online) during the course of the year. Please pick the answer that is most applicable to your/ your experience

During the school year, other kids in school…

	Not at all	Once	2-3 times	4 times or more times	I choose to not answer
9.1 Called me names or swore at me	☐	☐	☐	☐	☐
9.2 Tried to get me into trouble with my friends	☐	☐	☐	☐	☐
9.3 Took something without permission or stole things from me	☐	☐	☐	☐	☐
9.4 Made fun of me for some reason	☐	☐	☐	☐	☐

9.5 Made me uncomfortable by standing too close or touching me	☐	☐	☐	☐	☐

9.6 Punched, kicked, or beat me up	☐	☐	☐	☐	☐
9.7 Hurt me physically in some way	☐	☐	☐	☐	☐
9.8 Tried to break or damaged something of mine	☐	☐	☐	☐	☐
9.9 Refused to talk to me or made other people not talk to me	☐	☐	☐	☐	☐

Section 10

Please answer these questions by either choosing “yes” or “no” or “choose to not answer At any time in your life…

	Yes	No	I choose to not to answer
10.1 Had an online “fight” with someone where angry and rude language was sent in a chat room or on a social network page via the computer or mobile phone?	☐	☐	☐
10.2 Have you had rude, offensive and insulting messages repeatedly being sent to you via computer or mobile phone?	☐	☐	☐
10.3 Has someone ever sent or posted cruel and harmful rumours about you with the intention of damaging your friendship or reputation?	☐	☐	☐
10.4 Had someone sharing your secrets or embarrassing pictures or information about you online with others without your permission or knowledge?	☐	☐	☐
10.5 Have you been threatened with harm or intimidated repeatedly by someone online (via the computer or mobile phone)?	☐	☐	☐
10.6 Has someone ever used your account and then pretended to be you by sending messages to others online trying to ruin your friendships or reputation, to hurt you, or	☐	☐	☐

Section 11

This next section is about your feelings about your friends.

	Almost Never or Never True	Not Very Often True	Sometimes True	Often True	Almost Always or Always True	I choose to not answer
11.1 My friends can tell when I'm upset about something.	☐	☐	☐	☐	☐	☐
11.2 When we discuss things, my friends care about my point of view.	☐	☐	☐	☐	☐	☐
11.3 Talking over my problems with friends makes me feel ashamed or foolish.	☐	☐	☐	☐	☐	☐
11.4 I wish I had different friends.	☐	☐	☐	☐	☐	☐
11.5 My friends understand me.	☐	☐	☐	☐	☐	☐
11.6 My friends encourage me to talk about my difficulties.	☐	☐	☐	☐	☐	☐
11.7 My friends accept me as I am.	☐	☐	☐	☐	☐	☐
11.8 I feel the need to be in touch with my friends more often.	☐	☐	☐	☐	☐	☐

	Almost Never or Never True	Not Very Often True	Sometimes True	Often True	Almost Always or Always True	I choose to not answer
11.9 My friends don't understand what I'm going through these days.	☐	☐	☐	☐	☐	☐
11.10 I feel alone or apart when I am with my friends.	☐	☐	☐	☐	☐	☐
11.11 I feel my friends are good friends.	☐	☐	☐	☐	☐	☐
11.12 My friends are fairly easy to talk to.	☐	☐	☐	☐	☐	☐
11.13 My friends care about how I am feeling	☐	☐	☐	☐	☐	☐
11.14 I can count on my friends when I need to get something off my chest.	☐	☐	☐	☐	☐	☐
11.15 I trust my friends.	☐	☐	☐	☐	☐	☐

Section 12

These next few questions about your neighbourhood (where you currently live). Please tick either "yes" or "no" or "I choose to not answer" to describe your neighbourhood and how you feel about it.

	Yes	No	I choose to not answer
12.1 I would like to get out of my neighbourhood.	☐	☐	☐
12.2 I like my neighbourhood.	☐	☐	☐
12.3 I feel safe in my neighbourhood	☐	☐	☐
12.4 There is crime in my neighbourhood	☐	☐	☐
12.5 There are fights in my neighbourhood	☐	☐	☐
12.6 There is drug selling in my neighbourhood	☐	☐	☐

Section 13

We would like to know what you thought of this questionnaire.

13.1 How important were the questions?

Not too important ☐	**Very important** ☐	**Important** ☐

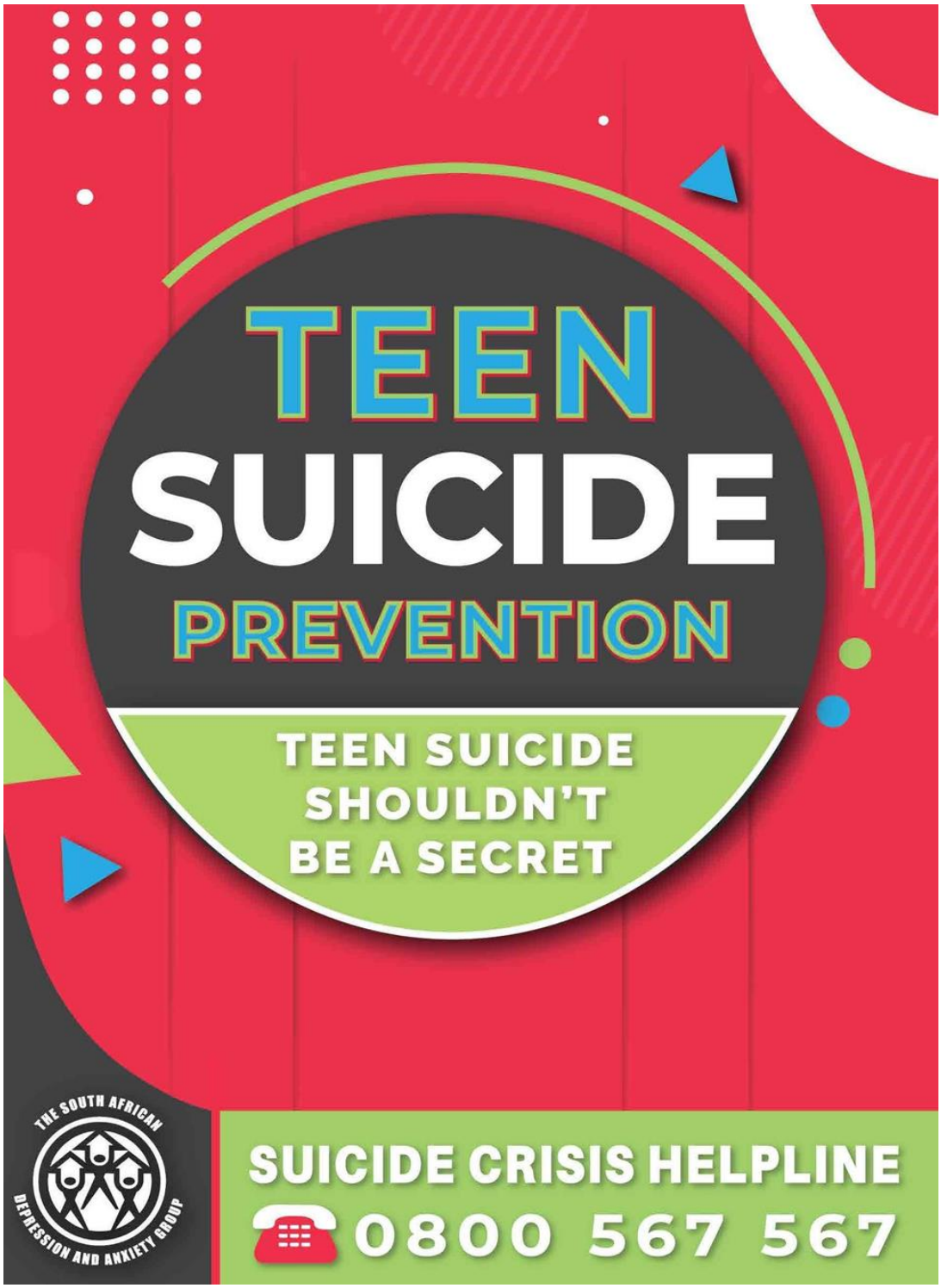
13.2 How honest were you in filling out this survey?

I was very honest ☐	**I was honest pretty much of the time** ☐	**I was honest some of the time** ☐	**I was honest once in a while** ☐	**I was not honest at all** ☐

Thank you very much for completing this survey!

You are helping us understand more about the lives of young people

Appendix H: SADAG suicide prevention brochure



TEEN SUICIDE PREVENTION

Being a teenager:

often means having lots of **emotional** ups and downs. School, parents, friends, relationships can be confusing and frustrating - things can be great one minute and horrible the next. Many people believe that sadness is just a normal part of growing up, but teens who feel really down and unhappy for two weeks or more at a time may have Depression.

Many teens get Depression, if you or a friend feels down, you are not alone. Depression is a "whole-body" illness that involves your body, mood and thoughts. It affects the way you feel about yourself, and the way you think about things.

Depression is not a sign of weakness, it can't be wished away, and people with Depression cannot just pull themselves together. The good news is people, who suffer from Depression can get better with the correct treatment so there is no need to feel this way. Take a look at the list and mark the things that describe your thoughts, feelings, or actions in the last two weeks.

If you have four or more of these feelings, and it lasted longer than two weeks?

- ☐ I feel guilty; I have no confidence?
- ☐ I feel I am a failure or have let my family down?
- ☐ I have lost interest in my hobbies. Most of the time I would rather be alone?
- ☐ I often feel restless or tired?
- ☐ I have trouble concentrating on things like homework or watching TV?
- ☐ I have trouble sleeping or I sleep too much?
- ☐ My appetite has increased or decreased?
- ☐ I have unrealistic ideas about the great things that I am going to do?
- ☐ My thoughts race. I can't slow my mind down?
- ☐ I often think about death. Thoughts about suicide pop into my mind?
- ☐ I use drugs and/or alcohol on a regular basis?

☑ **You may have Depression**

What causes Suicide?

There are many reasons why a teen may feel like they want to end their life.

1. **Depression -** is the leading cause of suicide. Depression makes people feel hopeless, helpless and often they see no reason
2. **Alcohol and Drug Use -** is often connected to suicide. Alcohol & drugs can actually add to Depression, and make it worse in depressed people. They also affect your judgement, and lessen self-control.
3. **Bullying -** is a common problem in schools and many children & teens who are bullied feel worthless and hopeless. Being bullied can make people feel depressed and sadly many teens who are targets of physical or cyber bullying attempt suicide or become very depressed.
4. **Self-harm -** many people believe that teens who hurt or injure themselves are suicidal. This isn't always true. People hurt themselves as a way to cope with problems. This isn't a healthy way and there is help!

How to talk to someone who may be feeling or thinking about Suicide

- ○ Stay connected to the story being shared
- ○ Help them stay calm by speaking softly and taking deep breaths together
- ○ Make sure that you are in a place to have a deeper conversation
- ○ "I've noticed you haven't been yourself lately, are you okay? Let's talk about it?"
- ○ Give them time to share at their own pace without passing judgment
- ○ Check in often. If struggling persists find help together and reach out to us
- ○ Remember, their feelings matter - and they feel very real and scared
- ○ Listen, ask questions and try to understand what they are dealing with
- ○ Ask them directly if they have any thoughts or plans of suicide

MY SAFETY PLAN

When thoughts of Suicide are overwhelming, staying safe takes a great deal of strength. A safety plan is something to use during those crisis times. It's not a cure to the issues and feelings you are suffering, but it will give you the time to seek professional help. Keep it near you to keep you safe!

EMERGENCY CONTACTS:

If things get too much and you can't distract yourself with the self-help measures, here is a list of your people that you know who will be there for you when you need them most:

Name _____ **Contact number** _____

Name _____ **Contact number** _____

Name _____ **Contact number** _____

Activities to help me feel better:

My go-to coping hobbies are (e.g. playing sport, art, reading a book, taking a walk, listening to music, etc.)

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Places I feel most safe:

List the places you feel safe and can get help: e.g. your best friends home or your school counsellors office.

1 _____

2 _____

3 _____

4 _____

5 _____

YOU ARE NOT ALONE

0800 567 567

REACH OUT TO US FOR SUPPORT

www.sadag.org **(8am – 5pm) 076 882 2775**