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FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

**RISK AND PROTECTIVE FACTORS OF PARA-SUICIDE AMONG THE YOUTHS OF
CHEGUTU URBAN DISTRICT.**

**BY
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**A DISSERTATION SUBMITTED TO THE FACULTY OF SOCIAL SCIENCES IN
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DEGREE IN PSYCHOLOGY**

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DEDICATION

To my dearest and special Mother, Otilia Zigadza who gave me her all for me to be where I am today and for this very reason I dedicate this dissertation to you.

To my late Father Samson Chiwandire I just wish you were here to celebrate my achievements with me and I know wherever you are, you are proud of the person I have become.

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ABSTRACT

The research was mainly concerned in knowing the risk and protective factors of para-suicide among the youths of Chegutu as well as assessing the extent in which the youth of Chegutu were at risk of para-suicide. The fact that the youths are the ones that are at risk of suicidal behaviours is what drove the researcher to carry out a study to scientifically prove the extent of this truth. In the collection of her data the researcher used a quantitative approach on the bases that the target population was too huge. The descriptive research design guided this research so as to describe and interpret findings. The researcher used a sample of 169 youths from Chegutu Urban educational institutions that is two high schools and one self help college, this was made possible by cluster sampling where by the participants placed her participants in clusters and further on conducted a random sampling. Data was analysed by the SPSS version 21 which is statistical manual which analyses data numerically, cross tabulation tables were run analysing para-suicide which in this research was the depended variable against other risk and protective factors which were in-depended variables. The main findings in this research was that indeed the youths of Chegutu Urban are at risk of para-suicide as the those who had low risks were 24.4%, those with moderate risk were 11.2% and those with a high risk were 1.2% however it should be noted that in the study 63.3% of the youths were are not at risk of para-suicide. The research also brought to light that there were risk factors of para-suicide and these were hopelessness, depression, family factors, alcohol and substance use as well as stressful life events. Protective factors were also known and they were hopefulness, family factors, refraining and low use of substances, social support from peers and significant others and religious beliefs. This led to the conclusion that further research is needed to be done in Zimbabwe as a whole on the issue of para-suicide, its risk and protective factors. In Chegutu, the community as whole must work hand in hand so as to protect the youths from para-suicide by making use of the protective factors and the recommendations mentioned in this study.

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LIST OF ACRONYMS

DHS	Depression Hopelessness and Suicide Screening
DSM-V	Diagnostic and Ststistical Manual of Mental Disorders, 5 th Edition.
GSHS	Global- School Based Student Health Survey
NFSB	Non- Fatal Suicidal Behavior
SBQ	Suicide Behavior Questionnaire
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This chapter is going to focus on the fundamental aspects of the study looking at the background of the study where the researcher will briefly explain the issue of para-suicide among the youths, followed by the statement of the problem which will show what really motivated the researcher to conduct her study. The purpose of the study will highlight the reasons why the research was conducted, the research questions stated in this chapter will help guide the study as well as explaining how the research purpose will be achieved. It will then be followed by the significance of the study which will show the importance of the study to the various populations of Chegutu and then the delimitations which will clearly state the boundaries of the study as well as the limitations which will highlight the research conditions which the researcher cannot control. The chapter will be concluded by the definition of key terms which will help the reader to know the exact meaning of the terms in the context of her study.

1.2 BACKGROUND OF THE STUDY

The word para-suicide is comparable to suicide but are however different, para-suicide is a term which was firstly introduced by Kreitman (1977), he defined it as a non-fatal, intentional self-injurious behavior resulting in actual tissue damage, illness or risk of death, or as any ingestion of drugs or other substances not prescribed or in excess of prescription with clear intent to cause bodily harm or death. Retterslot (1993), also alluded that para-suicide is defined as a conscious and voluntary act which the individual has undertaken in order to injure himself, and which the individual could not have entirely be certain of surviving but where the injury has not led to death. Nock (2012), further posits that the term para-suicide have been used to refer to self-injury with the intentions of not dying and self-injury with the intentions of dying. This then shows that people who are said to be para-suicidal some of them it will be a suicidal attempt whilst for others it will be just self-injury with no suicidal ideations.

The methods in which people indulge in para-suicide acts are almost similar globally. In a study conducted by Vanik et al., (2008) noted that with that data provided by the European Alliance Against Depression (EAAD) project which is an international partnership of sixteen European countries, the most frequent means of suicidal attempts was hanging (49.5%), seconded by poisoning by drugs (12.7%), jumping (9.5%), firearms (7.6%), poisoning by other means (5.1%), jumping or lying before moving object (5.0%). In a study conducted in South Africa by Naidoo and Shcelebusch (2014) it showed that the most frequent main methods used to commit and attempt suicide were as follows hanging which accounted for nearly two thirds in both 2006 (61%) and 2007 (62%), seconded by guns, jumping from heights and overdose. These four methods accounted for 88% of all completed and attempted suicides in 2006 and 94% of all completed and attempted suicides in 2007. In a study conducted in Zimbabwe by Munikwa, Mutopa and Maphosa (2012), on the nature and causes of para-suicide in the Hurungwe District many methods of para-suicidal acts came into play and these were taking an overdose of medication and poisonous substances, hanging oneself, and taking dangerous herbs

Cases of suicide and para-suicide have been on the increase worldwide and have reached alarming levels of late. According to the global suicide rates provided by the World Health Organisation (2012), there were an estimated 804 000 suicide deaths worldwide in 2012 making it the 15th cause of death worldwide. The proportion of all deaths due to suicide and rank of suicide as the cause of death vary greatly by age. Globally among the young adults 15-29 years of age suicide account for 8.5% and it is ranked as the second cause of all deaths. Among the adults aged 30-39 it accounts for 4.1% of all deaths and it is 5th leading cause.

Remarkably, in high income countries and in the low and middle income countries of the South East region suicide accounted for 17.6% and 16.6% respectively of all death among the young adults aged between 15-29 and represents the leading cause of death for both sexes(WHO, 2012). The fact that para-suicidal cases are under reported it is very difficult to know the exact global rate of para-suicide numerically but however WHO (2012), noted that for every suicide there are many more people who attempt suicide each year. Goldman- Meller et al. (2013), noted that the overall rate of young people suicide attempts is three times higher than the rates of adults over 30 years. WHO(2012) also noted that the prevalence of para-suicidal acts is estimated to be ten to

twenty times higher than completed suicides .This then shows that completed suicides are only a tip of the iceberg compared to suicidal attempts thus posing a public health concern specifically of the young people.

The prevalence of youth who are para-suicidal varies amongst countries. Looking at the youths of Alberta Canada according to Health Trends Alberta (2015),in 2012 and 2013 there were 2248 para-suicidal cases among the youths, this survey also noted that the para-suicidal event rate was four times higher in female youths compared to the males. In western countries research done by Langille, Asbridge, Kisely and Rasic (2012) estimated prevalence's of par-suicide among the youths were 4.4% in Boston USA, 4.9% in Nova Scotia, Canada and 6.3%–8.1% in nationally representative samples of American students . Nock et al (2008) alluded that the lifetime rate of suicide attempts for the 12–20 age group in Norway is 8.2%, with 2.7% having attempted in the last two years. In the west pacif regions suicide attempts are on the rise (WHO, 2012).

Further more in Africa, basing from the information compiled by Jamison, Freachem, Makgoba et al. (2006), it showed that in Ethiopia out of 10, 203 adults in Addis Ababa who were suicidal attempters 66% of the people who engaged in parasuicidal acts were under the age of 25 and this is according to Alem and Kabele (1999) . Also in Ethopia according to Alem , Kabede, JacobsonandKullglen (1999) under a survey of 10,468 adults the most frequent age group for suicide attempt ranged from 15-24 years .In Zimbabwe in the year 2000 it showed that out of the 47 patients admitted at a certain hospital who had suicidal burns the median age of these people was 24.

Looking at the issue of para-suicidal acts or any other suicidal behavior in Africa, Randall , Doku, Wilson and Peltzer (2014), notes that much of the information has been collect in high income countries and in low income countries to be particular those in Sub Saharan Africa let alone Zimbabwe information is very little..Hence there is need to conduct more studies so as to know the problems facing Africans when it comes to suicidal behaviors.

1.3 STATEMENT OF THE PROBLEM

According to the empirical rates mentioned above it showed that the most frequent age group at risk of para-suicide are the youths ranging from 15 -24 years. Thus the problem that stimulated the researcher to conduct her study is the fact that youths are at the greatest risk of being para-suicidal when compared to all the age groups as this was indicated by the World Health Organization. Due to this reason, citizens of Chegutu Urban community are not aware of the real causes of these para-suicidal acts among the youths as some are attributing this problem to the avenging spirits such as Ngozi. Little do they know that there are risk factors that can be explained psychologically as well as protective factors that can hinder these acts. Thus if this issue is not attended to the youths will remain at a great risk.

1.4 PURPOSE OF THE STUDY

The purpose of the study is assess the extent to which the youths of Chegutu urban are at risk of para-suicide as well as looking at the factors that are causing them to exhibit this suicidal behavior and to try and present protective factors against para-suicide that will help parents, teachers and guardians to identify and avoid these factors at an early stage.

1.5 RESEARCH OBJECTIVES

- 1 To assess the extent in which youths are at risk of para-suicide.
- 2 To examine factors that is causing suicidal attempts among the youths.
- 3 To try and develop protective factors that will help prevent para-suicide among the youths in Chegutu Urban district.

1.6 RESEARCH QUESTIONS

1. Are the youths of Chegutu Urban at risk of para-suicide?
2. What factors are leading the youths in Chegutu Urban district to attempt suicide?
3. What are the protective factors of para-suicide among the youths in Chegutu Urban District?

1.7 SIGNIFICANCE OF THE STUDY

This importance of this study is to explore the reasons why youths are engaging in para-suicidal acts which are characterized by deliberate self harm and suicide attempt and also to look at the possible protective factors that can help prevent youth para-suicide. The significance of this study is also to help youth be familiarized with the risk factors that results in para-suicide. Mentioning of the risk factors will make them familiarize with the factors to a point where by if they experience them they will not resort to suicidal attempts instead they will consider talking about it with their parents, guardians, teachers and even with counsellors at various health institutions in Chegutu Urban District. The protective factors will act as a preventive measure where exposure to such factors does not prompt them to resort to suicidal attempts but instead consider seeking guidance and advice from parents, guardians, teachers and even councillors at various health institutions in Chegutu Urban district. The study will also help Parents/ Guardians by helping them closely monitor their children and to asses if they are not at risk of being para-suicidal and also to know the measures to take if their children are at risk.

According to the United Nations youths are people whose ages range from 15-24 years. This then shows that the majority of these people spend most of their time in high school or in colleges this research will also help teachers to closely monitor their students for any signs and symptoms that may lead to para-suicidal acts and intervene at an early stage. It will also help teachers to introduce clubs and awareness programmes on risk and protective factors of para-suicide. The research will help counselors who are mainly in the Ministry of Health to take the issue of para-suicidal acts of adolescents and young adults seriously. This will then cause counselors to carry out awareness campaigns as well as provide free counseling to adolescents both in schools and at home whether highly exposed or less exposed to the risk of para-suicidal tendencies. The research will push sector ministries such as Ministry of Youth and the Ministry of Social Welfare and Child protection to take into considerations the introduction of programs of suicidal prevention which will target all the youths in Chegutu District thus targeting the youths in and out of school.

1.8 DELIMITATIONS

The researcher is going to focus on the risk and protective factors of para-suicide among the youths of Chegutu because when it comes to the issues of para-suicidal acts the youths ranging from 15-24 years both in school and out of school are the ones that are at greatest risk. Also the writer chose Chegutu Urban District because no research has been conducted there in terms of para-suicide thus filling the gap pointed out by Munikwa, Mutopa and Maphosa (2012) that there is need to conduct para-suicidal studies at all district levels. The study could not be conducted in all districts because it is difficult to obtain large information within a short space of time.

1.9 LIMITATIONS

The issue of para-suicide is very sensitive and it may evoke hidden emotions hence which might make it difficult for participants to open up. Youths may also fail to take the research seriously especially when they are answering questionnaires as their age group is characterized with lack of seriousness so the researcher will try by all means to maintain seriousness when collecting her data. Considering the fact that the target populations are the youths that are ranging from 15-24, the research can be problematic because children under the age of 16 need informed consent from their parents hence this can be time consuming the researcher might consider targeting the youths who do not need informed consent from their parents thus she will start from 16 years onwards. Use of sampling is a limiting factor as inference is made based on the sample and not the whole population. The research has to be carried out within a specified period of time using limited resources thus affecting the outcome.

1.10 ASSUMPTIONS

Youths are engaging in para-suicidal acts, para-suicide is most prevalent among the youths, there are factors that are leading the youths to be para-suicidal and there are factors which can help stop those para-suicidal acts.

1.11 KEY TERMS

1.11.1 Suicide

According to Maris (1992) suicide is defined as an act of ending one's life intentionally. WHO (2012) noted that suicide is the act of deliberately killing one's self. Durkheim (2005) further posits that suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this result.

1.11.2 Para-suicide

Para-suicide according to Linehan (1993) is a term given to non fatal , intentional self injurious behavior resulting in actual tissue damage, illness or risk of death or any ingestion of drugs or other substances not prescribed or in excess of prescription with clear intent to cause bodily harm or death. WHO (2012) described suicide attempt as a term used to mean any non- fatal suicidal behavior and it refers to intentional self – inflicted poisoning injury or self harm which may or may not have a fatal intention or outcome.

Diekstra (1989) et al provided characteristics of para- suicide. They stated that a) para-suicide is a non habitual act with no fatal outcomes, b) that is deliberately initiated and performed by the individual involved in expectation of such an outcome, c) that causes self harm or with intervention from others will do so or consist of ingestion of a substance in excess of its generally recognized therapeutic dosage and d) the outcome being considered by the actor as instrumental in bringing about desired changes in consciousness or social condition.

1.11.3.Suicidal Behavior

These are actions and self destructive thoughts of ending one own life and these include suicidal ideations, attempted suicide and completed suicide. It also refers to a range of behaviors that include thinking about suicide (ideation) , planning for suicide , attempting suicide and suicide its self (WHO, 2012).

1.11.4 Youth

The United Nation defined youths as people between the ages of 15 and 24.

1.11.5 Risk Factors

These are conditions that increase the risk of youth to be para-suicidal.

1.11.6 Protective Factors

These are preventive measures against para-suicide

1.12CHAPTER SUMMARY

This chapter served as an introduction to the research highlighting the background of the study, purpose, significance, delimitations, limitations, research questions and the definition of the key terms which will be used throughout the research.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter seeks to highlight the relevant literature that is in line with the topic of the study and it will be focusing on the issues that surround the risk and protective factors of para-suicide among the youths. The literature review will not only be guided by the research topic but by the research objectives and research questions. This chapter therefore seeks to identify the literature that has been identified in the previous research study and also to provide an analysis of current information relevant to the study. As well as highlighting the theoretical framework that guided this research and the knowledge gap that exists on this subject.

2.2 THE CONCEPT OF SUICIDAL BEHAVIOR AND PARA-SUICIDE

WHO (2012), noted that suicidal behavior is a complex phenomenon that is influenced by several interacting factors - personal, social, psychological, cultural, biological and environmental. Nock et al. (2008), further posited that suicidal behavior is the leading cause of injury and death worldwide. Suicidal behavior which is sometimes referred to suicidal related behavior or suicidality (Heilbron, Compton , Daniel and Goldston 2010) characterizes a wide range of behaviors which ranges from suicidal ideations, to suicidal plan , to attempted suicides and then finally completed suicides To add on Nock et al. (2008), posits that non-fatal suicidal thoughts and behaviors (hereafter called suicidal behaviors) are classified more specifically into three categories which are as follows, suicidal ideation which refers to the thoughts of engaging in behaviors intended to end one's own life, suicidal plan which refers to the formulation of a specific method through which one intends to die and suicidal attempt which refers to engagement in potentially self- injurious behavior in which there are at least some intent to die.

Suicidal behaviors are classified into two categories that is fatal suicidal behaviors and non- fatal suicidal behaviors (NFSB). Sidharta and Jena (2006) defined non- fatal suicidal behaviors as those behaviors that do not result in death they comprises all other behaviors which are suicidal ideation, plans and attempts except of completed suicide and fatal suicidal behavior is the behavior which results in death (completed suicide). Non- fatal suicidal behaviors are closely

related to non-suicidal self injury hence it can be seen as risk factor for attempted and completed suicide (Coughlin and Sher 2013) . In their study Non-suicidal self injury as a gateway to suicide in young adults, Whitlock et al. (2012), alluded that their findings brought out evidence that young adults who had a non-suicidal self injury past have the possibility attempting suicide. Glenn and Klonsky (2011), in their study noted that roughly 50 – 85% of people who engage in self injuries had made at least a suicide attempt. Whitlock et al., (2012) concluded their study stating that non – suicidal self injury and suicidal behaviors amongst adolescents and young adults poses as a significant medical and global concern.

Pajoumand et al. (2012) defined para-suicide as an apparent attempt at suicide, commonly called a suicidal gesture in which the aim is not death. To add on to the understanding of para-suicide Linehan (1993), posits that the term para-suicide is a term which was introduced by Kreitman in 1977 as a label for non – fatal, intentional self-injurious behavior resulting in actual tissue damage, illness or risk by death or by any ingestion of drugs not prescribed or in excess of prescription with clear intent to cause body harm or death. Linehan (1993) further states that para-suicide as defined by Kreitman includes both actual suicidal attempts and self-injuries with little or no intent of dying. Attempted suicide as defined by Shidhartha and Jena (2006) is a potential action in which an individual injures himself or herself with a non fatal result for which there is evidence either outwardly or inwardly that the individual planned to harm himself or herself.

Bille – Brahe (2004), described that there are at least four ways in which the term para-suicide can be used in practice. The first one is that para-suicide is a sub-category of attempted suicide characterized by low levels of intention to die this perspective is favored in America. The second one is that attempted suicide is a more specific sub-category of para-suicide characterized by a strong intention to die and this perspective is favored in Europe .The third is that para-suicide and attempted suicide are mutually exclusive, the former describing cases with low suicidal intent and the later used to label cases where the intent to die is clearly evident. The fourth and final perspective according to Bille-Brahe et al. (2004), is that para-suicide and attempted suicide are used interchangeably recognizing the difficulties inherent in ascertaining intent.

Hence this shows that para-suicide is a term which is used to describe self- injurious behaviors and suicidal attempts.

2.3 YOUTH PARA-SUICIDE

The World Health Organization (2012) reported that young people are among those that are mostly affected by suicide and suicide is regarded as a second leading cause of death between persons of the ages between fifteen and twenty-nine years globally and in the South east Asia region suicide represents the leading cause of death . The sectioning of all deaths and the rank of suicide as a cause of death vary greatly by age , globally among young adults thus from the ages from fifteen to twenty- nine suicides accounts for 8.5% of all deaths and is ranked as the second cause of death (WHO ,2012) . Outstandingly , in high income countries and in low and middle income countries of the south-east Asian region suicide accounts for 17.6% and 16.6% respectively and all deaths among the young adults between fifteen and twenty-nine and represents the leading cause of death for both sexes. Now as the Center for Disease Control and Prevention alluded that there are twenty-five suicide attempts made for every completed suicide this then shows that completed suicides are a smaller part of a deeper public health concern which is attempted suicide,(Goldman-Mellor and Saxton 2011).

Moving on to the overall rate of suicide attempts , Goldman-Meller (2013) noted that the overall rate of suicide attempt among the young adult is three times higher than the rate among adults older than thirty years old and he also noted that young people are more likely to survive an attempt. Hence this then shows that the life time population burden of negative outcomes after a suicide attempt may be especially concentrated among the young attempters. In their study Goldman- Meller et al., (2013) ‘Suicide Attempt in Young People , A Signal for Long Term and Social Needs , as they conducted a research on young adults who had attempted suicide they found that as adults approaching midlife, young suicide attempters were significantly more likely to have persistent mental health problems such as depression, substance dependence, and additional suicide attempts compared with non attempters. They were also more likely to have physical health problems such as metabolic syndrome and elevated inflammation. They engaged in more violence like that of violent crime and intimate partner abuse and needed more social support , long-term welfare receipt and unemployment. Furthermore, they reported being lonelier

and less satisfied with their lives. This then shows that there is serious need to do a follow up on all the young adults who would have attempted suicide because as it is there are under great danger as it is seen that there are a vulnerable before attempting and after attempting suicide.

Looking at the prevalence of youth para-suicide , females have high non –fatal suicidal attempts. Parajoumand et al., (2012) in their study ‘Suicide Epidemiology and Characteristics among Young Iranians at Poison Ward at Loghman- Haking Hospital ‘ which was a study whereby they looked at the causes of suicide attempts at the youths who had been admitted at Lonhman – Haking Hospital noted that girls are more likely exposed to the risk of para-suicide when compared to the males. They further posited that over a ten year period (1997 – 2007), 6414 young people attempted suicide as recorded at Longhnam-Haking Hospital. Of these Parajoumand et al (2012) stated that 1451 (22.6%) were males and 4963 (77.4%) were females. .Ikealumba and Couper (2006) also noted that in a study comprising of forty five patients in Namibia 53% of the patients who had committed suicide were females. In a study conducted in Zimbabwe on ‘ The Prevalence of Depression in Deliberate Self –Injury (Para-suicide) Chibanda,Sebit and Acuda (2002) noted that the high proportion of female attempters in the current study was a cause for concern .

2.4 RISK FACTORS ASSOCIATED WITH YOUTH PARA-SUICIDE

Moscicki (1997) defines risk factor as a characteristic, variable or hazard that increases the likelihood of the development of an adverse outcome which is measurable and which precedes the outcome. There are a number of risk factors that the writer came across whilst reviewing literature of other authors on the risk factors associated with para-suicide among the youths.

2.4.1 Alcohol and Substance Abuse

Alcohol and substance abuse as defined by DSM-V is a maladaptive pattern of substance use marked by recurrent and significant negative consequences related to the repeated use of substances (CSAT, 2005). Abuse of drugs, alcohol, and chemical or psychoactive substances in DSM V can be defined as a maladaptive pattern use indicated by ...continued use despite knowledge of having a persistent recurrent social, occupational, psychological or physical

problem that is caused or exacerbated hazardous by the use or by recurrent use in situations in which is physically hazardous.

Lancet (2008) noted that the overall, dangerous and damaging drinking patterns seem to be on the rise among adolescents and young adults. In young people between the ages of sixteen and twenty-four, the most recent NHS Information Statistics on Alcohol (2008) reported that 26% of males and 24% of females drink over the recommended weekly limits for low risk drinking in adults, which are 21 units for men and 14 units for women. Furthermore it is shown that 9% of young males and 6% of young females drank over 50 units per week which is indicative of high risk drinking in adults NHS Information Statistics on Alcohol 2008). Heavy drinking by young people is more pronounced in areas with high social deprivation .The highest levels of alcohol consumption are reported by young people in the North-East of England and Yorkshire and Humberside according to Fuller (2007) where they are 1.5 times more likely to have drunk alcohol during the last week than young people living in the rest of England . In a survey conducted by Talbot and Crabbe (2008) of 1,250 young people living in deprived communities in Britain found that over a third did not know what a unit of alcohol was and did not understand the term binge drinking. Thus the adverse effects of social deprivation on young people may become compounded by possible health and social problems related to heavy drinking

The World Health Organization (2014) global status report on alcohol and health in their research for the rate of consumption of alcohol among young people provided percentages of students who drank at least one drink of alcohol in a period of 2003-2010 . The data was obtained through the GSHS , in Africa Botswana had 30,7% students who consumed alcohol, Ghana had 55.7% children , Seychelles had 123.6% and Zambia had 83,4% unfortunately the percentages of Zimbabwe was not provide for. In the regions of the Americas Argentina had 105,3%, in Dominican 114% and in Uruguay 119.7%. Then in the Eastern Mediterranean region in the Lebanon 40.8 students consumed alcohol and in Morocco 7.1% . In European regions in the former Yugoslav Republic Macedonia there was 80.4 % , in the south east Asia region Thailand had a 32% of student alcohol consumption and lastly in the west pacific region China had 16.3% and the Philippines had 32.5%. Hence this shows that globally alcohol consumption is prevalent among the young adults.

Looking at the relationship between alcohol and substance abuse and suicide behavior (suicidal ideation, attempts and completed suicides) , Conner, Bagge , Goldston&Iigen (2014) noted that there are two types of alcohol abuse that are related with all suicide behaviors which are acute use of alcohol (AOA) and alcohol use disorder (AUD). Looking at relationship between alcohol use disorder and suicide attempts, Roy &Janal (2007) in their study Risk Factors for suicide attempt among alcohol dependent patients noted that alcohol use disorder is a risk factor for suicide attempts among the youths. Conner et al. (2014) further noted that an empirical review of published studies reported that a median of 37% of suicides and 40% of suicide attempts are preceded by acute use of alcohol. Bagge& Sher (2008) states that it is necessary to determine the mechanisms by which acute use of alcohol suicidal thoughts and behaviors, these include alcohol related psychological distress , depressed mood and anxiety , aggressiveness, impulsivity and cognitive constriction. Conner , McCloskey and Duberstein (2008) further noted that acute use of alcohol may also lead to acute interpersonal conflict and disruption that may serve to increase risk for stress reactive suicidal behavior. Farhadi, Hartalab&Poroolajahal (2015) in their study noted that their meta-analysis revealed that Alcohol use disorder was significantly associated with an increased risk of suicidal ideation, suicide attempt, and completed suicide. Alcohol and psychiatric disorder have a complicated relationship.

Looking at the risk factors for suicidal attempts on alcohol dependents patients, Klimkiewicz, Iigen,Bohnert, Jakubczyk, Wojnar& Bower (2012) in their study stated that acute alcohol intoxication itself may act as a trigger for suicidal thoughts and attempts among individuals at risk and may influence potential lethality of the suicide attempt. Dejong et al (2010) noted that alcohol may also influence lethality of the methods of suicide attempts. In a study of youth with depression, alcohol and or other drugs present at the time of the attempt it was shown that 25% of them attempted suicide with low lethality and 36% of them attempted using high lethality methods. Hence it shows that indeed alcohol and substance use is a risk factor for suicide attempts.

According Randall,Doku, Wilson and Peltzer (2014) in his study on the suicidal behavior and related risk factors among school aged youths in Benin he pointed out that substance abuse was one of the top four risk factors of multiple suicide attempts among the school going youths of

Benin. Also in a study conducted by Pajoumand et al (2012) he noted that according to the etiology reasons of attempted suicide among the young Iranians at a Prison ward at Hakim hospital substance abuse was the second most common underlying factor which led to suicidal attempts among the young patients. Aseline et al (2009) examined the relationship between heavy episodic drinking (HED) and adolescent suicidal attempts. They found out that adolescents who participated in HED were at 2.6 times greater risk of reporting a suicide attempt compared to those who did not participate in HED.

2.4.2 Psychopathology

Psychopathology also known as a mental disorder and is believed to be a risk factor of parasuicide. The glossary of mental health and mental illness terminology defines psychopathology or mental disorder as a health condition characterized by alterations in thinking, mood or behavior or a combination of the three. The glossary of mental health and mental illness terminology went on further to posit that mental disorders are mediated by the brain and associated with distress and or impaired functioning, they can be the result of family history genetics or other biological , environmental , social or behavioral factors that occur alone or in a combination. Torrey (1995) also notes that common behaviors of individuals with mental disorders are but not limited to physical sedentary, negative body image, low self esteem and negative feelings of general competence.

Looking at the prevalence of psychopathology in young people, Patel, Flisher, Hetrick and McGorry (2007) affirm that mental disorders account for a large proportion of the disease burden in young people in all societies. They went on further to state that most mental disorders begin during the age of 12 -24 and they are detected later in life. In their study Patel et al. (2007) looked at the global occurrence of young people suffering from mental disorders by percentages, Austria had 27%, Netherlands 8% , USA had 21% Switzerland had 23% and South Africa had 15%. Murphy and Fonagy (2012) further posited that in a survey of adults between the ages of 16-24 in England 2.2 %experienced a depressive episode, 4,7% were screened for post partum depression , 16,4%% experienced anxiety, 0,2% psychotic illness and 1,9% had diagnosable personality disorder. In a study conducted in Zimbabwe it showed that young people mostly in the rural area are at risk of mental disorders (Lanhanget al., 2007). In their study mental health

was assessed using the SSQ for affective disorders, notably depression and anxiety disorders. Lanhaung et al. (2007) noted that participants scoring more than eight points were considered at risk of being affected by mental disorders and participants who scored more than eleven were at risk of being severely affected. Out of 1495 participants aged between (15-23) 93.1% completed the questionnaire and of these 51.7% scored were at risk of mental disorders and 23.8% were at greater risk. Hence this shows that indeed there is a high prevalence of mental disorders globally among young people.

Hoertel, Franco, Wall, Oquendo, Kerridge, Lismon and Blanco (2015) states that most of mental disorders when examined independently are associated with an elevated risk of suicide attempt. Taking for instance the link between suicide and depression, the symptoms of depression alone show that mental illness are a risk factor for suicide let alone suicide attempts. The Canadian Mental Health Association noted that inability to experience pleasure, hopelessness and loss of mood reactivity which is the inability to feel mood uplift in response to something positive. More recently, by using data from the 2010 Minnesota Student Survey, Taliaferro and Muehlenkamp (2014) found that apart from other factors depressive symptoms emerged as important risk factors to distinguish youth who reported suicidal ideation or behavior from those without a history of suicidality. According to Chibanda, Sabit and Accuda (2002) in their study in Zimbabwe noted that the prevalence of major depression was 20.7% and according to the DSM-IV criterion it was seen as a cause for para-suicide.

Looking at the studies on youth suicidal attempts caused by mental disorders globally shows that, in a study conducted at a hospital in Iran on the motivators of suicidal attempts of adolescents, communicative disorders was the number one risk factor and this is according to Pajoumand et al. (2012). Nock et al. (2008) states that the presence of a psychiatric disorder is among the most consistent risk for suicidal behavior. Cash and Bridge (2009) posits that psychiatric disorder is present in up to 80-90% of adolescent victims and attempters from both community and clinical settings. Keer, Muehlkamp and Turner (2010), in trying to answer on the factors that lead to para-suicide they noted that the most important and major cause of para-suicide among adolescents and young adult is the occurrence of psychiatric disorders. A study

conducted in the United States shows that 40% to 80% of teenagers who are para-suicidal will be suffering from a psychiatric disorder such as Borderline personality disorder, dissociation and disso-active disorders as well as eating disorders. Sansone et al (2002) noted that prevalence rates for attempted suicide vary depending on the eating disorder.

2.4.3 Parent/ Family Factors

Family and or parent factors are also seen as a risk factor for suicide attempts and suicidal behaviors. Radhakrishnan and Andrade (2012) posits that risk factors related to family and suicide behaviors include parenting style , family history of mental illness and suicide, an physical and sexual abuse in childhood . Brigde ,Goldstein and Brent (2006) also noted that family factors, including parental psychopathology, family history of suicidal behavior, family discord, poor quality of the parent-child relationship, and maltreatment, are associated with an increased risk of adolescent suicide and suicidal behavior.

Looking at the studies that show the prevalence of family and or parent factors as a risk factor for suicidal behaviors for instance a study conducted in Nigeria the study looked at the association between parental pathology and suicidal behavior among adult offspring. Oladeji and Gereje (2011) noted that the study found that parental panic disorder was associated with suicide attempts in off springs. in the same study parental panic disorder was also reported to predict the onset of suicidal ideation and suicide attempts. Atwoli, Nock, Wlliams and Stein (2014) noted that in South Africa a quarter of the 4315 participants who attempted suicide reported parental psychopathology. Prior studies in non – African settings have shown that suicidal behavior tends to run in families and it has been suggested that some aspects of this are mediated at least in part by mental illness among relatives. Mann et al. (2009) in New York conducted a study and observed that suicide attempts are likely to be more associated with a family history of impulsive disorders.

Donath, Graessel, Bailer and Hillemacher (2014) in their study conducted in Germany the lifetime prevalence of suicide attempts investigated as well potential predictors including parental parenting it was observed that neglecting parenting style increases the risk of suicidal attempts more than 1.5 times compared to children reared using authoritarian parenting. Also in a study conducted in South Africa on the reasons para-suicide for patients at Limpopo hospital by

Obida , Clark and Govender (2013) they noted that most participants came from dysfunctional families characterized by intimate partner violence, lack of trust and rejection therefore they felt these factors contributed to their suicide attempts. In a study on suicide among students in Iran found that most suicide attempts were caused by family conflict (Farzaneh,Mehrpour , Alfred Moghadam ,Behnoush and Seghatoleslam . 2010)

2.4.4 Anxiety and Hopelessness

In a study conducted by Zayas, Gulbas, Fedoravicus and Cabassa (2010) on their qualitative research on the Pattern of distress, precipitating events and reflections on suicide attempts by young American Latinas noted that the participants (girls) who verbalized deliberate self-harm with a clear intent to die described feeling depressed, sad, guilty and unworthy as factors that led them to attempt suicide. Randall et al. (2014) in his study noted that anxiety was one of the four most significant variables for the youths of Benin who were multiple attempters of suicide in the year 2009. In the Minnesota student survey , hopelessness is shown to be another important risk factor for adolescent suicidal behavior (Taliaferro & Muehlenkamp, 2014). Consistent with previous findings in Alberta , Canada anxiety and loneliness were associated with increased suicide attempts (Randall, Rowe and Colman 2012). Cheung et al. (2006) in China confirmed that issues of hopelessness, depression and social factors put people at great risk of committing suicide

2.4.5 Sexual and Physical Abuse

Sexual and physical abuse have many negative effects that affects young people and these are physical, emotional, social and psychological effects. If these effects are not solved they might lead an individual not to see the reason for living thus thoughts of suicide might occur.

Looking at the studies of physical and sexual abuse as a risk factor for attempted suicide, in a study conducted by Hadlad et al. (2015) in Vancouver Canada history of childhood maltreatment was strongly associated with risk of attempted suicide, with youth who reported previous physical abuse, emotional abuse, or emotional neglect 3 to nearly 5 times as likely to report attempting suicide. Pillai, Andrews, and Patel (2009) conducted a cross-sectional study of

3662 youth (16–24 years) from rural and urban communities in Goa, India. They found that suicidal behavior was associated with physical abuse at home, female gender, not attending school or college, independent decision making, premarital sex, life time experience of sexual abuse and probable common mental Fergusson, Boden and Horwood (2008) in their study in New Zealand on the exposure to childhood sexual and physical abuse and adjustment into early adulthood observed that children who would have been exposed to sexual and physical abuse are mostly likely to have suicidal ideations and behaviors between the ages of 16-25 disorders. In a study conducted by Bruwer ,Goverder , Bishop , Willian , Stein and Seedat (2012) in South Africa they concluded that physical abuse and sexual abuse were among the identified significant risk markers for suicide attempts as they had the strongest association with lifetime suicide attempts.

2.4.6 Stressful Life Events

According to Shaheen (2014) a large number of studies found that adolescents who attempted suicide were more likely to have experienced stressful life events such as interpersonal difficulties, conflicts, or losses and environmental consequences.

In trying to explain the reasons why the rate of suicide attempts was high among the youths of Benin in comparison to the previous year's, Randall et al. (2014) noted that the survey was conducted in the year of abnormal hardships for Benin as the country experienced flooding and was affected by a global economic crisis. , Zayas and Gulbas (2012), in American Latina have shown that suicide attempts among young people were associated with critical life course experiences which cause stress and shame in the family and with the experiences at hand, youths usually thought to resort to suicidal behaviors so as to escape from the circumstances. Swahn et al. (2012) in their study in Atlanta USA, noted that while sadness was highly associated with both self-harm and suicide attempt, suicide attempt only and self-harm only, the students who reported both self-harm and suicide attempt had higher prevalence of child maltreatment, impulsivity and less parental support when compared to students who reported suicide attempt only, self-harm only and these can be seen as stressful life events. In a study conducted in South Africa by Bruwer , Govender, Bishop, Williams, Stein and Seedat (2014) participants who were

18 years and older showed that two or more childhood adversities were associated with a twofold higher risk of lifetime suicide attempts.

To add on, Zayas et al. (2010), in a study of the patterns of distress, precipitating events and reflections on suicide attempts carried out on teenage Latinos aged between the ages of 11-19 living in New York who attempted suicide, results showed that the pathways to the suicide event consisted of a pattern of continuous escalating stress (primarily at home) that created the emotionally combustible condition for the attempt. In a study on suicide among students in Iran found that most suicide attempts were caused by romantic disappointment (Farzaneh ,Mehrpour , Alfred , Moghadam , Behnoush , Seghatoleslam 2010).

2.5 PROTECTIVE FACTORS

Shaheen(2014) notes that protective factors are those factors that decrease the probability of an outcome (para suicide) in the presence of elevated risk. In the course of reviewing literature the writer came across a number of protective factors that various authors thought could help decrease the probability of risk of youth para-suicide.

2.5.1 Family Factors

In a research to find out the relationships of depression and suicide attempts as well as finding the protective factors in their literature review Wyatt, Ung ,Park , Kwan and Trinh- Shenrin (2015) concluded that there are protective factors that can address both suicide and depression. Juang and Cookston (2009) found that higher levels of family obligation were associated with fewer depressive symptoms among Chinese American adolescents; increasing family obligation behaviors were associated with decreasing depressive symptoms over time. Park (2009) found that parents care to their children is not linked with depression among Korean adolescents, and Qin, Pak, Rana et al (2012) found that when a family is united it is possess as a protective of depression among Chinese adolescents. According to Willgerodt (2008), family bonds had a significant negative effect on emotional distress (depression) over time among Pilipino and Chinese adolescents, and Wong (2001) found that positive peer and parent relationships were associated with lower depression levels among Chinese and Southeast Asians. Nock et al (2008) also noted that perceptions of social and family support and

connectedness also have been seen to decrease the rates of suicidal behavior. Wong and Maffini (2011) found that family relationships were protective of suicide attempts for Asian Americans.

2.5.2 Support from friends/peers and significant others

Social support is anything that leads someone to “believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations” (Cobb, 1976).

Kleiman and Liu (2013) after a research they done on all black Americans concluded that findings suggest social support is associated with decreased likelihood of a lifetime suicide attempt, it is a highly modifiable factor that can be used to improve existing suicide prevention programs worldwide. They also went further to posit that social support may also mean the presence of others that can help individuals cope with stressful events and difficulties associated with psychopathology, which may reduce risk for suicide. In addition to the empirical evidence that social support may be a protective factor in suicide, there is strong theoretical support as well. For example, the presence of social support may increase feelings of belongingness, which is negatively associated with suicide risk within Joiner’s Interpersonal Theory of Suicide (Joiner, 2005; Joiner et al., 2009;)focused on poor social network as a risk factor for suicidal behavior, emphasizing the importance of evaluating a patient's social support system as part of the management plan for suicide attempters.

2.5.3 Spirituality / Religious beliefs

Shaheen (2014) posited that noted that religiosity can be defined as the position of being sentimental to a particular religion or religious belief in a higher power (i.e., God) and is an important protective factor against any suicidal behavior.

In a study which was conducted in Brazil on the impact that religion as a protective factor for suicidal behavior Caribe at al. (2012) posited that after evaluated 110 participants who had attempted suicide , religiosity was measured and religiosity was shown to be an important protective factor against suicide attempts, even after controlling for relevant risk factors associated with suicidal behavior: After a study conducted among University students in India . According to Nock et al (2008) in his journal of Suicide and Suicide Behavior, religious beliefs, religious practices and spirituality has been associated with decreased probability of suicide

attempts (Garrouste, Golderg, Beals et al 2003). Tubergen, Grotenhuis and Ultee (2005) also set out to explore critically Durkheim's study of suicide, particularly to investigate the support provided by religious networks and/or religion-based moral sanctions on suicide. This cross-sectional study used data from the Netherlands (1936-73) of Catholic, Protestant and non-churchgoing suicide completers (n=14744). They found that suicide rates decreased among populations with rising proportions of church attendees in a community. In a study conducted in China by Wu, Wang and Jia (2015) on religion and completed suicide they discovered that religion plays a protective role against suicide in a majority of settings where suicide research is conducted.

2.5.4 Being Optimistic, reason for living and hopefulness.

Meadows et al. (2005) discovered that one of the main protective factors against suicide attempts among economically, educationally, and socially disadvantaged African-American women who had experienced recent intimate partner violence and who had attempted suicide was hopefulness. Those with high levels of hope were less likely to have attempted suicide than those with low levels of hopefulness.

Also in a study conducted by Malone et al (2000) cited in McLean. Maxwell, Platt, Haris, Jepson (2008) to test the hypothesis that 'reasons for living' might protect United States patients with major depression from attempting suicide. He observed that participants who scored high on the reason for living inventory had never attempted suicide. Hence this showed that there was a link between reason for living and not attempting suicide.

Shaheen (2014) noted that studies have shown hope and optimism as potential protective factors against suicidality among students (Hirsch & Conner, 2006).

2.6 PARA-SUICIDE IN ZIMBABWE

In Zimbabwe there is little information on the risk and protective factors of para-suicide centering on the youths. Looking at the research that was done in the Hurungwe district on the

nature and causes of para-suicide cases handled by traditional healers in Zimbabwe Munikwa, Mutopa and Maphosa (2012) noted that in Hurungwe district suicide and para-suicide are attributed to avenging spirits. They further noted that this was an Afro-centric view of suicide and para-suicide and is in contrary with the Eurocentric views. Chibanda ,Sebit and Acuda (2002) in their study also noted that in our African setting especially in Zimbabwe, people view para-suicide as a cultural/spiritual problem also known as ‘ngozi’ in Shona. This then shows that in Zimbabwe there is need to conduct research so as to know the real causes of suicide and para-suicide as Chibanda,Sebit and Acuda (2002) noted that further studies are needed to address some of the causes of deliberate self-harm (para-suicide) and Munikwa, Mutopa and Maphosa (2012) also noted that there is need to carry out research in other districts on the causes of para-suicide as well as at National level.

2.7 THEORETICAL FRAMEWORK

The study will be guided by three theories namely the theory of Reasoned Action formulated by Fishbein and Ajzen (1975), the theory of Planned Behavior formulated by Ajzen (1991) and the interpersonal theory propounded by Joiner (2005) .According to Fishbein and Ajzen (1975) the theory of reasoned action posits that individual behavior is driven by behavioral intentions were behavioral intentions are as a function of an individual attitude towards a behavior and subjective norms surrounding the performance of that behavior.

The theory of Planned Behavior according to Ajzen (2005) is based on assumptions that human beings usually behave in a sensitive manner, that they take account of available information and implicitly or explicitly consider the implications of their actions. According to the theory of planned behavior as shown by Ajzen (2005) he further posits that intentions and behaviors are a function of three basic determinants, one person in nature, one reflecting social influence and a third dealing with issues of control.

The personal factor according to Ajzen (2005) is the individual’s attitudes towards behavior which he defined as the individual’s positive or negative evaluation of performing a particular behavior of interest. The second determinant of intention is person’s perception of social pressure to perform or not to perform the behavior under consideration and the factor is termed

the subjective norm. The third determinant of intention the sense of self efficacy or the ability to perform behavior of interest termed perceived behavioral control. Perceived behavioral control is whereby people intend to perform a behavior when they evaluate it positively, when they experience social pressure to perform it and when they believe they have means and opportunities to do so.

According to Nock (2014) the interpersonal theory by Joiner (2005) entails that suicide is as a result of interactions between two components that is feelings that one does not have a connection with others or feeling alienated from valued social groups such as peers and family(thwarted feelings) , thoughts and feelings that one is a burden to those around them thus the feeling of oneself being incompetent and feeling as a liability to others (perceived burdensomeness) and a greatly diminished fear of pain and death due to repetitive experience with habituation to painful and fear invoking life events (the acquired capacity to enact lethal self –injury).

2.8 KNOWLEDGE GAP

Whilst doing her literature review the writer observed that much of the research done on the risk and protective factors of adolescents or youths para-suicide was mostly centered in high income countries the likes of United States of America,Canada, United Kingdom to point but a few. There was little information on those factors relating to low income countries let alone Africa (Zimbabwe). So this research seeks to add information on the risk and protective factors in the context of Zimbabwe, Chegutu to be particular thus adding information on the risk factors and protective factors of para-suicide in low income countries.

Looking at the research that was done in Zimbabwe on para-suicide taking for instance the study done by Munikwa, Mutopa and Maphosa (2012), they recommended that emphasis should be placed on preventing cases of suicide attempts from occurring. Since their study focused on the nature and causes of para-suicide, the protective factors mentioned in this writer's research will help as preventive measures set against suicide attempts which if implemented by the youths, family, schools and the community of Chegutu as a whole will help lessen the suicidal attempts among the youths.

To date no research has been conducted in Zimbabwe's Chegutu District on the risk and protective factors of para-suicide. This factor alone will act as a knowledge gap as Chibanda, Sebit and Acuda (2002) noted that other studies are needed to address some causes of deliberate self-harm (para-suicide) and also Munikwa , Mutopa and Maphosa (2012) noted that there is need to carry out further research on suicide attempts in other districts and at national level too.

2.9 CHAPTER SUMMARY

To sum up, the literature review provided knowledge on previous findings in regards to the issues that are in line with the research topic. The chapter highlighted that the information on the risk and protective factors of youth para-suicide is mostly found in high income countries and there is little information of these factors in low income countries. The chapter also noted that the issue of para-suicide is most common in girls when compared to boys. Also the noting of recommendations in previous research especially those conducted in Zimbabwe helped the writer to identify the gaps and limitations in her own research.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology is a way to systematically solve the research problem. It is a scientific study of how research is done methodically (Kothari, 2004). The chapter was sub-divided into the following topics; research approach which showed the approach that the researcher took in her methodology, research design, population which is the targeted population that participated in the research, sampling technique and size which showed the methods of sampling that the researcher choose and the reasons why she choose them, research instruments which entails the instruments that were chosen which is the self administered questionnaire and the reasons why it was selected and data collection procedure simply shows all the steps that were taken in collection of data. The ethics that guided this research are also discussed and then the summary, these and other things shall unfold as the chapter progresses.

3.2 RESEARCH APPROACH

The researcher used a quantitative approach in collecting her data. Cohen (1980) described quantitative research as a social research that employs empirical methods and empirical statements, he further states that an empirical statement is defined as a descriptive statement about what 'is' the case in the real world than what should be. Creswell (1994) defined quantitative research as a type of research that is explaining occurrences by presenting data numerically and analyzing it by means of mathematically based methods.

Creswell (1994) posited that different types of research problems call for specific approach. He explained further stating that if the problem is of identifying factors that influence an outcome or the best predictions in an outcome then a quantitative approach is the best approach to use. The researcher chose this approach because her problem was of identifying factors that lead to an outcome, one outcome was that of para-suicide which was explained by the risk factors. Quantitative research method also relies on the analysis and correction of numerical data to explain, predict and describe data and one of the underlying view of quantitative research it is also a philosophical belief that the world is relatively steady and standardized, such that we can

measure and understand it as well as make broad generalizations about it as presented by Gay, Mills and Airasian (2009). Basing on the above statement the quantitative approach helped to interpret and analyze her data numerically in an understandable manner since her population size was huge .

3.3 RESEARCH DESIGN

Hussey and Hussey (1997:54) alluded that research design is the general approach to the research process, thus it starts from the theoretical foundation to the gathering and examination of data. Information of developing how the study will be executed is strongly determined by the research design, for this reason it shows that research design is a significant factor in research.

This study was guided by the descriptive research design, Aggarwal (2008) noted that descriptive research is committed to the gathering of information about existing conditions or situations so as to describe and interpret findings. Oppenheim (1992) further posited that the main purpose of a descriptive research design is the gathering of information from everyone, failure to gather information from everyone it then operates with a representative sample and then make conclusions about the population as a whole. For the purpose of this study the descriptive research was used so as to obtain a clear picture of the youths who are at risk of para-suicide and to also to know the risk factors as well as the protective factors of youth para-suicide. In the process the researcher did not sample all the youths of Chegutu but looked at a chosen sample and then made inferences about the population as a whole basing from the results she had.

Oppenheim (1992) in addition to descriptive research design stated that the most important factor of this research design is that it looks at how many members of a population have certain characteristics or how often certain events occur together. Looking at this research it was mainly concerned with knowing the youths who were at risk of para-suicide and their numbers at the same time seeking to understand the risk factors that are causing them to exhibit that behavior as well as the protective factors.

It should be noted that descriptive research designs are not meant for explanations or showing casual relationship between variables. The job of this survey is simply for fact finding and describing situation (Oppenheim 1992). Caution should be noted that in the research no

explanations were made neither was there any showing of relationships between variables but it was just fact finding and describing the risk factors and protective factors of para-suicide among the youths.

3.4 POPULATION

It is difficult to study the whole populace due to considerations of time, cost, energy, volume of data to point but a few. Target population is described by Jacobsen (2012) as the universal populace that the study seeks to understand. The population that the researcher targeted was the youths who ranged from 16-24 years both in schools and colleges because that is where the age range is found. The population of youths amongst the range that the researcher wanted was at least 1400.

3.5 SAMPLE SIZE AND SAMPLE PROCEDURE

3.5.1 SAMPLE SIZE

In selecting her sample size the researcher used the Sakaran table for guidance Sakaran (1992) to select her sample size. The researcher wanted a confidence level of 83.4% and a margin error (degree of accuracy) of 0.05 thus her sample size became 169 youths

3.5.2 SAMPLING PROCEDURE

A sample according to Frey, Carl and Gray (2000), is a sub-category or a small component of a population. Berinstein (2003) describes it as a small taste of a group. The sample should be representative in the sense that each sample no matter how small it is will be able to represent the qualities of the whole population.

In collecting her data the researcher used a cluster sampling which falls under the probability sampling method. In probability sampling as described by Frey, Carl and Gray (2000) every participant has the same chance of being chosen as it get rid of the problem of bias whilst selecting participants. Cluster sampling is a sampling technique where the population elements are first divided into clusters and then clusters are randomly selected with all their elements to constitute the sample elements. Clusters become the sampling elements. Cluster sampling is cost effective where the population is spread over wide geographic area (Kothari, 2004). The researcher came up with her cluster according to the geographical locations of schools in

Chegutu Urban. Chegutu Urban has six schools, these schools were divided into three clusters until three schools were chosen which are NMB Commercial College, Courtly Academy and Mupfure College. The clusters were chosen with regards to issues of commonality and representation of entire population under study. In choosing these schools the researcher did it in such a way that those from 16-19 years came from NMB College and Courtly Academy and those from 20-24 came from Mufure College. So three institutions were selected, after the selection of these institutions the researcher did not sample all the population but randomly selected students that is not less than 45 students per institution.

3.6 RESEARCH INSTRUMENTS

Research instruments are used for the collection of data used in the research. Data collection is a process of gathering suitable data for answering research questions (Walcholder, Mchaughling, Siverman et al., 1992). In this study the researcher used a self-administered questionnaire in the collection of her data. A questionnaire is a tool used for gathering of raw data (Degu and Yigzaw, 2006). It contains a list of questions which seek to source data from the people to answer certain laid down research objectives. Trochim (2006) noted that this type of a questionnaire is whereby the respondents complete questions on their own. The questionnaire was based on a Likert scale which uses interval responses and it is defined as a controlled scale from which respondents select an alternative which suits perfectly with their situation. It inquires about the degree to which respondents are in agreement or disagreement with a particular matter (Losby and Wetmore 2012).

The researcher used several research instruments so as to come up with her questionnaire. Firstly the researcher used the Suicidal Behavior Questionnaire propounded by Ossman et al (2001) so as to assess the risk of para-suicide in youth. In evaluating the risk and protective factors the researcher used the 39-item Depression Hopelessness and Suicide screening form (DHS) propounded by Mills and Kroner 2003 to screen for depression and hopelessness, the Family Environment Scale by Moos and Moos (1974) so as to know the family factors that might lead to para-suicide, the Coping Competence Questionnaire by Schroder (2004) so as to assess how youths act when faced with stressful life events. Not all questions were used from these questionnaires by the researcher; she only took those which applied to her research. Caution

should be noted that the researcher did not wholly depend on these questionnaires but constructed few questions so as to answer some of her research questions and objectives which were not addressed by the adopted research instruments.

3.6.1 Validity and Reliability of Research Instruments

Heale and Twycross (2015) defined validity as the degree to which a notion is accurately measured. Validity of a questionnaire is observed by the construction of the questionnaire, in this research all the questions were directly in line with the research questions and objectives thus showing its validity. The research instruments were also valid because they addressed issues which the researcher wanted to answers such as assessing the risk of suicidal attempts in youth (Osman et al 2001 Suicide Behavior Questionnaire) and evaluating the risk and protective factors of para-suicide (DHS Form Mills and Kroner 2003; Family Environment Scale Moos and Moos 1974 and Coping Competence Questionnaire by Schroder 2004). The fact that it addressed some of the research questions showed that concepts were being accurately measured hence that is validity. These instruments also apply in the African context because most of the questions that the researcher took from the research instruments were not culturally oriented for instance a question extracted from the Hopelessness and depression Form Mills and Kroner (2003) “I don’t think I amount to anything” this question applies to both western or African cultures because it need a personal point of view.

Data validity and reliability was also improved in this research by upholding the ethic of confidentiality. The respondents were honest because they knew that their names were not going to be revealed to anyone. The questionnaire for youths had three sections, section A answered demographic issues such as age, sex, religion and educational level. Section B assessed the risk of para-suicide this was done by tapping into different dimensions of suicidality paying particular attention to suicide attempts and section C looked for the risk and protective factors of para-suicide.

3.7 DATA COLLECTION PROCEDURE

The researcher got an approval letter from the Midlands State University department of Psychology which helped her to seek for permission to carry out her research in Chegutu. The researcher then made appointment with Principals of MNB Commercial College, Courtly Academy and Mupfure College as per collection of data of youth in schools. The researcher chose these schools because that is where the majority of youths who ranges from sixteen to twenty years attend school in Chegutu and the geographical locations of these schools is also another added advantage. Courtly Academy is located in such a way that children from low and medium density attends to that school and NMB Commercial College is located in a way that children from the high density attends to that school hence all youths will be targeted. Since this population comprised of young youths the researcher read the questionnaire for them and explained every stage of the questionnaire whilst they were answering.

As for the youth who ranges from twenty one years and older the researcher choose Mupfure Self Help College where she was granted permission by the Vice Principal of the College and was also assisted by the Dean of Students to reach out to the targeted population. The researcher gave a brief background of her study and explained her questionnaire before the student answered the questionnaire.

3.8 DATA ANALYSIS

The researcher used a statistical package called the SPSS version 21 in her data entry and analysis. SPSS is a window based program that is used to carry out data entry and analysis and to create tables and graphs (Field 2009). Aruga (2008) posits that SPSS is numerical package that can undertake extremely obscure data handling and breakdowns at the same time asconstructing diagrams explaining concepts. Cross tabulation tables were used as well as correlations.

3.9 ETHICAL CONSIDERATIONS

The ethics that guided this research were confidentiality, informed consent and right of participant withdrawal.

3.9.1 Confidentiality

Defend respondents from harm and this can be done by assuring participants that their information will not be revealed to anyone. Respondents will be assured that the data they provide on the questionnaire will not be shown to anyone Creswell (2007). Therefore, the researcher ensured confidentiality by not including names and surnames of participants on the questionnaire hence no one knew which participant revealed the information.

3.9.2 Informed Consent

Best and Kahn (2006) noted that informed consent is whereby an individual may decide regardless of the consequences whether to take part or not to in a study and it is the researcher's task to assure that participants have complete understanding of the procedures in the study, the duty of the participants and the dangers they may face. Hence in the research the researcher made sure that all participants who took part in the study had informed consent and they were free to withdraw at any time. The researcher made sure that the participants understood each and every thing that seemed to confuse participants.

3.9.3 Right to withdrawal

Right of withdrawal as an ethic is by the participant are free at any time in research not to take part or continue with the research. Since the issue of para-suicide is a very sensitive case the researcher made it clear to her participants that if they felt like pulling out from answering the questionnaire it was understandable.

3.10 CHAPTER SUMMARY

The chapter was mainly discussing the ways in which the researcher collected her data, how she chose her participants, the research instruments and the ethics that guided the research.. This was shown by the sub topics such as research paradigm, research design, population, sample technique and size, data collection procedure, data analysis and the ethics that guided the collection process.

CHAPTER 4

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter provides presentations of the results of the study and provides answers to research questions and at the same time addressing the research objectives.

4.2 DEMOGRAPHIC INFORMATION: CHARACTERISTICS OF PARTICIPANTS

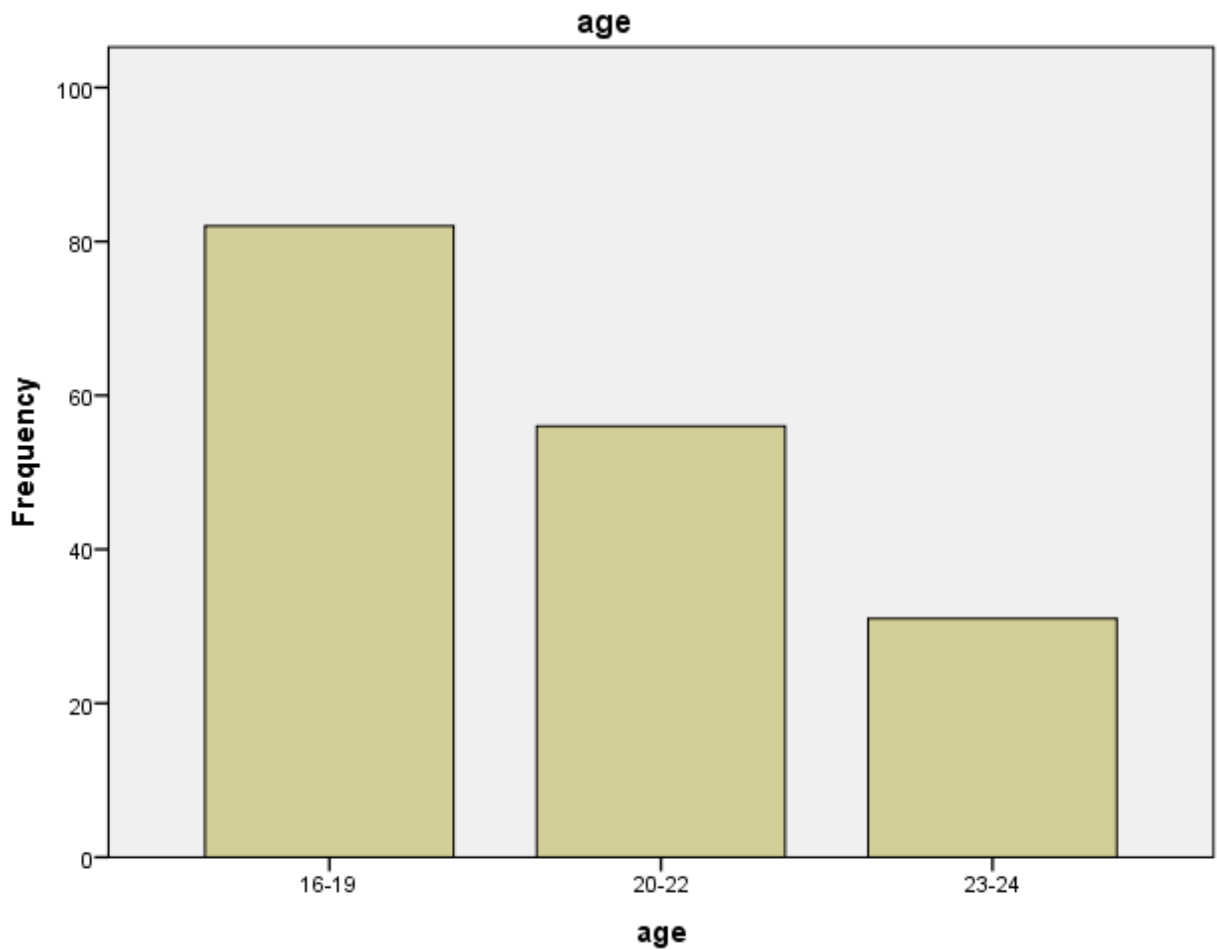


Figure 4.1 shows the total number of participants who were targeted by the researcher together with the frequency of their age. The researcher's sample size was 169 and out of the 169

participants reached 82 ranged from 16 to 19 years of age, 56 ranged between 20 to 22 years and lastly 31 participants belonged to the 23 to 24 age group.

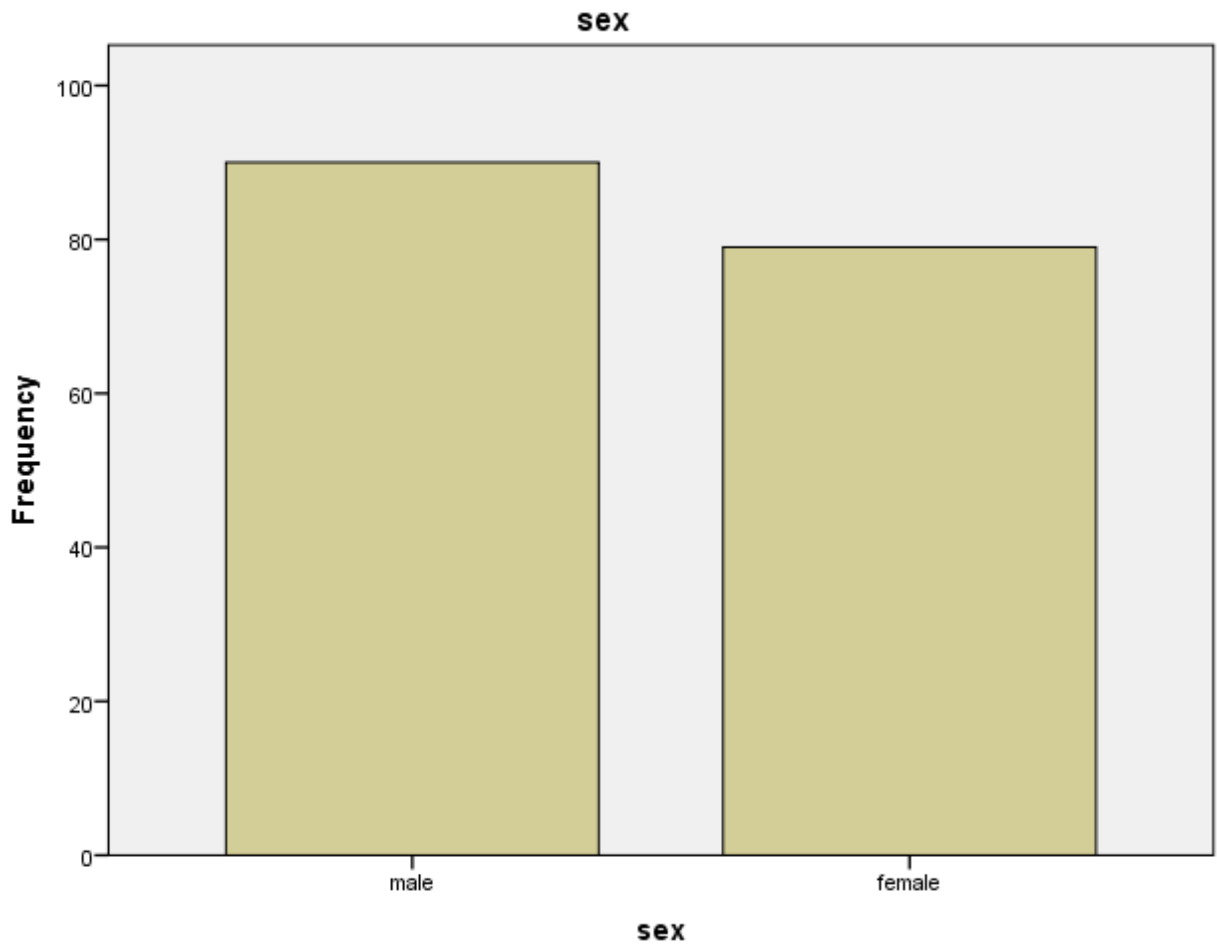


Figure 4.2 shows that in the study out of the 169 participants, male participants were 90 and females were 79.

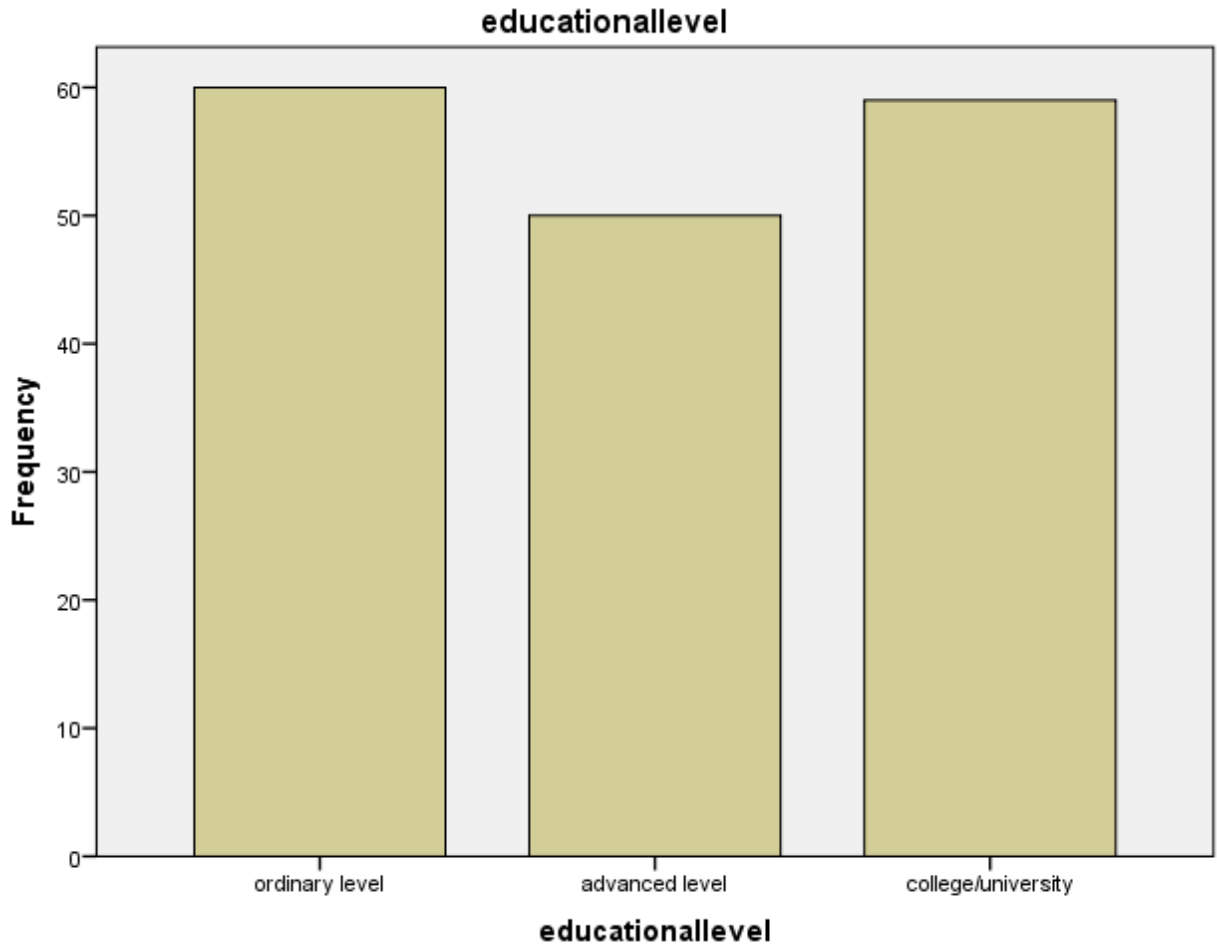


Figure 4.3 shows frequency of participants by educational level, 60 participants were ordinary level students, 50 were advanced level students and 59 students were from college students (tertiary education).

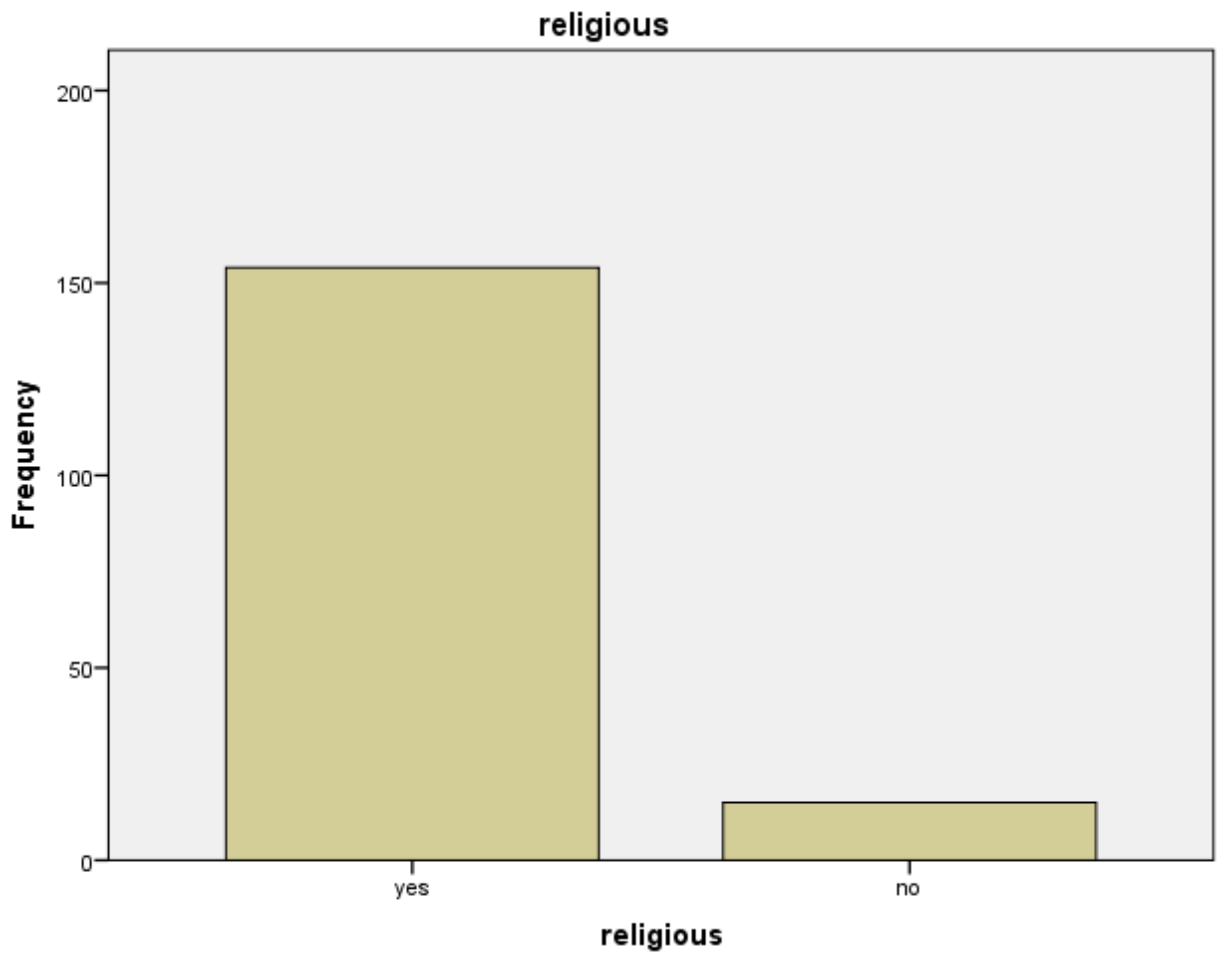


Figure 4.4 shows that in regards to religion 154 participants claimed that they were religious whilst 15 stated that they were not.

4.3 ARE THE YOUTHS AT RISK OF PARA-SUICIDE.

Table 4.1 Overall outcome of youth Para-suicide in Chegututu

No		Low		moderate		High		Total	
N	%	N	%	N	%	n	%	n	%
107	63.3%	41	24.3%	19	11.2%	2	1.2%	169	100%

Table 4.1 shows the numbers and percentages of participants who were at and not at risk of para-suicide, (63.3%), showed no risk, (24.3%) of the participants showed low risk, (11.2%) of the participants showed moderate risk and (1.2%) of the participants showed a high risk of para-suicide. The letter n represents the number of participants and the symbol % represents percentages

Table 4.2 Have you ever attempted to kill yourself.

Age	Sex	Never		it was, just a brief passing thought		I have had a plan at least to kill myself and really wanted to die		I have attempted to kill myself but did not want to die		I have attempted to kill myself and really hoped to die		Total
		n	%	n	%	n	%	n	%	n	%	
16-19	Male	30	75%	3	7.5%	1	2.5%	3	7.5%	3	7.5%	40
	Female	22	52.4%	7	16.7%	2	4.8%	10	23.8%	1	2.4%	42
20-22	Male	22	55%	8	20%	2	5%	5	12.5%	3	7.5%	40
	Female	5	31.3%	4	25%	0	0	6	37.5%	1	6.3%	16
23-24	Male	4	40%	2	20%	1	10%	1	10%	2	20%	10
	Female	11	52.5%	2	9.5%	1	4.8%	7	33.3%	0	0	21

Table 4.2 shows the frequency of how participants responded to the first question which wanted to know if participants had ever thought or attempted to kill them (para-suicide). The researcher used a spilt file to make comparisons of age and sex as per response to the question. Under the 16-19 age group a total of 40 male participants responded, 30 (75%) participants stated that they never thought of neither where they para-suicidal, 3 (7.5%) participants stated that they thought of being killing themselves, 1 (2.5%) alluded that he had made a plan to end his life and really wanted to die. 3(7.5%) alluded that they had attempted to kill themselves but did not want to die and also 3(7.5%) had attempted suicide and really hoped to die. Looking at the females under the same age group a total of 42 participants responded to the question, 22(52.4%) participants responded that they never thought neither did they ever committed suicide whilst 7(16.7%) participants noted that they had a brief passing thought, 2 (4.8%)participants noted that they had made plans to end their lives but no action was taken, 10(23.8%) alluded that they had attempted to kill themselves but did not want to die whilst 1 (2.4%) participant noted that she attempted suicide and really hoped to die.

Moving on to the next age group which is the 20-22 age group a total of 36 participants responded to the question with a breakdown of 40 males and 16 females. 22 (55%) female participants responded that they never that they never had thoughts neither were they para-suicidals whilst 5(31.1%) females also agreed with the same verdict. 8 (20%) male participants responded that they just had a brief passing thought whilst 4(25%) also agreed with the above mentioned view. 2 (20%) of male participants responded that they had made plans to kill themselves and really wanted to die, no female participants responded to this answer. 5 (12.5%) male participants noted that they had attempted to kill themselves but did not want to die and on the other hand 6 (37.5 %) female participants shared the same view. 3(7.5%) male participants responded that they attempted to kill themselves and really wanted to die whilst only 1 (2.4%) agreed with the same response .

Moving on to the 23-24 age group a total of 31 participants responded to the question with a breakdown of 10 males and 21females. Out of the 10 male participants 4(40%) said that they never thought neither have they ever attempted suicide, 2(20%) participants reported that it was just a brief passing thought, 1(10%) participant noted that he had made a plan, also another

1(10%) participant noted that he had attempted suicide but did not want to die and finally 2(20%) participants had attempted suicide and really hoped to die. Looking at the female participants 11(52,4%) participants reported that they never thought neither did they attempt to kill themselves, 2(9.5%) participants reported that they only thought about it, 1(4.8%) participant noted that she only made plans , 7(33.3%) participants reported that they attempted suicide but did not want to die. Hence with the above figures it shows that youths are at risk of para-suicide. It should be noted that the letter n represents the number of participants and the symbol % represents percentages.

Table 4.3 How often have you thought about killing yourself in the past.

Age	Sex	Never		Rarely 1 time		Sometimes 2 times		Often 3-4 times		Very often 5 or more times		Total
		n	%	n	%	n	%	n	%	n	%	
16-19	Male	31	77.5%	4	10%	3	7.5%	2	5%	0	0	40
	Female	23	54.8%	6	14.3%	8	19%	4	9.5%	1	2.4%	42
20-23	Male	22	55%	7	17.5%	7	17.5%	2	5%	2	5%	40
	Female	5	31.3%	3	18.8%	3	18.8%	3	18.8%	2	12.5%	16
24-25	Male	4	40%	1	10%	3	30%	1	10%	1	10%	10
	Female	11	52.4%	4	19%	4	19%	2	9.5%	0	0	21

Table 4.3 shows the frequency of how participants responded to the question which asked them, how often they thought about killing themselves in the past. For analysis the researcher compared age, sex and the response to the question with a split file for comparisons. On the 16 -

19 age group 31 (77.5%) male participants noted that they never thought about it, 4 (10%) responded that they rarely thought about it, 3(7.5%) noted that they sometimes thought about it whilst 2(5%) responded that they often thought about it however no participants responded that they thought about killing themselves very often. Looking at the females 23(54.8%) participants noted that they never thought about it whilst 6 (14.3%) participants responded that they rarely thought about it, 8(19%) participant said that they sometimes thought about it, 4 (9.5%) participants noted that they thought about killing themselves often and only 1(2.4%) participant responded that she thought about killing herself very often.

Moving on to the 20 -23 age group 22 (55%) male participants reported that they never thought about killing themselves whilst 7(17.7) participants noted that they rarely thought about it , another 7 (17.7%) participants responded that they sometimes thought about it , 2(5%) participants noted that they often thought about suicide and lastly another 2 (5%) participants reported that they thought about killing themselves in the past very often. Looking at the female participants 5 (31.3%) reported that they never thought of killing themselves in the past whilst 3(18.8%) participants noted that they rarely thought about it, another 3(18.8%) participants reported that they sometimes thought about it. 3(18.8%) participants responded that they often thought about it and lastly 2(12.5%) participants noted that they thought about killing themselves very often

The 23-24 age group showed that 4(40%) male participants reported that they never thought or attempted to kill themselves in the past, 1(10%) participants responded that he rarely thought about it whilst 3(30%) participants responded that they sometimes thought about suicide. 1(10%) participant responded that he often thought about it whilst another 1(10%) participant noted that he thought about suicide very often. Moving on to the females 11(52.4%) participants responded that they never thought about it , 4 (19%) participants noted that they rarely thought about suicide whilst another 4(19%) participants said that they sometimes thought about it and finally 2(4.5%) participants noted that they often thought of killing their selves in the past . It should be noted that no female in this category selected the very often answer. Caution must be taken that the letter n represents the number of participants and the symbol % represents percentage

Table 4.4 Have you ever told someone that you were going to commit suicide or that you might do it.

Age	Sex	No		Yes, at one time but did not want to die.		Yes, at one point and really wanted to die.		Yes more than once but did not want to do it		Yes more than once and really wanted to do it		Total
		n	%	n	%	n	%	n	%	n	%	
16-19	Male	34	85%	3	7.5%	1	2.5%	1	2.5%	1	2.5%	40
	Female	33	78.6%	3	7.1%	1	2.4%	2	4.8%	3	7.1%	42
20-22	Male	26	65%	8	20%	0		3	7.5%	3	7.5%	40
	Female	10	62.5%	4	25%	2	12.5%	0	0	0	0	16
23-24	Male	9	90%	1	10%	0	0	0	0	0	0	10
	Female	16	76.2%	3	14.3%	0	0	1	4.8%	1	4.8%	21

Table 4.4 shows how participants responded to the question which assessed if they ever told someone that they were going to commit suicide or that they might do it. Participants under the 16-19 age group showed that 34 (85%) male participants respondent that they had not told anyone that they that they were going to commit suicide or that they might do it whilst females were 33(78.6%) , at the same time 3 (7.5%) male participants reported that they had told someone though they did not want to die , 1(2.5%) participant responded that he had told someone and really wanted to die, another 1(2.5%) participant reported that he told someone more than one time but did not want to commit suicide and lastly 1(2.5%) participant responded that he told someone once and really wanted to do it.

Looking at the 20-22 age group 26 (65%) male participants and 10(62.5%) female participants stated that they never told someone , 8(20%) male participants said yes they did they did not want to die whilst the female participants were 4(25%) , no male participants said they told someone that they wanted to commit suicide but did not want to do it however 1(4.8%) female participant selected this response and finally 1(4.8%) said that they told someone and really wanted to do it again no male participants selected this response.

Looking at the last age group which is the 23-14 age group 9(90%) male participants and 16(76.2%) female participants stated that they never told someone , 1(10%) male participants said yes they did they did not want to die whilst the female participants were 3 (14%), no male participants said they told someone but did not want to do it , no female participants selected this response and finally 3(7.5%) participants said that they told someone and really wanted to do it again no female participants selected this response. It should be noted that the letter n represents the number of participants and the symbol % represents percentage

Table 4.5 How likely is it that you will attempt suicide someday.

Age	No		Not at all		Likely		Rather likely		Very likely		Total
	n	%	n	%	n	%	n	%	n	%	
16-19	36	43.9%	27	32.9%	2	2.4%	17	20.7%	0	0	82
20-22	21	37.5%	22	39.3%	2	3.6%	11	19.6%	0	0	56
23-24	4	12.9%	21	67.3%	3	9.7%	3	9.7%	0	0	31

Table 4.5 shows how participants responded to a question which assessed how likely was that they would attempt suicide someday the response in the 16-19 age group showed that 36 (43.9%) participant responded that they will never attempt suicide someday, in the 20 -21 age group participants who responded in the same manner were 21(37.5%) whilst in the 23-24 age group were 4(12.9%). Those who responded with a “not at all answer by age group were 16-19 age group 27(32.9%), 22 (39.3%) and in the 23-24 age group they were 21(67.3%) respectively. 2

(2.4%) participants in the 16-19 age group responded that they will likely attempt suicide someday whilst in the 20 – 22 age group 2 (3.6%) participants 3.6 % responded in the same manner as well as 3 (9.7%) participants in the 23-24 age group .17 (20.7%) responded with a rather likely together with 11(19.6%) participants in the 20-21 age group as well as the 3 (9.7%) participants in the 23-24 age group. It should be noted that amongst these three groups no one selected the option “very likely”. The letter n represents the number of participants whilst the symbol % represents percentage

4.4 RISK FACTORS OF PARA-SUICIDE

Table 4.6: Cross tabulation of hopelessness symptoms and para-suicide.

		Hopelessness Symptoms					
		Moderate		High		Total	
		n	%	n	%	n	%
Para-suicide	Low risk	15	8.9%	13	7.7%	28	16.6%
	Moderate risk	9	5.3%	4	2.4%	13	7.7%
	High risk	1	.6%	1	.6%	2	1.1%
	Total	25	14.8%	18	10.6%	43	25.4%

Table 4.6 shows participants who showed hopelessness symptoms at the same time showing risks of para-suicide. The researcher used a cross tabulation so as to obtain the stated data. Out of 169 participants that the researcher reached out to 43(25.4%) participants showed hopelessness symptoms and were also at risk of para-suicide. The breakdown is as follows, participants who had low risk that is to say who only had ideations of para-suicide and had moderate symptoms of hopelessness were 15(8.9%) and those with low risk of para-suicide and high hopelessness

symptoms were 13 (7.7%). Participants who had moderate risk of para-suicide meaning to say those who planned about it those who actually made plans and really wanted to die were 9(5.3%) and those who had high symptoms were 4 (2.4%). Lastly a participant who showed high risk of para-suicide and had moderate depressive symptoms was 1(0.6%) and again those who had high para-suicidal risk and high depressive symptoms were 1 (0.6%).The letter n represents the number of participants whilst the symbol % represents percentage

Table 4.7 Breakdown cross tabulation of hopelessness symptoms and para-suicide.

Hopelessness symptoms

Have you ever thought about or attempted to kill yourself		Moderate		High	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Brief passing thought	6	3.6%	4	2.4%
	Planned at least once	3	1.8%	3	1.8%
	Attempted but did not want to die	18	10.6%	7	4.1%
	Attempted and really wanted to die	1	0.6%	5	2.9%
How often have you thought About killing yourself in the Past	Rarely	9	5.3%	5	2.9%
	Sometimes	11	6.5%	8	4.7%
	Often	5	2.9%	5	2.9%
	Very often	3	1.8%	1	0.6%
How likely is it that you	Likely	6	3.6%	0	0%

will attempt suicide someday.	Rather likely	10	5.9%	13	7.7%
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Table 4.7 further breaks down para-suicide and hopelessness symptoms looking at how participants who had hopelessness symptoms responded to questions which assessed para-suicide so as to clearly see the link between hopelessness symptoms and risk of para-suicide. The above table shows that when participants were asked if they have ever thought of attempted to kill themselves the table shows that 10(5.9%) had ideations this a combination of participants with moderate and high hopelessness symptoms, 6(3.6%) participants only made plans, 25(14.7%) participants attempted but did not want to die and 6(3.6%) attempted and really wanted to die. When asked about how often they thought about killing themselves 14(8.2%) said rarely, 19 (11.2%) said sometimes, 10(5.9%) said often and 4 (2.4%) participants said very often. When asked how likely it was that they will attempt suicide someday 6 (3.6%) said likely and 23(16.6%) said very likely. It simply reveals that people who responded to showing risk of para-suicide be it ideation, planning or completed attempted suicide also showed moderate and high hopelessness symptoms as shown by the figures above hence it shows that there is a relationship between hopelessness symptoms and para-suicide for this reason it can be seen as a risk factor for para-suicide. The letter n represents the number of participants and the symbol % represents percentage

Table 4.8 cross tabulation of depressive symptoms and para-suicide.

Depressive symptoms

		Moderate		High		Total	
		n	%	n	%	n	%
Para-suicide	Low risk	20	11.8%	3	1.8%	23	13.6%
	Moderate risk	9	5.3%	1	0.6%	10	5.9%

	High risk	1	0.6%	1	0.6%	2	1.2%
	Total	30		5		35	20.7%

Table 4.9 shows participants who both have depressive symptoms and para-suicidal risk at the same time. The cross tabulation table was used to show the above data. Out of the 169 participants reached by the researcher 35 (20.7%) participants seemed to show both depressive symptoms as well as having risk to para-suicide meaning to say students who scored high in para-suicide also scored higher at depressive symptoms. Hence this shows that youths who are depressed might end up being at risk para-suicide be it ideation, plans or completed attempted suicide hence it can be seen as a risk factor. The breakdown of the numbers are as follows participants who showed low risk of para-suicide that is those people who are at risk of para-suicide but at low rates however still at risk and at the same time showing moderate depressive symptoms were 20(11.8%) and those who were at risk showing high depressive symptoms were 3 (1.8%). Participants who showed moderate risk of para-suicide and moderate symptoms of depression were 9 (5.3%) and those with a moderate risk of para-suicide and high depressive symptoms was 1 (0.6%). Lastly 1 (0.6%) participant showed high para-suicide risk as well as depressive symptoms and another 1(0.6%) participant showed high para-suicide risk and high depressive symptoms. The letter n represents the number of participants and the symbol % represents percentage

Table 4.9 Break down cross tabulation of depressive symptoms and para-suicide.

Depressive symptoms

Have you ever thought about or attempted to kill yourself		Moderate		High	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Brief passing thought	8	4.7%	2	1.2%
	Planned at least once	3	1.8%	0	0%
	Attempted but did not want to die	21	12.4%	0	0%
	Attempted and really wanted to die	5	2.9%	3	1.8%
How often have you thought About killing yourself in the Past	Rarely	13	7.7%	1	0.6%
	Sometimes	15	8.9%	1	0.6%
	Often	6	3.6%	3	1.8%
	Very often	3	1.8%	0	0%
How likely is it that you will attempt suicide someday.	Likely	14	8.3%	0	0%
	Rather likely	15	8.9%	5	2.9%

Table 4.9 shows a cross tabulation table of the breakdown of para-suicide questions and how participants with depressive symptoms responded. Thus it seeks to show the relationship between depressive symptoms and para-suicide that is to say that people who scored high in depressive symptoms also scored higher on questions relating to the risks of para-suicide. The above table shows that when participants were asked if they have ever thought of attempted to

kill themselves the table shows that 10(5.9%) had ideations this a combination of participants with moderate and high depressive symptoms, 3(1.8%) participants only made plans, 21(12.4%) participants attempted but did not want to die and 8(4.7%) attempted and really wanted to die. When asked about how often they thought about killing themselves 14(8.3%) said rarely, 16 (9.5%) said sometimes, 9(5.4%) said often and (1.8%) participants said very often. When asked how likely it was that they will attempt suicide someday, 14(8.3%) said likely and 20(11.8%) said very likely. It simply reveals that people who responded to showing risk of para-suicide be it ideation, planning or completed attempted suicide also showed moderate and high depressive symptoms as shown by the figures above hence it shows that there is a relationship between depressive symptoms and para-suicide for this reason it can be seen as a risk factor for para-suicide. The letter n represents the number of participants and the symbol % represents percentage

Table 4.10 Cross tabulation of family factors and para-suicide.

Family factors

Para-suicide		Moderate		High		Total	
		n	%	n	%	n	%
	Low risk	21	12.4%	4	2.4%	25	14.8%
	Moderate risk	4	2.4%	3	1.8%	7	4.1%
	High risk	1	0.6%	0	0%	1	0.6%
	Total	26		7		33	19.5%

Table 4.10: shows a cross tabulation of family factors and para-suicide. That is the number of participants who scored higher in both para-suicide and family factors. Showing that those who scored higher scored high in the section of para-suicide showed risk of para-suicide as shown in

the table and it should be noted that in this research low risk was not an exception because it showed that the participants had para-suicidal ideations hence that is a risk on its own. Moving on to family factors, participants who scored higher in family factors it showed that the youth family environment was not favorable and could likely lead to youth being at risk of para-suicide. The unfavorable family environment included low family support, no feelings of togetherness and a gap between parents guardians and the youths to point but a few. The explanations of the above numbers are as follows participants who had low risk of para-suicide at the same time moderate risky family factors were 21(12.4%) and those who had high family factors were 4(2.4%).Participants who had moderate para-suicidal risk and high family factors were 4 (2.4%) and those with severe family factors leading to para-suicide were 3 (1.8%). Only 1participant with high risk of para-suicide showed moderate scores in family factors.The letter n represents the number of participants and the symbol % represents percentage.

Table 4.11 Breakdown cross tabulation of family factors and para-suicide.

Family factors

		Moderate		High	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Brief passing thought	8	4.7%	0	0%
	Planned at least once	5	2.9%	0	0%
	Attempted but did not want to die	13	7.7%	5	2.9%
	Attempted and really wanted to die	3	1.8%	2	1.2%
	Rarely	9	5.3%	2	1.2%
How often have you thought	Sometimes	16	9.5%	1	0.6%

About killing yourself in the Past	Often	4	2.4%	3	1.8%
	Very often	0	0%	0	0%
How likely is it that you will attempt suicide someday.	Likely	1	0.6%	0	0%
	Rather likely	12	7.1%	4	2.4%

Table 4.11 represents breakdown cross tabulation table of para-suicide and family factors .it seeks to show a relationship of para-suicide and family factors which includes low family support, unfavorable family environment to point but a few . The above table shows that when participants were asked if they have ever thought of attempted to kill themselves the table shows that 8(4.7%) had ideations this a combination of participants with moderate and high family factors , 5(2.9%) participants only made plans, 18(10.6%) participants attempted but did not want to die and 5(2.9%) attempted and really wanted to die. When asked about how often they thought about killing themselves 11(6.5%) said rarely, 17 (10.1%) said sometimes, 7(4.2%) said often and no participants said very often. When asked how likely it was that they will attempt suicide someday, 1(0.6%) said likely and 16(7.5%) said very likely. It simply reveals that people who responded to showing risk of para-suicide be it ideation, planning or completed attempted suicide scored high in family factors showing a relationship between family factors and para-suicide for this reason it can be seen as a risk factor for para-suicide. The letter n represents the number of participants and the symbol % represents percentage

Table 4.12 Cross tabulation of substance use and para-suicide

Substance use

		Moderate		High		Total	
Para-suicide	Low risk	10	5.9%	2	1.2%	12	7.1%
	Moderate risk	2	1.2%	1	0.6%	3	1.8%
	High risk	1	0.6%	0	0%	1	0.6%
	Total	13		3		16	9.5%

Table 4.12: shows the number youths who were at risk of para-suicide and those who consumed alcohol in other words the number of youths who both where substance users and at risk of para-suicide. It then shows that a total of 16 (9.5%) participants were substances users and were at risk of para-suicide. This shows a link between substance abuse and para-suicide because the reasons why these youths are taking substances as well as the actions they do after being drunk poses a threat to their lives. The breakdown of the numbers are as follows 10(5.9%) participants were moderate substance users with a low risk of para-suicide and 2 (1.2%) participants were high substances users and had a low risk of para-suicide. 2 (1.2%) participants were moderate substance users and were at a moderate risk of para-suicide and 1(0.6%) participant was at high alcohol user and at a moderate risk of para-suicide. Only 1(0.6%) participant was a moderate substance user and had a risk of para-suicide. Hence it shows that alcohol and substance use has an impact on youths who are at risk of para-suicide. The letter n represents the number of participants and the symbol % represents percentage

Table 4.13 Breakdown cross tabulation of substance use and para-suicide

Substance use

		Moderate		High	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Brief passing thought	5	2.9%	0	0%
	Planned at least once	2	1.2%	0	0%
	Attempted but did not want to die	7		1	0.6%
	Attempted and really wanted to die	1	0.6%	2	1.2%
How often have you thought About killing yourself in the Past	Rarely	3	1.8%	1	0.6%
	Sometimes	7	4.1%	0	0%
	Often	2	1.2%	2	1.2%
	Very often	2	1.2%	0	0%
How likely is it that you will attempt suicide someday.	Likely	1	0.6%	1	0.6%
	Rather likely	8	4.7%	1	0.6%

Table 4.13 further breaks down para-suicide and substance use so as to clearly see the link between substance use and risk of para-suicide. The above table shows that when participants were asked if they have ever thought of attempted to kill themselves the table shows that 5(2.9%) had ideations this a combination of participants with moderate and high substance use , 2(1.2%)

participants only made plans, 8(4.7%) participants attempted but did not want to die and 3(1.8%) attempted and really wanted to die. When asked about how often they thought about killing themselves 4(2.4%) said rarely, 7 (4.1%) said sometimes, 4(2.4%) said often and 2(1.2%) participants said very often. When asked how likely it was that they will attempt suicide someday, 2(1.2%) said likely and 9(5.4%) said very likely. It simply reveals that people who responded to showing risk of para-suicide scored high in substance use showing a relationship between substance use and para-suicide, for this reason it can be seen as a risk factor for para-suicide. The letter n represents the number of participants and the symbol % represents percentage

Table 4.14 Cross tabulation of stressful life events and para-suicide.

Stressful life events

Para-suicide		Moderate		high		Total	
	Low risk	12	7.1%	17	10%	29	17.1%
	Moderate risk	7	4.1%	6	3.6%	13	7.7%
	High risk	0	0%	2	1.2%	2	1.2%
	Total	19		2		44	26%

Table 4.14 shows youths who were not able to cope with stressful life events as well as showing risk of para-suicide. It then shows that when people are really faced with hardships in life some might resort to para-suicide. This is so because those who were at low risk of para-suicide and showed signs of not coping stressful life events were 29(17.1%) and those who were at a

moderate risk of para-suicide and not coping well with stressful life events were 13(7.7%) participants and those who has a high risk of para-suicide showing signs of not coping well with life events were 2(1.2%).The letter n represents number of participants and the symbol % stands for percentages

Table 4.15 Break down of stressful life events and para-suicide.

		Moderate		High	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Brief passing thought	10	5.9%	5	2.9%
	Planned at least once	1	0.6%	5	2.9%
	Attempted but did not want to die	7	4.1%	15	8.8%
	Attempted and really wanted to die	4	2.4%	4	2.4%
How often have you thought About killing yourself in the Past	Rarely	6	3.6%	9	5.3%
	Sometimes	9	5.3%	12	7.1%
	Often	4	2.4%	7	4.1%
	Very often	4	2.4%	4	2.4%
How likely is it that you will attempt suicide someday.	Likely	3	1.8%	1	0.6%
	Very likely	12	7.1%	13	7.6%

Table 4.15 represents a breakdown cross tabulation table of para-suicide and stressful life events this to see how participants who cannot handle stressful life events responded to para-

suicidal questions .It seeks to show a relationship between these two variables that is para-suicide and stressful life events.The above table shows that when participants were asked if they have ever thought of attempted to kill themselves the table shows that 15(8.8%) had ideations this a combination of participants with moderate and high stressful life events, 6(3.6%) participants only made plans, 22(13.1%) participants attempted but did not want to die and 8(4.7%) attempted and really wanted to die. When asked about how often they thought about killing themselves 15(8.8%) said rarely,21 (12.4%) said sometimes, 11(6.5%) said often and 8(4.7%) participants said very often. When asked how likely it was that they will attempt suicide someday, 4(2.4%) said likely and 25(14.8%) said very likely. It simply reveals that people who responded to showing risk of para-suicide scored high in substance use showing a relationship between substance use and para-suicide, for this reason it can be seen as a risk factor for para-suicide.The letter n represents the number of participants and the symbol % represents percentage

4.5 PROTECTIVE FACTORS OF PARA-SUICIDE

Table 4.16 cross tabulation of hopefulness and para-suicide

Hopefulness symptoms

		No		Low	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Never	60	35.5%	24	14.2%
How often have you thought About killing yourself .	Never	62	36.7%	24	14.2%
How likely is it that you	No	39	23%	11	6.5%

will attempt suicide someday.	Not at all	32	18.9%	21	12.4%
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Table 4.16 shows that hopefulness is a protective factor of para-suicide mainly because youths who scored low in para-suicide risks also showed low and no hopelessness symptoms. For instance when participants were asked if they had ever thought about or attempted to kill themselves 60(35.5%) participants said never and at the same time they showed no hopelessness symptoms. Also 24(14.2%) participants with low hopelessness symptoms also answered never. When asked on how often participants had thought about killing themselves in the past participants with no and low hopelessness symptoms answered that they never and when asked if they will attempted suicide someday 32 (18.9%) participants with no hopelessness symptoms said not at all as well as 21 (12.4%) participant who had low hopelessness symptoms. This then shows that when one is hopeful it is difficult or rather impossible for them to think of para-suicide. The letter n represents number of participats and the symbol % stands for percentages.

Table 4.17 Cross tabulation of family factors and para-suicide

Family factors

Have you ever thought about or attempted to kill yourself		Moderate		High	
		n	%	n	%
	Never	68	40.2%	24	14.2%
How often have you thought About killing yourself .	Never	71	42%	23	13.6%

How likely is it that you will attempt suicide someday.	No	43	24.4%	12	7.1%
	Not at all	36	21.2%	19	11.2%

Table 4.17 above shows family factor as a protective factor against para-suicide this data was obtained through cross tabulation. That is families with high levels of togetherness and support as well as strong relationships the youths from such households scored both low in family factors and no in para-suicide to show no risk. the table shows that when participants were asked if they ever thought or attempted to kill themselves 92(54.5%) said never. When asked how often they thought about para-suicide 93(55%) said never and when asked if they will ever attempt suicide in their life time 120(71%) disagreed. the reasons why participants responded in this manner was because their family factors were showed high levels of supports and togetherness. The letter n represents number of participants and the % symbol represents percentages.

Table 4.18 Cross tabulation of substance use and para-suicide

Substance use

Have you ever thought about or attempted to kill yourself		No		Low	
		n	%	N	%
Have you ever thought about or attempted to kill yourself	Never	81	47.9%	7	4.1%
How often have you thought About killing yourself.	Never	87	51.5%	8	4.7%
How likely is it that you will attempt suicide someday.	No	47	27.8%	9	5.3%
	Not at all	57	33.7%	6	3.6%

Table 4.18 shows that refraining from or low consumption of alcohol and substance use can serve as a protective factor when it comes to para-suicide. Taking a look at the table above it shows that participants who scored less in para-suicide also scored less in alcohol and substance use that is they did not/ consume low alcohol and other substances. For instance when participants were asked if they ever thought about killing themselves those participants who said never showed low and no signs of alcohol and substance use and they were 81(47.9%) and 7(4.1%) respectively . When asked if they ever thought about attempting to commit suicide those with no levels(87.5%)and low levels (4.7%) said that they never thought about it and they were asked if they were going to attempt suicide someday , non alcohol consumers that is a total of 47(27.8%) participants said no and 57(33.7%) participants said not at all and low alcohol consumers 9 (5.3%) participants said no whilst 6 (3.6%) responded with a not at all. The letter n represents number of participants and the symbol % represents percentages.

Table 4.19 Cross tabulation of stressful life events and para-suicide

Stressful life events

		No		Low	
		n	%	n	%
Have you ever thought about or attempted to kill yourself	Never	64	37.9%	24	14.2%
How often have you thought About killing yourself.	Never	65	38.5%	25	14.8%
How likely is it that you will attempt suicide someday.	No	36	21.3%	16	9.5%
	Not at all	32	18.9%	19	11.2%

Table 4.19 shows that knowing how to cope with stressful life events can be seen as a protective factor of para-suicide. This is so because participants who had not at risk of being para-suicidal showed that they knew how to cope with stressful life events and situations. Also the table showed that those who scored low in para-suicide also had low scores in stressful life events. For instance when participants were asked if they ever thought about or attempted suicide 64(37.9%) participants had showed signs of coping well with stress said never and 24 (14.2%) participants who had low levels of coping with stress also said never. Lastly participants who were asked how likely they were to commit suicide someday 36(21.3%) participants who showed signs of knowing how to cope well with stressful life events said no whilst 16(9.5%) who showed low levels of coping with stress also said no. Still on the same question 32 (18.9%) participants who said not at all showed signs of knowing how to cope with stress whilst 19(11.2%) participants who with low levels of not knowing how to cope with stressful life events responded also responded with a not at all. The letter n represents the number of participants and the % symbol represents percentages.

Table 4.20 cross tabulation of religious beliefs / spirituality and para-suicide

Para-suicide	I usually pray to God when I feel overpowered by problems and obstacles			
	strongly agree		Agree	
	n	%	N	%
No risk	58	34.3%	39	23%

Table 4.20 shows that spirituality or religious beliefs can save as a protective factor against para-suicide that is the feeling of knowing that there is a higher force which can help you when you cannot continue any more. The table shows that participants who said they prayed to God when

they feel overpowered by problems showed no risk of para-suicide 58 (34.3%) participants strongly agreed and 39 (23%) participants. The letter n represents number of participants and the % symbol represents percentages.

Table 4.21 supports from peers and para-suicide

Para-suicide	When faced with problems I find it easy to discuss it with my friends			
	strongly agree		Agree	
	n	%	n	%
No risk	48	28.4%	35	20.7%

Table 4.21 shows that having a feeling of social support be it from peers or significant others can act against para-suicidal risk. This is so because participants who showed that they opened up to friends when faced with problems showed no risk of para-suicide and they 48(28.4%) strongly agreed and 35(20.7%) agreed. Letter n represents number of participants and % symbol stands for percentages

4.6 CHAPTER SUMMARY

The chapter was mainly focusing on the presentation of data and its purpose was to answer the research questions and objectives. This chapter has revealed that the youths of Chegutu are at risk of para-suicide some have actually attempted to kill themselves whilst some have ideations and plans. It should be noted that there are some who are also not the risk of para-suicide. The chapter also has revealed that risk factors that are linked to para-suicide in this study were hopelessness and depression, risky family factors such as low family support and lack of bond between parents and siblings, alcohol and substance use and failure to cope with stressful life events. The protective factors against para-suicide in this study were hopefulness, family factors that is a good and protective family for the youths, refraining and or low uptake of alcohol and

substance use , knowing how to cope with stressful life events as well as high levels of spirituality and lastly feelings of social support from peers and significant others.

CHAPTER 5

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter seeks to present the discussions of the findings of this study, as well as proving conclusions and recommendations. Therefore this chapter is divided into three sections the first one will be looking at the research questions and objectives this is where by the researcher will be discussing her research questions as per the results she obtained in the collection of her data . The conclusions will follow up and then lastly the recommendations. These and other issues shall be discussed as the chapter unfolds.

5.2 DISCUSSION OF RESULTS

The researcher sampled 169 youths in her study ranging from 16-24 years of age. These youths were reached in schools and at one tertiary institution thereafter the researcher managed to get her results. This section therefore is mainly discussing research questions that guided this study.

5.2.1 ARE THE YOUTHS OF CHEGUTU AT RISK OF ATTEMPTING SUICIDE?

This research question was meant to assess if youths of Chegutu were at risk of para-suicide, by youths the researcher targeted those from 16-24 years old. For assessment purposes the youth used Osman's (2001) Suicidal Behavior Questionnaire .The researcher observed that the youths of Chegutu were at risk of para- suicide mainly because out of the 169 participants the researcher targeted in assessing the risk of para-suicide 41 participants (24.3%) had a low risk of para-suicide , 19 participants (11.2%) had a moderate risk of para-suicide and 2 participants (1.2%) had a high risk of para-suicide .In total the overall percentage of youths who were at risk of attempting suicide was 36.7% hence this showed that indeed they youths were at risk. The issue of the youths being at risk of para-suicide is in line with what Goldman-Meller (2014),said , he noted that among young adults the rate of suicide attempt is 3 times higher than the rate among adults older that are 30 years old. Also the Centers for Disease control and Prevention (2009), noted that prevalence of suicide ideation and attempts was high with a percentage of 14.5% in the United States of America among the 9th to 12th grade scholars. Hence this shows that youths are seen as being at risk of para-suicide.

To assess whether or not students were at risk of para-suicide the researcher used four questions however in this discussion the researcher is going to focus on two questions which really brought out the risk that para-suicide had on youths and they were adopted from Osmans (2001) suicidal behavior questionnaire .The first question assessed the level of suicidality of the youths that is looking at whether the youths were , were not at risk and whether they had really attempted suicide. In Chegutu 15.1% of the youths had ideations, 4.1 % made plans of attempting but they didn't execute, 18.9% attempted to kill themselves but did not want to die and 5.9% attempted to kill themselves and really wanted to die The second question assessed if the youths would attempt suicide someday. The response the researcher got was that 4.1% of the youths said likely and 18.3% of the participants responded with a very likely hence this still showed that the youths are at a risk of para-suicide.

5.2.2 WHAT FACTORS ARE LEADING THE YOUTHS OF CHEGUTU TO ATTEMPT SUICIDE

This research question was mainly aimed at examining the factors that caused the youths to resort to para-suicidal acts, these factors can also be referred to as the risk factors. Meehan (2014) described a risk factor as a factor that influences a person to engage in any suicidal behavior and in this case para-suicide.

5.2.2.1 Hopelessness

One of the risk factors of para-suicide that was present in the researchers study was hopelessness. Among the youths who were at risk of para-suicide, 43 participants that is 25.3% showed hopelessness symptoms hence it is safe to say hopelessness can be said to be a factor leading youths to attempt suicide. This is similar to what Cheung et al (2006) said in his study in China that issues of hopelessness put people at risk of attempted and completed suicide .Also in a study conducted in Minnesota by Taliaferro and Muehlenkamp (2014) after a student survey their results showed that hopelessness was regarded as another risk factor for suicidal behavior.

5.2.2.2 Depression

Depression was another risk factor of para-suicide in the research this is so because 35 participants that is a percentage of 20.7% showed depressive symptoms at the same time being at

a great risk of para-suicide hence it is safe to conclude that depression can be regarded as a risk factor for para-suicide. This is related with what Zayas ,Gulbas , Fedoravicius and Cabassa (2010) found in their study on the patterns of distress , precipitating events and reflections of suicide attempts by young Latinas they pointed out that participants who were interviewed to give reasons why they attempted suicide it was seen that the desire of their attempt was strongly linked to emotions and some participants described feeling depressed , sad and lonely prior attempt. Cheung et al (2006) in his study also noted that in China, depression place people under great risk of attempted and completed suicide. Data from the 2010 Minnesota Student Survey referred by Taliaferro and Muehlenkamp (2014) found that apart from other factors depressive symptoms emerged as important risk factors to distinguish youth who reported suicidal ideation or behavior from those without a history of suicidality . According to Chibanda ,Sabit and Accuda (2002) in their study in Zimbabwe noted that the prevalence of major depression among participants was 20.7% (n=80, 95%)and was seen as a cause for para-suicide.

5.2.2.3 Family Factors

Upon analyzing her results the researcher noticed that 33 participants that is 19.5% showed that family factors were the reasons behind their para-suicidal behavior. This is so because those who scored high in family factors also scored high in para-suicide risk assessment, meaning to say that family factors have an impact on para-suicide. By family factors the researcher was basically looking at levels of family support, levels of family togetherness, family relationships and the family environment as a whole. Hence with the above mentioned percentage it shows that family factors were a risk factor of para-suicide among the youths of Chegutu.

The above information is parallel with what Donath, Graessel, Bailer and Hillemacher (2014) said in their study conducted in Germany on the Lifetime Prevalence of Suicide Attempts they noted that in parental parenting it was observed that neglecting parenting style increases the risk of suicidal attempts more than 1.5 times compared to children reared using authoritarian parenting. Also in a study conducted in South Africa on the reasons para-suicide for patients at Limpopo hospital by Obida and Clark (2013) they noted that most participants came from dysfunctional families characterized by intimate partner violence, lack of trust and rejection therefore they felt that these factors contributed to their suicide attempts. In a study on suicide

among students in Iran found that most suicide attempts were caused by family conflicts (Farzaneh et al. 2010).

5.2.2.4 Alcohol and Substance use

Alcohol and substance use in this study was also seen as a risk factor for para-suicide this is so because 16 that is a percentage total of 9.4% of the participants who showed being at risk of para-suicide reflected a great use of alcohol and other substances. This then shows that alcohol and substance abuse can be seen as a risk factor for para-suicide. This is supported by a research done by Roy and Janal (2007) on Risk Factors for Suicide Attempt among Alcohol Dependent patients they noted that alcohol use disorder was a risk factor for suicide attempts among the youths. Conner, Bagge, Goldston and Iigen (2014) further noted that an empirical review of published studies reported that a median of 37% of suicides and 40% of suicide attempts are preceded by acute use of alcohol also Farhadi, Hartalab and Poroolajahal (2015) in their study noted that their meta-analysis revealed that alcohol use disorder was significantly associated with an increased risk of suicidal ideation, suicide attempt, and completed suicide.

Alcohol and substance use alone cannot be said to be an ultimate risk for para-suicide but it should be noted that the reasons why alcohol and other substances are consumed as well as the state of mind of the consumer was in and the actions that are done afterwards is what qualifies alcohol and other substances to be regarded as a risk factor for para-suicide. This further explained by Jakubczyk, Klimkiewicz, Iigen ,Bohnert , Wojnar and Bower (2012) in their study who stated that acute alcohol intoxication itself may act as a activator for suicidal thoughts and attempts among individuals at risk and may manipulate the possible lethality of the suicide attempt.

5.2.2.5 Stressful life events

Stressful life events were seen as another risk factor of para-suicide among the youths in this study. This is so because 44 participants (26%) of the youths who showed para-suicide risk also showed failure to cope with stressful life events. This equivalent with what Zayas and Gulbas (2012), in their study of American Latinas whereby they wanted to know why they attempted

suicide. Their findings have showed that suicide attempts among young people was associated with critical life course experiences which cause stress and shame in the family and with the experiences at hand, youths usually thought to resort to suicidal behaviors so as to escape from the circumstances. Nock et al (2008) posited that stressful life events like failure in study exam, break up of love relationships to point but a few are important contributors to suicidal behavior among young students. Also Hawton, Saunders, O'Connor and Lancet (2012) added that in youths suicidal behavior is highly associated with life stressors.

However it should be noted that it is only after an individual fails to cope with a stressful life event that it is referred to as a risk factor and this is in line with what JG et al (2010) in their study who noted that failure to cope with stress may lead up psychological problems and even suicidal behaviors.

5.2.3 WHAT ARE THE PROTECTIVE FACTORS OF PARA-SUICIDE AMONG THE YOUTHS.

This research question was mainly looking at the factors that goes against or that hinder the youths from attempting suicide known as protective factors. Upon collection of data the researcher managed to get a hold of protective factors as per the research and they are as follows.

5.2.3.1 Feelings of Hope/Hopefulness

Hopelessness was the first protective factor that the researcher noticed upon analysis of her data . This is because the youths who were not at risk of para- suicide showed low or no signs of hopelessness. For instance when the participants were asked if they ever thought or attempted to kill themselves in the past 84 participants who said never had no signs of hopelessness meaning to say they were very hopeful and this is contrary to what youths who were at risk or who have had attempted suicide would answer. This is in line with a study conducted by Meadows et al (2005) who discovered that one of the main protective factors against suicide attempts among economically, educationally, and socially disadvantaged African-American women who had experienced recent intimate partner violence and who had attempted suicide was hopefulness. Those with high levels of hope were less likely to have attempted suicide than those with low levels of hopefulness

5.2.3.2 Family Factors

Family factors can also be seen as a protective factor against para-suicide in the study it showed that participants who showed no risk of para-suicide or those who had never attempted suicide before, when assessing their family factors they showed signs of family support in the family, levels of support, cordial family relationships and a good family environment. Hence this left the researcher to note that the association between favorable family factors and para-suicide showed that indeed family factors can be seen as protective factors against para-suicide. This is similar to what Nock et al (2008) said who noted that perceptions of social and family support and connectedness also have been seen to decrease the rates of suicidal behavior. Wong and Maffini (2011) found that family relationships were protective of suicide attempts for Asian Americans.

5.2.3.3 Refraining from or low consumption of Alcohol and Substance use

Refraining from or low consumption of alcohol can act as protective factor of para-suicide mainly because people usually take alcohol so as to attempt to kill themselves that is if they do not have the bravery to do so. Looking at the participants who had no risk of para-suicide they also showed no or low use of alcohol and substance. This is comparable with the study of Chatterji, Dave, Kaestner and Markowits (2003) who noted that when dealing with suicidal attempters who are also alcohol users they note that there should be interventions that can recognize and help these youths such as screening and treatment programs these may be more effective in the reduction of suicidal attempts.

5.2.3.2 Religion/ Spirituality

Religion or spirituality in this study showed that it protects against para-suicide that is it can be seen as a protective factor. Religion or spirituality helps a lot because makes a person feel there is a higher force that can help you continue when you feel like there no reason to live anymore. When asked about praying to God when overpowered by obstacles and problems 58 participants who agreed and 39 participants who strongly agreed showed no risk of para-suicide neither have they ever attempted to kill themselves hence it can be seen that religion can act as a protective factor. This is related to a study by Nock et al (2008) in his journal of Suicide and

Suicide Behavior, who noted that religious beliefs, religious practices and spirituality has been associated with decreased probability of suicide attempts (Garroue, Golderg, Beals et al 2003). In a study conducted in China by Wu, Wang and Jia (2015) on religion and completed suicide they discovered that religion plays a protective role against suicide. Wingate et al (2005) also noted that religion can be viewed as a protective factor for black Americans as it acts as a buffer against suicidal thoughts and behaviors. However in contrary to this view Colucci and Graham (2008) posited that religion can inspire fear in people as well as guilt leading to a higher risk of suicide.

5.2.3.3 Social support from peers and significant others

Social support from peers and significant others was another protective factors for youth para-suicide mainly because youths who scored very low when assessing the risk of para-suicide they showed that they opened up friends and families then afterwards they got the support. For instance when participants were asked if they discussed their problems with others participants who had no risk of para-suicide are the same participants who showed that they opened up and receive support from their peers and significant others. This is akin to what Kleiman and Liu (2013) said after a research they done on all black Americans they concluded that findings suggest social support is associated with decreased likelihood of a lifetime suicide attempt, it is a highly modifiable factor that can be used to improve existing suicide prevention programs worldwide. This is also in line with Joiner's theory of Interpersonal theory of suicide who noted that to avoid a person from attempting suicide one have to evaluate a patients social system as a part for management plan for suicidal attempters(Joiner, Van Orden, Witte et al., 2009) hence social support is important when preventing suicide.

5.2.3.4 Coping with stressful life events

Coping with stressful life events was a protective factor against para-suicide in this study mainly because people showed an ability to cope well with stressful life events showed no risk of para-suicide. Similar to these findings is a study conducted by Tang, Xue and Qin (2015) on Chinese students on the interplay of coping skills and stressful life events where they concluded saying their results showed that the better approach coping skills lowers the risk for suicidal behavior.

5.3 CONCLUSIONS

Looking at the results obtained by the researcher in her research and those from other studies in some parts of the world it is imperative to note that suicidal behavior (ideations, plans, attempts and completed suicide) among the youths is indeed a major public health concern. Youths are at risk of para-suicide some having ideations, some having plans and others already attempted to kill themselves. Though the numbers are not huge the fact still remains that they are still at risk. There are related risk factors of para-suicide that cut across cultures and borders and these include feelings of depression and hopelessness, family factors, alcohol and substance as well as stressful life events. The above factors were also seen to be risk factors among the youths of China, Mexico and of the Latinas of America. However it should be noted that communities and the youths can help in this problems by creating family environments that are favorable for the youths, social support, having feelings of hopefulness, being religious and coping well with life stressors.

As noted before many studies have been done on the risk factors and protective factors of para-suicide among the youth in high developed countries but however little research has been done in low income countries let alone in Zimbabwe and particularly at district level. So, from this study the researcher noticed that para-suicide was a risk factor and they were related risk and protective factors but the problem was that community at large did not know that there are risks factors neither were there any protective factors that can promote or hinder para-suicide except for a few. There are behaviors that the youths are doing such as alcohol and substance use whilst they do not know that it poses a threat to their life especially for those who will be at risk of para-suicide, also looking the families there are some behaviors that the parents are doing that they do not know are dangerous for their children such as low family support, low levels of togetherness creating a unfavorable family environment and poor parenting styles that if they continue doing might increase the risk for the youths.

As we all know the period of being a youth that is from 15-24 years a lot of transitions happen in this age group in psychology there are an emotional, physical and social development that happens as people mature into adulthood and really needs one to be prepared for them. Youths fall in love, get disappointed and responsibilities start to emerge to point but a few. Basically what this means is that around this age group the youths need proper guidance and counseling as

well as being taught how to have good coping skills when faced with life adversities this guidance should come from families, schools, religious institutions and government institutions.

5.4 RECOMMENDATIONS

Ministry of Health and Child Care should deploy counselors in schools and in colleges where youths can go freely and discuss their problems mainly because they spend most of their times at school and these counseling services must be on-going.

The Sector Ministries such as Ministry of Youth and Social Welfare must initiate youths programs that targets all the youths in and out of school and those in colleges .These programs will teach the youths about para-suicide and the risk factors of para-suicide as well some protective factors. Youths must be given knowledge that when they face any problem they should talk to their parents and if they are not free to talk to their parents they should go and get counseling .These sector ministries must also create youth support groups were the youths can meet once a week to discuss life issues and support each other with the help of a facilitator.

Ministry of Education must deploy School psychologist in schools so as to train teachers about para-suicide and how to assess para-suicidal children as well as making them aware of the risk factors of para-suicide on children so that they can target or intervene at an early stage and avoid para-suicidal acts of the youths. This is so because in Chegutu schools there are no school psychologist.

Parents should be reached out to by teachers through meetings where they are told that their parenting, the relationship they have with their children and the time they spend with their children as well as the way they treat their children can hinder or promote para-suicide on their children. They should also be informed about the types of parenting and the effects it has on children as well as to discuss factors contributory to para-suicide and how they can overcome them for the sake of their children's safety.

Parents must always encourage their youths to be involved in church youth groups where they are taught about good faith and putting their trust in God and to know that God is the creator of the universe and of their lives. By so doing the youths will have a feeling that there is a God somewhere who can take care of them all the times thus it decreases the risk of para-suicide.

Further researches must be done on risk and protective factors of para-suicide among the youths targeting other districts of Zimbabwe and at national level too mainly because little research has been done in Zimbabwe regarding the issue of para-suicide. Looking at the research on para-suicide that was conducted in Zimbabwe for instance by Munikwa, Matopa and Mophosa(2012) it only focused on the causes and nature of para-suicide cases handled by traditional healers hence more research is needed to see the psychological perspectives of para-suicide because para-suicide have causes (risks) as well as protective factors that are psychological as highlighted by this research. Also as the researcher reviewed her literature she saw that most research only targeted the Universities hence more researches must be conducted to reach out to youths who are in high schools in Zimbabwean districts.

Further research must also be done to see how psychopathology and sexual abuse contribute to youths para-suicidal acts. Mainly because the researcher could not ask participants about those issues since they were very sensitive.

5.5 CHAPTER SUMMARY

The chapter was discussing the results found in the research as well as comparing them with what other researchers found in their studies this was done by attending to each research question in this study. There after recommendations were made in great anticipation that the problem will be addressed.

REFERENCES

- Aggrawal , Y. (2008). *Statistics in Education*. (2nd Ed) .Delhi :Sterling.
- Ajzen, I. (2005). *Attitude, Personality and Behavior* . New York :McGraw Hill Education
- Alem , A. Kadebe , D. Jacobsson, L. Kullgren, G. (1999) . Suicide attempts among adults in Butajira ,*Ethiopia*.*ActaPsychiatrScand Suppl.* :397:70-6.
- American Psychiatric Association.(1994)*Diagnostic and statistical mental and manual disorders*.(DSM-V). (4thed). Wahington DC: Author. .
- Aruga, K.(2008).*Introduction to SPSS short Courses* .Retrieved from<http://www-01.ibm.com/software/analytics/spss/>
- Asteline , R.H. , Schling , E.A., James, A., et al.(2009). Age variability in association between heavy episodic drinking and adolescents suicide attempts : findings from large –scale , school based screening programme .*J Am Acad Child Adolesc Psychiatry* .Mar : 48(3) :262-270.
- Bagge, C.L.,Sher,K.J.(2008). Adolescent Alcohol Involvement and Suicide Attempts: Towards the Development of a Conceptual Framework. *Clinical Psychology Review*, 28(8) .1283- 1296 .Retrieved from <http://doi.org/10.1016/j.cpr.2008.06.002>.
- Berinstein, P. (2003).*Business Statistics on the Web: Find Them Fast – At Little or No Cost*.New Jersey: CyberAge Books.
- Best, J.W. and Kahn,J.(2006).*Research in Education*: New Dehli:Prentice Hall of India Ltd.

- Bridge, J.A.,Goldstein, T.R., Brent, D.A.(2006). Adolescent suicide and suicidal behavior. *JChildPsychologyPsychiatry*372-394,47(3/4):. Doi:10.1111/j.14697610.2006.0161.
- Bruwer, B., Govender,R.,Bishop,M., Williams, D.R., Stein, D.S.,Seedat,S.(2014).Association between Childhood Adversities and Long-term Suicidality among South Africans Stress and Health study :across-sectional study.*BMJ Open*4:e004644doi :10.1136/bmjopen-2013-00644.
- Caribe , A.C., Nunez,R.,Montal , D., Ribeiro,L.,Sarmiento, S., Quarantini,L.C., Miranda-Scippa,A.(2012) Religiosity as a protective factor in suicidal behaviors: a case –control study. *Journal of Nervous and Mental Diseases.*,200(10):863-7.doi: 10.1097/NMD.0b013e1826b6d05.
- Cash, S.J.,Bridge, J.A.(2009).*Epidemiology of Youth Suicide and Suicidal Behaviors*.Public Access Author Manuscripts.doi: 10. 1097/mop.0b01e32833063e1.
- Centers for Disease Control and Prevention, *National Center for Health Statistics .Deaths: Final Data for (2007-2010)*.Retrieved from [http:// www.cdc.gov/nchs/data/nvsr/nvsr58 19](http://www.cdc.gov/nchs/data/nvsr/nvsr5819).
- Centers for Disease Control and Prevention. (2009) .Youth risk behavior surveillance-United Stated. *MMWR surveillance Summaries*.2010:59: 1-142.
- Centers for Substance Abuse Treatment (2005).Substance Abuse Treatment for Persons with Co-occurring Disorders.Roskville (MD) : Substance Abuse and Mental Health Services Administration.(*Treatment Improvement Protocol (TIP)Series , No.42.*)Retrieved from [:http://www.ncib.nlm.nih.gov/books/NBK64197/s](http://www.ncib.nlm.nih.gov/books/NBK64197/s)

- Chatterji,P., Dave, D., Kaestner, R., Markowitz,S.(2003).Alcohol Abuse and Suicide Attempts among Youth- Correlation or causation.*Social Science Research Network*: Retrieved from<http://ssrn.com/abstract=398542>
- Cheung, Y.B., Law, C.K., Chan,B., Liu,K.Y., and Yip,P.S.(2006) . Suicidal ideation and suicidal attempts in a population -based study of Chinnese people : risk attributable to hopelessness , depression, and social factors. *Journal of Affective Disorders* ,90(2), 193-199.
- Chibanda, D.,Sebit, M.B.,Acuda, S.W.(2002).Prevalence of major depression in deliberate self-harm individuals in Harare , Zimababwe.*East Africa Med Journal*.79:263-266.
- Cobb, S.(1976). Presidential Address- Social support as a moderator of life stress.*Psychosomatic Medicine Journal* 38(5) :300-14.
- Cohen, L. and Manion, L.(1980). *Research Methods in Education*.London: Groom Helm ltd.
- Colucci, E. and Graham, M..(2008).Religion and Spirituality along the Suicidal path.*Suicide and life threatening Behaviour*. 38:229-244.
- Conner,K.R.,McCloskey, M.S., and Duberstein ,P.R(2008). Psychiatritric risk factors for suicide in the alcohol dependent patient.*Psychiatric Annals*, 38(110):742-8.
- Conner, K.R., Bagge, C.L.,Goldston, D.B., and Ilgen , M.A(2014) .Alcohol and suicidal behavior : What is known and what can be done . *American Journal of Preventive Medicine* 47(3), S204-S208.

- Coughlin, S.S., and Sher, L.(2013). Suicidal Behavior and Neurological illness.*Journal of Depression and Anxiety*, Suppl9(1), 12443. Retrieved from <http://doi.org/10.4172/2167-1044.S9-001>.
- Cresswell, J.W.(1994).*Research Design:Qualitative and Quantitative Approaches*. London: SAGE Publications.
- Degu, G., and Yigzaw,T.(2006). *Research Methodology*.Gondor :University of Gondor.
- Dejong,T.M., Overholser, J.C., and Stockmeire, C.A.(2010). A Direct Comparison between Suicide Attempters and Suicide Completers.*Journal of Affective Disorders* 210:124:90-.7.Retrieved from<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2875283/>
- Diekstra.R.W.,Maris,R.,Platt, S.,Schmolth,A., and Sonneck (Ed) (1989). *Suicide and its Prevention.The roles and attitudes of imitation*.NewYork : Library Congress Catalogue.
- Donath, C.,Graessel, E.,Baier, D.,Bleich, S. and ,Hillemacher ,T.(2014). Is parenting style a predictor of suicide attempts in a representative sample of adolescents.*BMC pediatrics*, 14,S.113,ISSN:1471-2431.
- Durkheim, E.(2005). *Suicide a study in Sociology* .London: Taaylor andFrancis e-library.
- Eaton, D., Foti, K.,Brenner.,Brenner., Crosby, A., Flores, G.,andKann,L.(2011).Associations between risk behaviors and suicidal ideation and suicide attempts : Do racial/ ethnic variations in associations account for increased risk of suicidal behavior among Hispanic / Latina 9th –to 12 grade female students? *Archives of Suicide Research*, 15, 113-126.

- Farhadi, N., Haghtalab T., and Poorolaja ,J .(2015).Alcohol –Related Risk for Suicidal Ideation, Suicide Attempt, and Completed Suicide : A Meta- Analysis. *PLos ONE 10(5)*: e0126870. doi:10.1371/journal.pone.0126870.
- Farzanek. E., Mehrpour, O.Alfred ,S.MoghadamHH.,Behnoush,B.,andSeghatoleslam,T.(2010) Self-poisoning suicide attempts among students in Tehran,*Iran.Psychiatria Danubina,22(1):34-38.*
- Fegusson,D.M.,Boden,J.M.,andHorwood,L.J.(2008).Exposure to child sexual and physical abuse and adjustment in early adulthood. *Child Abuse Neglect32(6) :607-19*.doi:10.1016/j.chiabu.2006.12.018.Epub
- Field, A.P.(2009). *Discovering statistics using SPSS*.LosAngeles:SAGE Publications.
- Frey,L.R.,Carl, H.B., and Gray,L.K.(2000). *Investigating Communication: An Introduction to Research Methods*.2nded.Boston: Allyn and Bacon.
- Fuller, E.(Ed).(2007).Drug use, smoking and drinking among young people in England .In *National Centre for Social Research, National Foundation for Education Research* (2008).
- Garrouthe, E.M. , Goldberg, J. ,Beals, J., Herrell , R., Manson ,S.M.,et al.(2003). Spirituality and attempted suicide among American Indians.*Social Science and Medicine.56(7) :157 1-9.*
- Gay ,L.M., Mills,G.E., and Airasian , P.W.(2009) *Educational research:Compentncies for analysis and applications* (9th edition).Upper Saddle River, New Jersey: Prentice Hall.

Glenn, C.R. and Klonsky,E.D.(2011). Perspective prediction of non suicidal self-injury: A 1 – year longitudinal study in young adults.*Behavior Therapy* 42 (2011) 751-752.Available online at www.sciencedirect.com

Goldman-Mellor , S.J.,Caspi,A., Harrington ,H., Hogon,S.,Nada-Raja,S., Poulton, R.,andMoffit T.E.(2013) .Suicide attempt in young people : A signal for long term health care and social needs.*JAMA Psychiatry*71,119-127 .

Haris, E.C.,et al (1997) , “Suicide as an Outcome for Mental Disorders ,” *British Journal for Psychiatry*, vol.170,pp.205-8

Hawton, K., Saunders ,K.A.E.,and O’Connor, R.C.2012).Self –harm and suicide in adolescents. *Lancet* 2012: 379: 2373-2382.*The Lancet* .23:379(9834): 2373-82
doi:10.1016/S0140-6736(12)60322-5.

Heale, R.,andTwycross,A.(2015) Research made simple: Validity and reliability in quantitative studies. *Evidence- Based Nursing*,18(3), 66-67.doi:10.1136/eb-2015-102129.

Health Trensa Alberta (2015, April 28)*Parasuicide among the young in Argentina*Retrieved fromwww.health.alberta.ca/documents/HTA-2015-04-08Parasuicide.p.d.f

Heilbron, N.,Comptom, J.S.,Daniel,S.S.,andGoldston, D.B(2010). The problematic label of suicide gestures:Alternative for Clinical research and practice.*Professional Psychology Resesearch Practices*. Jun1:41(3) :221-227.

- Hirsch, J.K.,andConner,K.R.(2006) . Dispositional and explanatory style optimism as potential moderators of the relationship between hopelessness and suicidal ideation.*Suicide and Life Threatening Behavior*, 36(6) ,661-669.
- Hoertel, N.,Franco, S.,Wall,N.N.,Oquendo,M.A.,Kerridge,B.T.,Limosin,F.,andBlanco,C.(2015). Mental Disorders and a Risk of Suicide Attempt: A National Prospective Study. *Molecular Psychiatry* 20.718-726(June 2015). doi :10.1038/mp.201519.
- Hussey, J.and Hussey, R.(1997).*Business Research : A Practical Guide for undergraduate and post graduate students*.Basingstoke: Mackmillan.
- Ikealumba,N.,andCouper,I.D.(2006). Suicide and Attempted Suicide:The Rehoboth experience .*Rural Remote Health* : 6(4) :535.Epub2006 Oct 30.
- Jacobsen, K. H. (2011), Research Ethics: Principles, Practices, and Reporting. *World Medical & Health Policy*, 3: 1–7. doi: 10.2202/1948-4682.1161
- Jakubczyk,A.,Klimkiewicz,A.,Krasowska,A.,Kopera,M.,Slawinska-Ceran,A.,Brower,K.,and Wojnar,M.(2014) History of Sexual Abuse and Suicide Attempts in Alcohol – Depended Patients,*Child and Neglect* .38(9) , 1560-1568,http://doi.org.1016/j.chiabu.2014.06.010.
- Jamison,D.T., Feachem,R.G., Makgoba, M.W.,Bos,E.R., Baingana, F.K., Karen J Hofman,K.J., and Rogo, K.O. (Ed) .(2006). Disease and Mortality in Sub-Saharan Africa (2nded) .Washington (DC): World Bank .*ISBN-10: 0-8213-6397-2**ISBN-13:978-0-813-6397-3*

- Juang,L.P.,Cookston,L.P.(2009). Acculturation, discrimination, and depressive symptoms among Chinese American adolescents: A longitudinal study. *The Journal of Primary Prevention* ,30 ,pp.475-496.
- Joiner,T.E., Van OrdenK.A.,Witte T.K, et al.(2009). Main predictions of the interpersonal-psychological theory of suicidal behavior: empirical tests in two samples of young adults. *Journal of Abnormal Psychology*.118(3):634–64.
- Kebede, D., and Alem,A.(1999) Suicide Attempts and Ideation Among Adults in Addis Ababa, Ehtiopia. *ActaPsychiatricaScandavica Supplementum*.397:35-9.
- Keer, P.L, Muehlenkamp J.J., Turner, J.M. (2010). Nonsuicidalsself injury :A Review of Current Research for Family Medicine and Primary Care Physicians . *The Journal of American Boards of Family Medicine* 23.2doi 10.3122/jabfm.2010.01.090110 .
- Kothari, C.R .(2004). *Research Methodology :Methods and Techniques*(2nded) . New Dehli New Age International.
- Kleiman,E.A., and Liu,R.T.(2013) Social Support as a Protective Factot in Suicide:Findings from two National Representative Samples. *Journal of Affective Disorders* :150(2):540-5.doi:10.1016/j.jad.2013.01,033.
- Kreitman , N. (ed.) (1977).*Parasuicide* , John Wiley & Sons, Inc ., London
- Lancet (2008).Calling time on young people’s alcohol consumption. *Vol. 371:871* (<http://www.thelancet.com/journals/lancet/article/PIIS0140673608603864/fulltext?rss=yes>).

- Langhaug,L.F., Pascoe S.J., Mavhu,W., Woelk,G., Sherr,L., Hayes,R.J., Frances M. Cowan F.M. *Journal of Community Health*. 2010 August; 35(4): 355–364. doi: 10.1007/s10900-010-9261-6.
- Langille,D.B.,Asbridge, M.,Kisely.,and Rasic,D. (2012) Suicidal behaviors in adolescents in Nova Scotia, Canada: protective association with measures of social capital. *Social Psychiatry and Psychiatric Epidemiology* 47(10):1549-55. doi: 10.1007/s00127-011-0461-x. Epub 2011 Dec 27.
- Linehan, M.M.(1993).*Cognitive- behavioral treatment of Borderline Personality Disorders*. New York: The Guilford Press.
- Losby, Jan and Wetmore A. (2012). *CDC Coffee Break: Using Likert Scale in Evaluation Survey Work*. Retrieved from http://www.cdc.gov/dhdsp/pubs/docs/cb_february_14_2012.pdf.
- Malone, K.M., Oquendo, M.A.,Haas, G.L., Ellis, S.P., Li ,S., Mann, J.J.(2000). Protective factors against suicidal acts in major depression: Reasons for living. *American Journal of Psychiatry*, 157(7): 1084-1088.
- Mann ,J.J., Bortinger, J., Oquendo ,M. A., Currier, D.,, Li, S., Brent, D. A. (2005). Family history of suicidal behavior and mood disorders in probands with mood disorders. *Am J Psychiatry*.2005;162(9):1672–16792
- Maris, R.W. (Ed) (1992) *Assessment and Prediction of Suicide*.The Guilford Press: London.

Meadows,L.A., Kaslow, N.J.,Thompson,M.P., and Jurkovic, G.J.(2005) Protective Factors Against Suicide Attempt Risk Among African American Women Experiencing Intimate Partner Violence. *American Journal of Community Psychology*, Vol. 36, Nos. 1/2, September 2005 DOI: 10.1007/s10464-005-6236-3.

Mills, J. F., and Kroner, D. G. (2003). *Depression, Hopelessness and Suicide Screening Form (DHS): User Guide*

Moos, R. H., & Moos, B. S. (1981).*Family Environment Scale manual*. Palo Alto, CA: Consulting Psychologists Press

Moscicki, E. K. (1997) Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, 20, 499 -517

Munikwa ,J., Mutopa ,S., and Maphosa ,C .(2012). The Nature and Causes of Parasuicide Cases Handled By Traditional Leaders in Hurungwe District in Zimbabwe *J Hum Ecol*, 37(2): 93-102

Murphy, M. and Fonagy, P. (2012). Mental Health Problem in Children and Young People. Annual Report Available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252660/33

[571 29](#) [01304](#).

Naidoo ,S.S., Schlebusch, L. Sociodemographic Characteristics of Persons Committing Suicide in Durban, South Africa: 2006–2007. *African Journal of Primary Health Care and*

Family Medicine, North America 2014;6(1), Art. #568, 7 pages. Available at
<http://www.phcfm.org/index.php/phcfm/article/view/568>

National Center for Injury Prevention and Control Centers for Diseases Control and Prevention
,(2008) Non fatalInjurues: Non fatal reports. Available at
<http://webapp.cdc.gov/sasweb.ncipc/nfirates.html>.

NHS Information Centre.(2007) Statistics on Alcohol: England: The *NHS Information*
Centre. Part of the Governmental Statistical Service.

Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts,
R., Chiu, W. T., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J. M.,
Huang, Y., Karam, E., Kessler, R. C., Lepine, J. P., Levinson, D., Medina-Mora, M. E., Ono, Y.,
Posada-Villa, J., Williams, D. (2008). Cross-national prevalence and risk factors for
suicidal ideation, plans, and attempts. *British Journal of Psychiatry, 192, 98-105*.

Nock, M. K., Borges, G., Bromet, E., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and
suicidal behaviors.*EpidemiologicReviews, 30, 133-154*.

Nock, M. K. (2012). Future Directions for the Study of Suicide and Self-Injury. *Journal of*
Clinical Child and Adolescent Psychology, 41, 255-259.

Nock.K.M.(2014).*The Oxford Handbook of Suicide and Self Injury*.New York :Oxford
University Press.

Obida, M., Clark, C., and Govende, I. (2013). Reasons for Para-suicide among Patients admitted to Tshilidzini Hospital, Limpopo Province: A quality study. *South African Journal of Psychiatry Vol 19, No 4*

O'Connor, R.C., Rasmussen, S., Miles J., & Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. *The British Journal of Psychiatry, 194*, 68–72.

Oppenheim, A.N. (1992). *Questionnaire design, interviewing and attitude measurement*. London: Pinter Publishers.

Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire–Revised (SBQ–R): *Validation with clinical and non-clinical samples. Assessment, 8*, 445–455

Pajoumand A, Talaie H, Mahdavinejad A, Birang S, et al. (2012). Suicide epidemiology and characteristics among young Iranians at poison ward, Loghman-Hakim Hospital (1997-2007).]. *Archives of Iranian Medicine 15(4):210-3*.

Park, W. (2009). Acculturative stress and mental health among Korean adolescents in the United States. *Journal of Human Behavior in the Social Environment. ;19(5):626–634*.

Patel, V., Flisher, A.J., Hetrick, S., McGorry, P. (2007). Mental health of young people: a global public-health challenge; *Lancet 369: 1302–13*. DOI:10.1016/S0140-6736(07)60368-7

- Pillai, A., Andrews, T., & Patel, V. (2009). Violence, psychological distress and the risk of suicidal behaviour in young people in India. *International Journal of Epidemiology*, 38, 459–469. *Int J Epidemiol* 2009 Apr;38(2):459-69. doi: 10.1093/ije/dyn166.
- Qin, D.B., Rak, E., Rana, M. et al. (2012). Parent-child relations and psychological adjustment among high-achieving Chinese and European American adolescents. *Journal of Adolescence*. 2012;35(4):863–873
- Radhakrishnan, R., and Andrade, C. (2012) Suicide :An Indian Perspective. *Indian Journal of Psychiatry*. Available from:
<http://www.indianjimpsychiatry.org/text.asp?2012/54/4/304/104793>
- Randall, J. R., Rowe, B. H., & Colman, I. (2012). Emergency department assessment of self-harm risk using psychometric questionnaires. *Canadian journal of psychiatry*, 57(1), 21-28. Available: <http://www.ncbi.nlm.nih.gov/pubmed/22296964>
- Randall, J.R., Doku, D., Wilson, M.L., & Peltzer, K. (2014) Suicidal Behaviour and Related Risk Factors among School Aged Youth in the Republic of Benin. *PLoS ONE*, 9(2), e88233. doi:10.1371/journal.pone.0088233
- Retterslot, N. (1993). *Introduction and Definitions*. In: *Suicide: A European perspective*. 4th ed. Cambridge: Cambridge University Press; (1993). p. 9-20
- Rowe, C.A., Walker, K.L., Britton, P.C., & Hirsch, J.K. (2013). The relationship between negative life events and suicidal behavior: *Moderating role of basic psychological needs*, *Crisis* 34, 233-241.

- Roy,A.,andJanal,M.N.(2007). Risk Fators for Suicide among Alcohol Dependent Patients.Archivesof Suicidal Research : *Official Journal of the International Academy of Suicide Research* : 11(2) :211-7.
- Royal College of Psychiatrists press release,(2002) , Suicide Leading Cause of Death among New Mothers,” Availabe at www.rcpsych.ac.uk
- Sansone ,R.A.,et al.(2002). Self –Harm Behaviors among Those with Eating Disorders: An Overview.*Eating Disorders*, vol 10,pp.205-13.
- Schroder, K. E. E. (2004). Coping Competence as a Predictor and Moderator of Depression among Chronic Disease Datients.*Journal of Behavioral Medicine*, 27, 123-145.
- Shaheen, H (2012) Risk and Protective Factors linked to suicidal behavior :A Review of Literature: *The International Journal of Human and Social Stuies* 2321-9203 Volume 2 Issue6
- Sidharta ,T., and Jena.(2006) Suicidal Behaviots in Adolescents. *Indian journal of Patriatrics* .73(9) :783-8
- Swahn M.H., Ali B., Bossarte R.M., van Dulmen M., Crosby,A.,Jones,A.C.,andSchinka.K.C. (2012). Self-Harm and Suicide Attempts among High-Risk, Urban Youth in the U.S.: Shared and Unique Risk and Protective Factors. *International Journal of Environmental Research and Public Health* 9(1), 178-191. doi: 10.3390/ijerph9010178
- Taliaferro, L.A., and Muehlenkamp, J.J. (2014).Risk and protective factors that distinguish adolescents who attempt suicide from those who only consider suicide in the past year.*Suicide and Life-Threatening Behavior*, 44(1), 6-22.

- Talbot S, Crabbe T. Binge drinking: young people's attitude and behaviour: Positive Futures, Crime Concern; (2008)
- Tang, F., Xue, F., & Qin, P. (2015). The interplay of stressful life events and coping skills on risk for suicidal behavior among youth students in contemporary China: a large scale cross-sectional study. *BMC Psychiatry*, 15, 182.<http://doi.org/10.1186/s12888-015-0575->
- Torrey, E. F. (1995). *Surviving schizophrenia: A manual for families, consumers and providers*. (3rd ed.). New York: HarperCollins
- Trochim, W.M. (2006) Research methods knowledge base.*Drake University*. Retrieved from:
<http://www.socialresearchmethods.net/kb/intreval.htm>
- Wacholder, S., McLaughlin, J.K., Silverman ,D.T, et al. Selection of controls in case-control studies. I. Principles. *Am J Epidemiol* 1992,135:1019-28.
- Wang, M.-C., Lightsey, O. R., Tran, K. K., & Bonaparte, T. S. (2013). Examining Suicide Protective Factors Among Black College Students. *Death Studies*, 37(3), 228–247.
<http://doi.org/10.1080/07481187.2011.623215>
- World Health Organisation (2012) *Suicidal Rates Absolute of Suicide by Country*. Available online
<http://www.who.int/mentalhealth/prevention/suicide/accessedNovember272015>
- World Health Organisation (2014) *Preventing Suicide a global imperative* .Genevia :WHO
Library cataloguing in Public Data.

- Willgerodt MA. Family and peer influences on adjustment among Chinese, Filipino, and White youth. *NursingResearch*. 2008;57(6):395–405. Available at <http://www.ncbi.nlm.nih.gov/pmc/article/pmc2887097/>
- Wong, Y., Maffini, C.(2011) Predictors of Asian American Adolescents' Suicide Attempts: A Latent Class Regression Analysis. *Journal of Youth & Adolescence*. 2011;40(11):1453–1464.
- Wu A, Wang J-Y, Jia C-X (2015) Religion and Completed Suicide: a Meta-Analysis. *PLoS ONE* 10(6): e0131715. doi:10.1371/journal.pone.0131715
- Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: a systematic literature review. *Journal of Health Care for the Poor and Underserved*, 26(20), 191–237. <http://doi.org/10.1353/hpu.2015.0059>
- Zayas, L. H., and Gulbas, L. E. (2012). Are suicide attempts by young Latinas a cultural idiom of distress? *Transcultural Psychiatry*, 49(5), 718–734. <http://doi.org/10.1177/1363461512463262>
- Zayas, L.H., Gulbas, L.E., Fedoravicius, N., and Cabassa, L.J. (2010) Patterns of Distress, Precipitating events and reflections on suicide attempts on young Latinas. *Journal of Social Science and Medicine* 70(11) :17773-9. doi10.1016/j.socscimed.2010.02.013.

Zong, J. G., Cao, X. Y., Cao, Y., Shi, Y. F., Wang, Y. N., Yan, C., ... and Chan, R. C. (2010).

Coping flexibility in college students with depressive symptoms. *Health and quality of life outcomes*, 8(1), 1.

APPENDIX A: RESEARCH INSTRUMENT

My name is Rejoice Chiwandire , I am studying BSC Honours degree in Psychology at Midlands State University level 4.2. I am carrying out a research on the RISK AND PROTECTIVE FACTORS OF PARA-SUICIDE (SUICIDE ATTEMPTS) AMONG THE YOUTHS OF CHEGUTU URBAN DISTRICT. I need your assistance through your participation in answering this questionnaire .Your participation is strictly voluntary and you can withdraw any time when you feel like doing so. I benevolently ask you to be truthful in your answers. Please do not write your name on the questionnaire.

Section A : Demographic Information

Use a tick to show your answer.

1) Sex:

Male

Female

2)Age

16-19

20-22

23-24

3)Educational Level

Ordinary Level

Advanced Level

College/ University

4) Are you a religious person

Yes No

Section B: Para-suicide

Use a tick to show your answer, only tick in one box.

5)Have you ever thought about or attempted to kill yourself

- Never
- It was, just a brief passing thought
- I have had a plan at least once to kill myself and really wanted to die.
- I have attempted to kill myself but did not want to die
- I've attempted to kill myself and really hoped to die

6)How often have you thought about killing yourself in the past.

- Never
- Rarely (1 time)
- Sometimes (2 times)
- Often (3-4 times)
- Very often (5 or more times)

7)Have you ever told someone that you were going to commit suicide or that you might do it

- No
- Yes, at one time but did not want to die.
- Yes, at one time and really wanted to die.
- Yes more than once but did not want to do it.
- Yes more than once and really wanted to do it.

8)How likely is it that you will attempt suicide someday

- No
- Not at all
- Likely
- Rather likely
- Very likely

SECTION C: Risk and Protective Factors

Hopelessness and depression

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
9)Most things do not seem to go my way.					
10)No matter what I do things do not get better.					
11)Its hard to see myself happy					
12)I do not think I amount to anything.					
13)I feel my situation is hopeless					
14)I am often bored and unhappy					
15)I feel down most of the times					
16)I feel like a failure and disappointed in my life.					
17)I feel sad most of the times					
18)I feel tired most of the times					

Family Factors

Only tick in one box

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
19)In our family there is feeling of togetherness					
20)In our family we spend a lot of time doing thing together					
21)My family members support each other.					
22)I feel free to discuss my problems with my family members					
23)My parents / guardians pay attention to me all the time.					
24) I am very close with my parents / guardians					
25)In our family we argue a lot					
26)My family members are sometimes violent					
27)One of my relatives once suffered from a mental illness					

Alcohol and Substance Use

Only tick in one box

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
28)I drink alcohol when I am sad					
29)Feelings of harming myself usually occur when I am drunk					
30)I usually drink because I want to escape from my problems					
31)When I am facing problems I take pills so as to harm myself and avoid my problems.					

Stressful life events

Only tick in one box

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
32)I lose faith in myself when I make mistakes					
33)I often feel overpowered by obstacles and troubles					
34)I feel unable to deal with problems					
35)When things do not go my way I feel like there is no reason for me to live anymore.					

36)I usually pray to God when I feel overpowered by obstacles and troubles					
37)When faced with problems I find it easy to discuss it with my friends.					

Thank you for your participation.

APPENDIX B : LETTER FOR PERMISSION TO COLLECT DATA


4-

**Midlands State
University**

Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 261
Fax: (263) 54 260233/260311



**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

Date: 17/03/16

To whom it may concern

Dear Sir/Madam

MNB COMMERCIAL COLLEGE
THE DIRECTORS:
0774 856 252, 0771 407 677
18 MAR 2016
STAND No. 50137
SIGNATURE [Signature]

RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION
FOR Chiwandire Rejora

BACHELOR OF PSYCHOLOGY HONOURS DEGREE

This letter serves to introduce to you the above named student who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore kindly request your organisation to assist the above-named student with any information that they require to do their dissertation.

Topic: Risk and protective factors of para-suicide among the youths of Chegutu.

For more information regarding the above, feel free to contact the Department.

Yours faithfully
[Signature]
F. Ngwenya
Chairperson

MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
18 MAR 2016
PRIVATE BAG 9055
GWERU

APPENDIX C: PERMISSION TO COLLECT DATA

Midlands State
University



Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 261
Fax: (263) 54 260233/260311

FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

Date: 17/03/16

To whom it may concern

Dear Sir/Madam

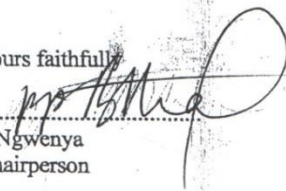
RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION
FOR Chiwandire Rejoice
BACHELOR OF PSYCHOLOGY HONOURS DEGREE

This letter serves to introduce to you the above named student who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore kindly request your organisation to assist the above-named student with any information that they require to do their dissertation.

Topic: Risk and protective factors of parasuicide among the youths of Chegutu.

For more information regarding the above, feel free to contact the Department.

Yours faithfully


F. Ngwenya
Chairperson

THE SCHOOL DIRECTOR
COURTLY ACADEMY
P. BAG 9052
CHEGUTU
18/03/16
SIS

MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
18 MAR 2016
PRIVATE BAG 9055
GWERU

APPENDIX D: PERMISSION TO COLLECT DATA


*THE DEAN OF STUDENTS
P.H. GUSTIN 21/03/16*

Midlands State University

Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 261
Fax: (263) 54 260233/260311



**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

Date: *17/03/16*

To whom it may concern

Dear Sir/Madam

VICE PRINCIPAL
MUPFURE COLLEGE
PO BOX 347, CHEGUTU

DATE: *21/03/16*

RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION
FOR *Chiwandire Rejora*

BACHELOR OF PSYCHOLOGY HONOURS DEGREE

This letter serves to introduce to you the above named student who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore kindly request your organisation to assist the above-named student with any information that they require to do their dissertation.

Topic: *Risk and protective factors of para-suicide among the youths of Chegutu.*

For more information regarding the above, feel free to contact the Department.

Yours faithfully

[Signature]
F. Ngwenya
Chairperson

[Signature]
21/03/16

MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

18 MAR 2016

P.BAG 9055
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APPENDIX E: AUDIT SHEET FOR STUDENT AND LECURER

Date	Activity	Supervisor's Comments	Supervisor's Signature	Student's Signature
01/12/2015	Proposal	Rework and resubmit		
12/12/2015	Proposal	Reviewed and Proceed		
4/01/2016	Chapter 1	Rework and resubmit.		
14/01/2016	Chapter 1	Reviewed and Proceed		
3/02/2016	Chapter 2	Rework and resubmit		
16/02/2016	Chapter 2	Reviewed and Proceed		
09/03/2016	Chapter 3	Rework and resubmit		
15/03/2016	Chapter 3	Reviewed and Proceed		
17/03/2016	Instrument	Reviewed and Proceed		
08/04/2016	Chapter 4	Rework and resubmit		
13/04/2016	Chapter 4	Reviewed and Proceed		
4/16/2016	Chapter 5	Rework and resubmit		
15/04/2016	Chapter 5	Proceed		
17/04/2016	First Draft	Rework		
21/04/2016	Second Draft	Submit		

Supervisor's signature.....

Student's signature.....

APPENDIX G: MARKING GUIDE**FACULTY OF SOCIAL SCIENCES**

DEPARTMENT OF PSYCHOLOGY

A GUIDE FOR WEIGHTING A DISSERTATION

Name of Student.CHIWANDIRE REJOICE REG No. R123788Z

	ITEM	Possible Score	Actual Score	Comment
A	RESEARCH TOPIC AND ABSTRACT clear and concise	5		
B	PRELIMINARY PAGES: Title page, approval form, release form, dedication, acknowledgements, appendices, table of contents.	5		
C	AUDIT SHEET PROGRESSION Clearly shown on the audit sheet	5		
D	CHAPTER 1 Background, statement of problem, significance of the study, research questions, objectives, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Addresses major issues and concepts of the study. Findings from previous work, relevancy of the literature to the study, identifies knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of design, target population, population sample, research tools, data collection, procedure, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 Discussion (10) Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical, implications, conclusions (5) Ability to use findings to draw conclusions Recommendations (5)	20		
I	Overall presentation of dissertation	5		
J	References	5		
	TOTAL	100		

Supervised by :