Assessment of Suicidal Thoughts among the Youth: The Case of Scottish Livingstone Hospital

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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ABSTRACT

This is a qualitative study which assessed suicidal ideation among the youth in the Kweneng district of the Republic of Botswana. It adopted the descriptive and exploratory research design following the probability sampling procedures and, the simple random sampling techniques to select a sample of 21 respondents. The respondents were selected based on their knowledge of factors influencing youth's suicidal ideation and those that contribute to suicidal ideation. It was established that the following factors: mental health problems (depression), behavioral problems (e.g drug and alcohol abuse) personality traits (maladaptive coping skills), and terminal illness and health conditions contributed to youth's suicidal thoughts. It was further discovered that available services to suicidal clients are not adequate and there is shortage of staff. It was also discovered that the psychosocial interventions were not fully utilized because many clients got to know about them by the time they were admitted. It is recommended that the health policy or guidelines and/or programs should address suicidal problems amongst the youth. Furthermore, future researchers should focus more on existing gaps in service provision and their impacts on suicidal ideation.

1. INTRODUCTION

Social work profession works with individuals, families, groups, and communities to enhance and restore social functioning. According to Mansaray and Stark [1] social work is defined by the International Federartion of Social Work (IFSW) as a practice-based profession and

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academic discipline that promotes social change and development, social cohesion and empowerment and liberation. This means social workers handle different kinds of problems affecting clients to bring about change into clients' lives. These problems include loss and grieve, child abuse, domestic violence and mental health problems including suicidal ideation. This study was prompted by the suicidal ideation expressed by the youth who visited the hospital as a major concern in their lives. Suicidal ideation is the desire to take one's own life and it is caused by different social, physical, genetic, neurobiological, and psychological factors [2]. Therefore, it is imperative for clinical social workers to understand the factors that influence suicidal ideation, and how they could be addressed effectively.

Globally suicidal ideation is a social and health concern that features across the lifespan. According to Saraceno, Mc Elligott & WHO [3] it is estimated that over a million people die by suicide every year. It is widely believed that the true number of self-inflicted deaths is higher due to underreporting in many countries. This indicates how alarming the suicidal ideation rate is around the world, and it calls for social workers to research it and intervene appropriately. In many African countries, suicidal ideation is often not documented or is underreported [4,5], and research on suicidal behavior is limited [6]. International research examining suicide ideations among the youth, for example, in Australia, indicated that it is the leading cause of death across all age groups. As such, suicidal thoughts and behaviors among youth warrant particular concern for numerous reasons. In Botswana also, suicidal ideations have severely affected the youth as it has increased at a scaring rate. According to the Scottish Hospital records [7] suicidal ideation cases reached 310 in 2019 and doubled in 2020. This calls social workers to pay more attention to the mental health phenomenon amongst the youth population.

2. STATEMENT OF THE PROBLEM

Suicidal ideation is not unique to Botswana. Research in Australia has shown that many young people commit or attempt suicide in their lifetime [8]. Suicide is a leading cause of death in Australia across all age groups, and as such, suicidal thoughts and behaviors among youth warrant particular concern for several reasons. According to WHO [9] suicide death accounts for 8.5% of all deaths among youth (15–29 years) around the world and a leading cause of death compared to other situations, such as car accidents, drug, and alcohol abuse. Each year, approximately 800,000 people die by suicide worldwide and young people are the most affected [9]. One of the reasons is that the sharpest increase in the number of suicide deaths throughout the lifespan occurs around the young-adulthood stage [10,9]. Secondly, suicide ranks higher as a cause, of death during the youth stage compared to other developmental stages.

In America suicide is considered the third leading cause of death among Black American youth aged 15–24 years, after homicides and accidents [11]. Accordingly, the suicide rate for young Black American youth was 2.68 per 100,000 [3] compared to non-Black Americans. Further, research has revealed that 42% of Black American college students reported experiencing suicidal ideation and 8% had engaged in suicide attempts in the past 12 months [11,12]. Statistics indicate that college-aged individuals, particularly Black college students appear to have a relatively high risk for suicidal behaviors compared to nonblack American. As such, college students' suicidality has become a greater concern because of an increasing number of students reporting their suicidal attempt [13]. Despite color, race or complexion, suicide ideation does not discriminate as the statistics above indicate.

In Africa, the annual suicide incidence rate is estimated at 3.2 per 100,000 people [14]. This means that even in Africa, rates of suicide have gone high. Suicidal behavior is a process, and it evolves through a continuum ranging from thoughts about suicide and an attempt to take one's life successfully. Studies on suicide indicate that cases of completed suicides are higher for males than females while suicidal ideation (SI), attempted suicides, and suicidal threats are higher among females [15,16]. Suicidal ideation is not only a health problem in Australia but also in many other countries. The reason is that people, who are unable to cope with life changes, end up experiencing suicidal thoughts which negatively change their perspectives (a desire to take their lives). Mostly the thoughts of ending one's life are higher among males than females.

The United Nations, for statistical purposes, defines 'youth', as those persons between the

ages of 15 and 24 years, without prejudice to other definitions by Member States [17]. Botswana Revised National Youth Policy [18] defines youth as persons of ages 15-35 years. According to Letamo, & Mokgatlhe, [19] the Botswana AIDS impact Survey (2008) shows that youth were faced with several challenges which included unemployment and HIV/AIDS which accounted for 25.9% of illnesses among them. These situations may contribute to youths experiencing suicidal thoughts because of prolonged stress, consequently depressed. The more they are depressed the more they think that the only solution to their problems is death. According to Botswana Police Statistics, a total of 783 cases of both attempted and completed suicide were reported [15]. This indicates seriously that suicidal thoughts might have a negative impact on both individuals and the community at large. On the other hand, suicide is not the leading cause of death in Botswana compared to Australia and the United States of America.

In 2017 Botswana Police Service indicated that 174 people committed suicide compared to 199 registered cases during the same period in 2016. Botswana Police Public Relations Officer, said after years of increasing cases of suicide, the suicide rate in the country has declined. It was further explained that this problem affected all age groups [20]. In addition, the Botswana daily news of 3rd November [21] indicated that an average of 312 people commit suicide annually in Botswana, and that over the past 10 years 3170 people committed suicide in the country. As such, a study that assesses suicidal thoughts amongst youth in Botswana is relevant because the Covid-19 pandemic has complicated youth lives as they have unemployment, depression, and life pressures. There are no guidelines that address suicide in Botswana but instead they have adopted the WHO Mental Health Gap Action Programme (MH GAP) which aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle-income [22]. It carefully asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, and averted from suicide to lead normal lives even where resources are scarce [22].

3. LITERATURE REVIEW

The literature seeks to shed some light concerning factors contributing to youth's suicidal thoughts, and describe services available for youth with suicidal thoughts, identify relevant psychosocial interventions for suicidal youths, and identify appropriate service provision for youth with suicidal thoughts to reduce their suicidal thoughts. The factors that contribute to youth's suicidal thoughts include mental health problems (depression), behavioral problems (drug and substance abuse), terminal illnesses and health conditions such as HIV/AIDS, and previous traumatic life experiences such as war events. Discovering the existence of factors that contribute to suicide has led researchers and therapists to further look for protective factors that prevent or reduce the risk of suicide.

3.1 Mental Problem

One may ask what triggered/instigated attempts or suicidal thoughts. Mental illness is an actual common factor which influences people having suicidal thoughts. According to Almeida, Draper, Snowdon, et al [16] eight respondents argued that their suicidal ideation was part of their mental illness. While five respondents argued that their thoughts of killing themselves were not their real or own thoughts, but rather the thoughts caused by their illness. "To articulate this point K posted, 'I am my brain, my brain is me. When it is not functioning well, it tells me lies', while F wrote, 'I had no control over the constant repetitive thoughts I heard. But the thoughts I have when depressed are likewise not my thoughts was deluded; under the influence of this disease' to explain her view. This was mentioned by the respondent of a study carried out by Osvaldo et al [16] in Britain.

3.2 Depression

Depression is an actual mutual mental health problem worldwide. The World Health Organization estimates that 121 million people currently suffer from depression, with 5.8% of men and 9.5% of women experiencing depressive episodes in any given year [3]. The high rates of depression are a cause of concern that mood disorders (of which depression is the major example) are the most common psychiatric condition associated with suicide. It is important to note, that depression encompasses a wide range of experiences and illness from mild to severe, transient to permanent, and the risk of suicide varies substantially with the type of depression. Swedes' adolescents with bipolar disorder are said to be at risk of completed suicide [23]. A study on Swedish adolescents,

found that majority of them made at least one medically significant suicide attempt. They found that depression in schizophrenia may be related to the fact that young people felt that they were falling apart and becoming mentally ill, and there is indeed evidence that suicidality and depression in these patients is related to good premorbid function, better insight, higher intelligence, and preservation of cognitive function [24].

According to Almeida et al, [16] the respondents reported that their suicidal thoughts emerged as a response to social stressors. The social stressor resulted from the deaths of family members who committed suicide way back. During this time, they experienced their closest encounters with wanting to kill themselves. They also mentioned that their social stressors came in the form of loss or change, including the loss of relationships, jobs, or changes in social connections in school or university. In Botswana, the level of youth unemployment has increased to 37.28% from 24.5% [25]. This might affect the youth negatively and might lead to depression complicated by poverty. Instead of being positive they exhibit narrow negative mindedness that considers suicide as the best solution. Korb & Plattner [26] argues that a positive relationship exist between depression and suicide ideation. They further argue that the higher the academic pressure for UB students the more they are depressed hence being suicidal. This emphasizes that life experiences of the youth who encounter academic pressure develop suicide ideation.

3.3 Behavioral Problems

A study by [15] of the 1669 University of Botswana students, found that suicide ideation was reported to be very often in 2.3 % of the subjects, and often in 3.1%, while suicide ideation was sometimes felt by 29.6%. With reference to suicide attempts, 12.5 % had attempted suicide and more females, 14.8%, compared to males 9.9%, and had attempted suicide. Factors that contributed to suicide ideation were academic failure, disappointment in family relationships, and fear of losing an intimate partner. Due to their situations, they were unable to control themselves but continued thinking about suicide. This indicates that if one is unable to control his/ her behavior due to failure, fear of losing loved ones, and other circumstances he or she may end up having suicidal thoughts [26]. The following are the behavioral problems:

3.4 Drug & Substance Abuse

Drug and alcohol abuse are some of the behavioral problems that contribute to people's suicidal thoughts. While most research efforts continue to cluster in North American and Western Europe, the World Health Organization (WHO) mortality estimates found the highest rates of youth suicide deaths worldwide in non-Western countries [9]. In the United States, approximately 17% of men and 8% of women engage in problematic drinking [27]. The problem drinking, results with significant morbidity and mortality (79,000 deaths ⁄year; DC, 2008) [28]. Despite the prevalence and profound consequences of alcohol addiction, empirically supported psychosocial alcohol interventions have widely varying outcomes [29]. Many people abuse drugs and substances which negatively manipulate their ways of thinking to the extent they become suicidal.

3.5 Bullying

In the United States of America strong evidence identifies bullying (i.e. peer victimization) as a risk factor for suicidal thoughts and behaviors among youth. Bullying consists of intentionally harmful behavior that is repeated and invokes a power differently. Longitudinal studies have demonstrated the impact of social exclusion, verbal / physical abuse, and coercion by peers during childhood and early adolescence on later suicidal ideation, suicide attempt, and suicide death [30-32]. It is one of the factors which contribute to youth suicidal thoughts. In Asia, cross-sectional studies have demonstrated that both perpetration and victimization from cyberbullying were associated with suicidal ideation and attempts [33-35]. It is indeed a contributing factor that people should pay attention to. In Botswana, some bullies express the explosive pain in their hearts without being aware of the consequences but realize when they are in trouble; they become pessimistic to the extent that they have suicidal thoughts. Others bullies because of fear of being called cowards, especially men, after beating women half dead they try to solve the problem by committing suicide [26].

3.6 Personality Traits

This involves the maladaptive coping skills, problem solving techniques, and pessimistic attitudes. Asante et al, [36] argues that the major reason for suicidal thoughts is the lack of proper

guidance to cope with the physical and emotional changes across age stages of development. It is very common to engage in maladaptive and risky behavior to meet challenges which may lead to poor mental as well as physical health. According to [37] Canadian youth experience makes them get involved in the use of drugs and substances as a way of coping with violence at home. In Botswana youth become more involved in the use of drugs and substances as a way of coping with poverty, unemployment, and life experiences [26].

3.7 Services for Youth with Suicidal Thoughts

3.7.1 Health care services

Suicide is one of the priority conditions in the WHO Mental Health Gap Action Programme (MH GAP) launched in 2008. It provides evidence-based technical guidance to scale up service provision and care for mental, neurological, and substance use disorders. In the WHO [36] Mental Health Action Plan 2013–2020, Member States have committed themselves to working towards the global target of reducing the suicide rate by 10% by 2020. In addition, the suicide mortality rate is an indicator of target 3.4 of the 2030 Sustainable Development Goals: which seek to reduce by one third premature mortality rates from non-communicable diseases through prevention, treatment, and promote mental health and well-being. This indicates that services offered globally should be up to standard to reduce this mental health problem. In Botswana, health care services consider suicidal thoughts as a health problem that need to be a priority. They offer counselling and admit a client who confirms that he or she will commit suicide if she or he goes back home: But if the client promises not to commit suicide he or she is allowed to go home despite being suicidal.

According to the Botswana Daily news of 3rd November [21] the Botswana Psychiatric Association (BPA) president has called on government to develop a national strategy on suicide prevention. Speaking at the World Mental Health Day commemoration in Lobatse recently, Dr Mpho Thula said it was important to have a national strategy providing guidance on how to reduce the rate of suicide deaths in Botswana. Strategy would force the government to commit resources to make sure that access to mental health services is improved in Botswana. Availability of mental health service facilities

around the country would result in better assistance to people with mental disorders, which would lead to a reduction in suicide cases. This indicates that services may not be adequate for these clients along with the resources.

3.7.2 Counselling

According to Singer & Slovak, [38] counselling is the best intervention service provided to suicidal youth. The social workers and psychologist play an integral part in the provision of mental health and crisis intervention services in schools and has reduced numbers of suicidal rates amongst the youth. However, it shows that counselling is provided for any kind of suicidal client because it helps the client to switch the mind from negative to positive thinking. It helps the client to identify the root cause of their problems. On the other hand, some professionals do not conduct thorough counselling and follow ups to check on the client coping and ensure that clients know that services are meant for their good [39].

3.8 Education Services

These are vital services for the youth to learn about their health problems. Only two interventions have been shown to prevent deaths by suicide [40] and only one form of psychotherapy is shown to prevent suicide attempts in more than one clinical trial [41]. However, education is the remedy of reducing suicidal thoughts in the community because the more people are taught the positives and negatives of these health problems the more, they resolve their problems effectively. It is also the key to obtain the mental health federation goals. In a nutshell there is inadequate literature concerning youth experiencing suicidal thoughts.

4. THEORETICAL FRAMEWORK

The study used interpersonal psychological theory by Thomas E Joiner and psychosocial development theory. The theory of interpersonal psychological theory of suicidal behavior was invented by Thomas E. Joiner in 2005 and outlined in "Why people die by suicide." Thomas was born in 1965 on the 7th of June in Atlanta USA and he is still alive at the age of 55 years. However, Mr. Joiner is well known for interpersonal theory of suicide. The theory focuses on attempts to explain why individuals engage in suicidal behavior and to identify individuals who are at risk. The theory consists of three components that together lead to suicide

attempts. Joiner [42] argues that the simultaneous experience of thwarted belongingness and perceived burdensomeness motivates the desire for suicide. While the desire for suicide is necessary, it alone will not result in death by suicide. Rather, Joiner asserts that one must also have acquired capability (that is, the acquired ability) to overcome one's natural fear of death.

According to [42] perceived burdensomeness is the view that one's existence burdens family, friends, and society. This view raises the idea that "my death will be worth more than my life to family, friends, society, etc." is important to emphasize, that represents a potentially fatal misperception. Past research, though not designed to test the interpersonal-psychological theory, nonetheless has documented an association between higher levels of perceived burdensomeness and suicidal ideation [43]. For instance, found that perceived burdensomeness toward family was correlated with suicidal ideation among community participants and high-suicide-risk groups.

4.1 Low Belonging/Social Alienation

A low sense of belongingness is the experience that one is alienated from others, not an integral part of a family, circle of friends, or another valued group. Van Orden, Witt, Bender, and Joiner, [44] acknowledges that there is abundant evidence that this factor is implicated in suicidal behavior. However, relatively little of this evidence derives from direct tests of the interpersonal-psychological theory. Indeed, a persuasive case can be made that, of all the risk factors for suicidal behavior, ranging from the molecular to the cultural levels, the strongest and most uniform support has emerged for indices related to social isolation [45].

4.2 Acquired Ability to Enact Lethal Self-Injury

While feelings of burdensomeness and low belongingness may instill a desire for suicide, they are not sufficient to ensure that desire will lead to a suicide attempt indeed, for this to occur, the theory suggests a third element must be present: the acquired ability for lethal self-injury which suggests that suicide entails a fight with self-preservation motives. Thomas Joiner [42] self-preservation influence individuals to develop the desire to die. The basis for this proposition rests primarily on the principles of opponent-process theory, which suggests that with

repeated exposure to an affective stimulus, the reaction to that stimulus shifts over time such that the stimulus loses its ability to elicit the original response and, instead, the opposite response is strengthened [46]. This results in habituation and, in turn, a higher tolerance for pain and a sense of fearlessness in the face of death. So, the past suicidal behavior will habituate individuals to the pain and fear of self-injury, making future suicidality, on average, more likely.

4.3 Psycho-social Development Theory

Erik Erikson [47] was an ego psychologist who developed one of the most popular and influential theories of development. While his theory was influenced by psychoanalyst Sigmund Freud's work, Erikson's theory is centered on psychosocial development rather than development. Eric Erikson was born in 1907 on 15th June in Frankfurt, Hesse in Germany. Sadly, he passed away at the age of 91 years in 1999 on the 12 of May in Massachusetts, Harwich in the USA. Erikson maintained that personality develops in a predetermined order through the eight stages of psychosocial development, from infancy to adulthood. During each stage, the person experiences a psychosocial crisis which could have a positive or negative outcome for personality development. According to the theory, successful completion of each stage results in a healthy personality and the acquisition of basic virtues. Basic virtues are characteristic strengths which the ego can use to resolve subsequent crises. Failure to successfully complete a stage can result in a reduced ability to complete further stages and therefore an unhealthier personality and sense of self. These stages, however, can be resolved successfully later.

4.3.1 Stage 1: trust vs. mistrust

The first stage of Erikson's theory of psychosocial development occurs between birth and 1 year of age and is the most fundamental stage in life. Because an infant is utterly dependent, developing trust is based on the dependability and quality of the child's caregivers. At this point of development, the child is utterly dependent upon adult caregivers for everything they need to survive including food, love, warmth, safety, and nurturing. If a caregiver fails to adequately care and love, the child will not trust or depend upon the adults in their life. Children who receive responsive care can

develop the psychological quality of hope. In addition, life is full of challenges and people's response differs according to how one is raised. The findings may show one being unable to cope and live with fear. For example, it may be due to challenges she faced during this age like being sexually molested by a caregiver (uncle or stepfather). So, a person or child needs psychosocial support to overcome fear and mistrust.

4.3.2 Stage 2: autonomy vs. shame and Doubt

This stage takes place between the ages of 18 months and 3 years and involves gaining a sense of independence and personal control. Success in this stage allows people to develop will and determination. In life the challenges are encountered daily one may be unable to act independently to the extent that when he/she is a youth member is unable to bear the academic pressure. The findings may show that one is unable to make one's own decisions to the extent that when they feel pressure, they cut themselves on their wrist feeling shame and doubt of themselves hence indicating suicidal ideation which needs to be satisfied psychosocially.

4.3.3 Stage 3: initiative vs. guilt

Between the ages of 3 and 6 years, children begin to explore their environment and exert more control over their choices. By successfully completing this stage, children can develop a sense of purpose. Furthermore, the findings may show that one may have suicidal thoughts due to being unable to accept the loss of their loved one. Due to the guilt that they have feeling like they could have assisted their (deceased) loved one to stay alive. This indicates the bad live experiences one had during their upbringing during this stage.

4.3.4 Stage 4: industry vs. inferiority

The stage that takes place between the ages of about 6 and 12 years is focused on developing a sense of personal pride and accomplishment. Success at this point in development leads to a sense of competence. The findings may show that individuals at the age of youth become depressed when they obtain A instead of Merit. This indicates that when one was at the age of 6 and 12 had a great sense of inferiority.

4.3.5 Stage 5: identity vs. confusion

The teen years are a time of personal exploration. Those who can successfully forge a healthy identity develop a sense of fidelity. Those who do not complete this stage well may be left feeling confused about their role and place in life. In this stage the findings may show a youth member being unable to deal with their unhealthy body more so that they will be suicidal to something that they do not have control over and become more confused to make their future.

4.3.6 Stage 6: intimacy vs. guilt

The stage that takes place in early adulthood is all about forging healthy relationships with others. Success leads to the ability to form committed, lasting, and nurturing relationships with others. At this stage one may always feel not worthy enough to fit in the society, family members to the extent that he/she develops negative thoughts. The findings may show that one is feeling that his/her death will be worthy enough because he/she is unwanted in the family along with society due to the past live events of when he/she was in her early adulthood. Furthermore, one may feel concerned with what people say and treat him or her due to how she looks and other things. For example, as we live with different family members who have illiterate opinions, can end their ties with their relatives who are diagnosed with HIV/AIDS and the findings may show that one experiences suicidal thoughts because she is stigmatized with HIV/AIDS status and lacks social support.

4.3.7 Stage 7: generativity vs. stagnation

At the stage occurring during middle adulthood, people become concerned with contributing something to society and leaving their mark on the world. Raising a family and having a career are two key activities that contribute to success at this stage.

4.3.8 Stage 8: integrity vs. despair

The final stage of psychosocial development takes place in late adulthood and involves reflecting on life. Those who look back and feel a sense of satisfaction develop a sense of integrity and wisdom, while those who are left with regrets may experience bitterness and despair.

4.4 Application of the Theory

Although the two theories are different, they are applied on complementary levels to appreciate the factors that might lead to suicide ideation and the relationship of these with the psycho-social

development stages of the youths. They enabled the researcher to appreciate the role parents, guardians, and caretakers play in the development of a youth who might contemplate suicide and the one might not despite similar circumstances in life. Below are some of the cross-cutting issues for consideration in the application of the theories.

4.5 Perceived Burdensomeness

There are so many challenging situations that the community faces like past stressful events of life which might include loss of loved ones, loss of jobs and un-accommodative situations like poverty, unemployment which make people develop pessimistic attitudes and maladaptive coping skills. So, the more they develop pessimistic attitudes the more they would not be able to accept situations and the more they would not develop relevant coping skills and live with that burden as the findings may show.

4.6 Low Belonging/Social Alienation

As people experience discrimination in their daily life situations, they might feel like they do not belong to the group or squad; especially when their social status level does not match with other peers. It can make them isolate themselves from their peers which might result in them having negative feelings leading to excessive stress which might trigger suicidal ideation.

4.7 Acquired Ability to Enact Lethal Self-Injury

Poor people struggle to get out of poverty and clear their debts, meet their needs they end being hopeless, feeling empty, and fail to cope, resulting in having suicidal thoughts to the extent that they become par suicide. Also the past life experiences such as; rape may be difficult emotional torture to cope with which can lead to one to have suicidal thoughts to the extent that one may inflict pain on themselves with a razor or blade to find relief.

The theories helped the researchers to understand the factors that might and might not discourage the youth from suicidal thoughts at the different stages of personality development. The theory uses stages which are applicable to both youth and adults. Interpersonal psychological theory of suicide and psychosocial development would work best when combined with suicidal model and cognitive therapy to establish the holistic approach of the interventions.

5. RESEARCH METHODOLOGY

This is a qualitative study because the kind of information collected is not numerical but rather textural. It gives us detailed information about the live experiences of youth as well as the factors that influence their suicidal thoughts and how best to assist them in the natural environment. It adopted the descriptive research design and exploratory design. Research design is the conceptual blueprint within which research is conducted [48]. This study addressed the question on services available for the youth with suicidal thoughts. It is a cross-sectional study that collected data from many different individuals at a single point in time.

5.1 Data Collection Method Procedure

Data collection methods are the processes of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes stated [49]. Data collection methods include interviews, focus groups, observations, and collection of documented material such as letters and diaries. As for this study, face - face interviews would be used along with observation. The researcher selected a face-to-face interview method because it is useful to measure the reaction of participants about factors contributing to their suicidal thoughts. Observation enabled the researcher to look at the physical location, immediate environment, and expressive movements [49]. These expressive movements are inclusive of facial, body language and physical expressions. The researcher observed the respondents in their natural settings during the face-to- face interview. Data was collected during the month of January.

5.2 Data Analysis Plan

The data collected was analyzed through thematic analysis by closely examining the data to identify common themes or topics, ideas, and patterns of meaning that come up repeatedly [50]. This is much more than simply summarizing the data; a good thematic analysis interprets and makes sense of it [51].

1. Familiarization with the data: This phase involved reading and re-reading the data, to become immersed, and intimately familiar with its content.
2. Coding: This phase involved generating succinct labels (codes) that identified important features of the data that were relevant to answering the research question. It involved coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.
3. Generating initial themes: This phase involved examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involved collating data relevant to each candidate theme.
4. Reviewing themes: This phase involved checking the candidate themes against the dataset, to determine that they tell a convincing story of the data, and one that answers the research question. In this phase, themes were typically refined, which sometimes involved them being split, combined, or discarded. In the thematic analysis approach, themes were defined as patterns of shared meaning underpinned by a central concept or idea.
5. Defining and naming themes: This phase involved developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each. It also involved deciding on an informative name for each theme.
6. Writing up: This final phase involved weaving together the analytic narrative and data extracts and contextualizing the analysis in relation to existing literature [52].

5.3 Sampling

The researcher chose random sampling to select her sample, she chose it because it is more manageable than other methods. A sample is a subset of the study population of individuals, groups, organizations, or social objects chosen to participate in the study [17]. In this method every element or unit of analysis has an equal chance of participating in the study, hence this eliminates bias in the sample selection. List of youth with suicidal thoughts was found in the clinical psychology file of para-suicide. This information was obtained from the clinical psychologist as he was the one who kept records

of the respondents at the Scottish Livingstone Hospital (Molepolole) Botswana. All the youth who have been diagnosed with para suicide in Scottish made a total of 150.

5.4 Inclusion Criteria (who will be included?)

✔ Youth who give informed consent
✔ Youth at the age of 15 to 29 years who were not at the primary school.
✔ Youth who were both male and female?

5.5 Exclusion Criteria

✔ Youth who did not give informed consent
✔ Youth who were 15 years and still at the primary school level
✔ Youth aged 30 to 35 years.

5.6 Sampling Technique

The sampling technique is a process of selecting subsets from the population of the study stated by [17]. The sample selection process used simple random sampling which included: assigning a code to each element from 1 to 150 corresponding with the names of youth listed in the clinical psychology file. Then all the numbers were put in a basket and shaken, then picked at random representing the picked 30 numbers (20% of study population) {150 x 20%}. These youth members formed the sample for the study. So, the sample size was 30 in total.

5.7 Pilot Study

The researcher randomly selected a group of 5 youth with suicidal thoughts diagnosed with par suicide. The researchers hosted a face-to-face interview to observe how they would react when answering questions to reduce instrumental errors. Thereafter, the interview guide was corrected to improve the accuracy of the questions.

5.8 Findings: Presentation and Analysis

The findings of a study are based on the following objectives: to explore factors that influence the youth's suicidal thoughts, to describe services available for suicidal youth at Scottish Hospital. The researchers interviewed 21 clients in Scottish Livingstone Hospital using a face-to-face interview. The suicidal clients included both male and female aged between 15 and 29 years.

5.9 Biographical Characteristics of Respondents

Table 1. Physical address of the respondents

Areas of coverage	Respondents
Lekgwapheng ward	8
Garanta ward	1
Bobididi ward	2
Lephaleng ward	1
Phuthadikobo ward	1
Magokotswane ward	1
Ntlolongwae	1
Mokgalung	1
MCE (Borakalalo ward)	2
Thebephatswa	1
Sojwe	1
Salajwe	1
Total	21

Table 1 above indicates the Scottish Livingstone Hospital areas of coverage in the Kweneng district. Although the hospital is situated in Molepolole, it serves Letlhakeng sub-district, Molepolole,and other areas across the country. Many respondents came from Molepolole with (n=18), other respondents were from Thebephatshwa (n=1), Sojwe (n=1). In Molepolole, Lekgwapheng ward has many respondents (n=8) followed by Bobididi ward (n=2) and one respondent (n=1) was from Garanta, one respondent from Ntlolongwae ward, Magokotswane ward, Lephaleng ward, Mokgalung ward, Phuthadikobo ward, and MCE (Borakalalo ward).

Table 2. Age of the participants

Age	Respondents
15-20	11
21-25	5
26-30	5
Total	21

Table 2: shows the age of the respondents who participated in the face- to- face interview. It indicates that the majority [11] of the respondents were 15-20 years old, 5 respondents were aged 21-25 years, and those aged 26-30 years were also 5.

Table 3. Marital status of the Respondents

Marital status	Respondents
Single	21
Married	0
Divorced	0
Total	21

The Table 3 shows that all the respondents were single (n-21) and none of them were either married or divorced.

Table 4. Highest educational qualification

Highest education level of qualification	Respondents
Junior certificate (JC)	7
Botswana General Certificate of Secondary Education (BGCSE)	11
Diploma	2
Degree	1
Total	21

Table 4 shows the highest educational qualification of the respondents. It indicated that many respondents have BGCSE [11] and junior certificate [7]. Only a few have a tertiary qualification which is diploma [2] and one has a degree.

Table 5. Occupation of the respondents

Occupation	Respondents
Student	7
Unemployed	7
Employed	7
Total	**21**

Table 5 shows the occupation of the respondents. The respondents who were unemployed were (n=7) while the ones who were working were (n=7) and the last (n=7) were students. This indicates an equal number of representations.

Table 6. Categories of religion

Religion	Respondents
Christianity	17
African Traditional Religion	2
None	2
Total	21

Table 6 above shows the categories of religious affiliations for the respondents. Many of the respondents were Christians (n=17) while the other (n=2) respondents were members in African traditional religion, and the last (n=2) respondents were in non- religious.

5.10 The Respondents Knowledge of Factors that Contribute to Youth Suicidal Thoughts

In face-to-face interviews, respondents were asked questions based on their knowledge

regarding the factors contributing to youth's suicidal thoughts. They were asked whether they view mental health problems (depression), behavioral problems (drug and alcohol abuse) personality traits (maladaptive coping skills), and terminal illness and health conditions contributing to youth's suicidal thoughts. They were also asked about factors that contributed to their suicidal thoughts. They were also asked about which factors dominated the youth's suicidal thoughts.

5.11 Depression

The respondents were asked to list factors that contributed to youth's suicidal thoughts, and it was realized that they listed depression as one of the factors contributing to youth suicidal thoughts. Most of them pointed out that depression was due to romantic relationship issues, family misunderstandings, financial problems, and difficult life experiences.

> *"Catching your partner red handed cheating you is a very shocking and striking depression, everything inside your mind, turn upside down, and you think it is the end of the world."*

> *"Depression is real is like a demon but only who has been heart broken by the lovers will understand."*

> *"I couldn't realize where I was and who I am? I felt weak until I realized that I had depression and I was not aware."*

As cited above by one of the respondents, depression is a factor that contributes to youth's suicidal thoughts. Many respondents also indicated that depression, especially the one for romantic issues, contributed to their suicidal thoughts. Whereas five (few) respondents differed with others who pointed out that depression caused by family misunderstandings or issues contributed to their suicidal thoughts. One respondent said:

> *"The pressure; the load we carry ngng! It makes my depression level go high day and night because I cannot stop thinking about taking my life away to relieve my family members from this (me) burden, "said respondent C.*

> *"Re bana mme re imetswe (we are young (children) but we are overburdened)" pointed out by respondent O.*

> *"There is no aching pain like being rejected by your own family members and knowing that you are a burden to them, the same people that were supposed to be your support system."*

Almost all respondents' suicidal thoughts resulted from depression caused by romantic relationship issues rather than family misunderstandings. But they knew that depression caused by family misunderstanding is a contributing factor to youth's suicidal thoughts. An interesting observation of respondents was that depression is a dominant factor contributing to youth's suicidal thoughts.

5.12 Alcohol and Drug Abuse

The respondents also listed alcohol and drug abuse as another contributing factor to youth's suicidal thoughts. They listed it as a behavioral problem and an application of maladaptive behavioral skills. They mentioned that others use it as a way of trying to escape from the pains and trauma that they are going through but it ends up worsening their situations. The two respondents indicated that:

> *"The more I consumed alcohol and had a few puffs of kats (ketheine) the more I felt happy and social vibe but when I became sober that pain (of my problems) hit me hard. Then I will be forced to increase the scale of my consumptions which made my life difficult than it was before"*

> *"After being high I see things that does not exists which scared me and my negative thinking capacity increased."*

It seemed that few [2] respondents pointed out alcohol and drug abuse as the factor contributed to their suicidal thoughts. But most of the respondents listed alcohol and drug abuse as another factor that dominated on contributing to youth's suicidal thoughts. They also indicated that the use of alcohol and drugs at first is initiated by their intentions of relieving themselves not to abuse it.

5.13 Health Condition/Terminal Illness

Moreover, the respondents listed health problems as another factor contributing to youth's suicidal thoughts. They mentioned that it is difficult to accept the health problems that they face especially when they cannot find help. As cited below by the two respondents:

"Going door to door of different doctors without any assistance lifted up the feeling of helplessness and hopelessness that I had".

It was realized that few respondents differed with other respondents as they indicated that health problems contributed to their suicidal thoughts. The difficulties with accepting their health problems, hinders their positive thinking capacity and leaves them feeling helpless and hopeless. They also mentioned that health problems are another dominated factor contributing to youth's suicidal thoughts. In addition, all the respondents have agreed (said yes) or viewed that mental health problems (depression), behavioral problems (e.g drug and alcohol abuse) personality traits (maladaptive coping skills), and terminal illness and health conditions contributed to youth's suicidal thoughts.

5.14 Services Offered to Suicidal Client

The respondents were also asked about the available services for suicidal clients (to assess whether they were aware of these services or not). They, were asked to identify the services they were offered and how they were offered? Below are services they identified:

5.15 Awareness of Clinical Social Work Services

Most of the respondents were not aware of the services before but only came to know about it after they received it when they were attended as par suicide case. The respondents indicated that they only knew that social workers help them with donations programs only they did not know about the clinical services. They identified clinical social worker services as the services that are available for suicidal people.

5.16 Awareness of Clinical Psychology Services

Almost all of the respondents were not aware of the clinical psychology services, but it came to their senses when they admitted for self-harm because they were offered the services of clinical psychology. They mentioned that counselling was offered to them to put their mind into a stable state. One respondent summarized this by saying:

"Clinical psychologist interprets our mind and put it back to normal functionality through

counselling, psychosocial support and ensures that we are equipped with suicide knowledge."

"When your mind is all over you do not see any positivity but having somebody who listens to you, you end up realizing yourself."

The respondents also indicated that these services are available to suicidal clients.

5.17 Awareness of Clinical Social Work Services

Many clients also indicated that the social work services are one of the services available for suicidal clients. They pointed out that they were not aware of these services before as they needed them or someone to talk to.

"Bottling up with problems inside your heart weighs you down every minute."

"I was shocked to see that somebody can just hit you with reality and every dark cloud disappear."
The respondents were aware of these services of which they found relevant to their situations.

6. DISCUSSION & RECOMMENDATION

The assessment was based on the following objectives: to explore factors that influence the youth's suicidal thoughts, to describe services available for suicidal youth at the Scottish Hospital, to identify relevant psycho-social interventions for youth with suicidal thoughts, to recommend services for youth with suicidal thoughts to reduce their suicide.

6.1 Factors Contributing to Suicidal Ideation of the Youth

It was established that the respondents have knowledge about factors contributing to the youth's suicidal ideation. They indicated depression, alcohol and drug abuse and health conditions. It was emphasized that depression is caused by romantic relationship issues and depression caused by family relation issues. Joiner [42] perceived burdensomeness is the view that one's existence burdens family, friends, and society. This view produces the idea that *"my death will be worth more than my life to family, friends, society, etc."* The researcher discovered that depression caused by family

relation issues contributed to few clients' suicidal thoughts as they perceived themselves a burden to their family members. Depression due to romantic relationship issues has contributed to many respondents. It shows that depression, alcohol and drug abuse and health conditions are indicated as the dominated factors contributing to suicidal ideation of the youth.

The findings indicated that the respondents viewed mental health problems (depression), behavioral problems (drug and alcohol abuse) personality traits (maladaptive coping skills), and terminal illness, and health conditions contributed to youth's suicidal thoughts. This indicates that the respondents are knowledgeable about factors that contribute to suicidal ideations. Linehan, Comtois, Murray, Brown, Gallop, Heard, et al, [41] asserts that knowledge is the remedy to solve a problem because it is difficult to assist a person who is not well equipped about his/her problems. Unlike the research done by Kunda [53] who identified the psycho-social causes of suicide among the youth which included personal, psychological, social, cultural, economic, and other psycho-social factors that influence suicide among the youth. My study explores the factors contributing to youth's suicidal ideation which were depression caused by life experiences, alcohol and drug abuse and health conditions. The study also identified the gaps of service provision to reduce the rate of suicidal ideation which give birth to suicide attempt.

6.2 Available Services Offered to Suicidal Clients

In addition, it was discovered that the respondents listed the clinical social work services, clinical psychologist services, and admission services as services available for suicidal clients. These services included counselling, education, psycho-social support, solution focused nursing from clinical social work, clinical psychology, and nurses. The researcher observed that the services mentioned above are the ones that are currently offered for suicidal clients. Admission services which include solution focused nursing, clinical psychology services which include psychosocial support, psycho education and counselling, clinical social work services which also include counselling, education, and family reunion. The researcher observed that the services available have not been effective as many were not aware of these

services before, but the services were all efficient as it helped clients to overcome their suicidal thoughts. Fleischmann, Bertolote. Bottega et al. [8] indicated that education, counseling, and all health care services are considered vital services which are provided to the youth. Furthermore, the study found that the services offered to suicidal clients were complementing each other to achieve their goals. The researcher also observed that not being aware of the services but only getting to know them when they are admitted does contribute to their suicidal thoughts. Therefore, there is an increasing rate of suicidal thoughts among the youth. It was also discovered that most of the respondents did not mention the admission services (solution focused nursing) as they were unhappy with the services because they were not attended properly and updated well. Eric Erikson's Psycho-social theory [47] explains that life is full of challenges and people's response to the challenges differs according to how they were raised. Those who distrust people, when they are not handled with caution, they might fall to suicidal thoughts.

6.3 Theoretical Bases of the Study

In a nutshell the findings confirm both theories of interpersonal psychological theory and psychosocial development theory. They helped to explain suicidal behavior or negative personality [42]. The study established that the youth become suicidal when they are depressed by life experiences, financial problems, and family issues, abuse of alcohol and drugs as a way of coping and when they have health problems. The interpersonal psychological theory shows that due to perceived burdensomeness the youth were suicidal due to depression caused by life experience, for example, romantic relationship issues, being unable to accept loss of their loved ones, family issues, and health conditions. These contribute to (abuse alcohol and drugs) the acquisition of maladaptive coping skills. The theory also indicated that social alienation in the families, leads youth to isolate themselves when there are family issues. In addition, the psychosocial development theory explains that the youth become suicidal when they fail to resolves each stage of development positively, for example, mistrust in stage 1(trust vs mistrust), shame and doubt in stage 2 (autonomy vs shame and doubt), guilt in stage 3 (initiative vs guilt), inferiority in stage 4 (industry vs inferiority), confusion in stage 5 (identity vs

confusion) and isolation in stage 6 (intimacy vs isolation) Erikson [47].

7. CONCLUSION

The aim of the study was to assess suicidal ideation among the youth which seemed to be the major problem reported at the Scottish Livingstone Hospital. It was important to assess suicidal thoughts among the youth to recommend the development of appropriate services. The major findings show that suicidal ideation results from depression, alcohol and drug abuse, and health conditions. Many of the clients know about them and they have contributed to their suicidal ideation. They also pointed out that it is a dominant contributing factor to youth's suicidal ideation. Depression is clinically analyzed or diagnosed; the findings indicate that it can be self-diagnosed due to the short and long-life experiences. The services available to suicidal clients are not adequate due to shortage of staff in the clinic. Furthermore, the psychosocial interventions were not reaching many clients who were not aware of the services until when they were admitted.

The study recommended the services for suicidal clients in the Scottish Livingstone hospital. Many of the respondents suggested that clinical social workers and psychologists should collaborate for effective strategies to reduce the rate of suicidal ideation. They also recommended that an awareness campaign and public education for the entire Kweneng district communities. The also proposed the formation of groups and youth committees, and that the follow ups should be mandatory. The shortage of staff should be addressed by the government hiring more clinical social workers and psychologists to reduce the suicidal ideation rates. The respondents were hopeful that the clinical social workers and psychologist will work with them to develop interventions.

DISCLAIMER

The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

CONSENT

As per international standard or university standard, Participants' written consent has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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