The psychosocial needs of parents of adolescents who attempt suicide

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Abstract

This qualitative study explored and described the psychosocial needs of parents of adolescents who had recently attempted suicide. Ten purposively selected parents (females = 10, age range 29 to 59) participated in semi-structured individual interviews on their lived experiences after their child attempted suicide. Thematic analysis of the data revealed the parents' psychological needs after the attempted suicide by their minor child to be characterized by emotional turmoil including feelings of regret, self-blame, guilt, fear and anxiety. The parents' social needs included resources for rebuilding their disturbed family relationships and coping mechanisms. Mental healthcare providers to parents of adolescents who survive suicide attempts should aim to help parents manage the complex feelings they experience and improve their self-awareness and parenting skills to prevent future adolescent suicide attempts.

Keywords: adolescent, family, parent, parenting, South Africa, suicide attempt

Introduction

The attempted suicide of an adolescent child is a disruptive event that evokes complex feelings in parents (Greene-Palmer et al., 2015). Adolescents who have attempted suicide before or who have a tendency to self-harm are at risk of future suicide attempts and completed suicide (Asarnow, Berk, Zhang, Wang, & Tang 2017). Around a third of adolescents with suicidal

ideation proceed to develop a suicide plan. Sixty per cent of those may attempt suicide within the first year of ideation (Nock et al., 2013; McLoughlin, Gould, & Malone, 2015). Healthcare providers and parents should be aware of how suicidality may progress in adolescents (Holland, Vivolo-Kantor, Logan, & Leemis 2017).

Risk for self-harm among adolescents calls for psychosocial interventions for families affected by suicidal attempts to help them prevent repeat attempts, which could result in fatality (Hawton, Saunders, & O'Connor, 2012). With appropriate and timely help, family members of adolescents with attempted suicide may be better able to prevent future attempts through closer engagement with the child who has attempted suicide (Grant, Ballard, & Olson-Madden, 2015). We sought to explore the lived experiences of South African parents of children with attempted suicide.

Prevalence of suicide among adolescents and young people

Suicide and accidental death from self-harm were the third leading cause of adolescent mortality in 2015, resulting in an estimated 67 000 deaths (World Health Organization [WHO], 2016; 2017). Death by suicide accounts for an estimated 6% of all deaths among young people, and is the second leading cause of death among 15-29 year olds globally. For each suicide, there are more than 20 suicide attempts (WHO, 2016).

In South Africa about 7.2% of 3000 adolescents reported suicide ideation, while 5.8% reported suicidal plans and 3.2% reported suicidal attempts in the month before the survey (Cluver, Orkin, Boyes, & Sherr, 2015).

While death by suicide is difficult to predict, symptoms common to these disorders, such as affective and behavioral dysregulation were stronger predictors of recurrent suicide events than the actual diagnosed disorder (Yen et al., 2013). Apart from psychopathology, other

factors that increase the risk of suicide in adolescents include impulsivity, delinquency, alcohol problems, family and friend suicide history (Thompson & Swartout, 2018).

Parent involvement in suicide risk among adolescents

Multiple studies have highlighted the association between disturbed parent adolescent relationships and suicide risk. The risk of suicide is intensified by authoritarian parenting styles, low parental warmth, support, attachment; and lower familial adaptability and cohesion (Sheftall, Mathias, Furr, & Dougherty, 2013; Miller, Esposito-Smythers, & Leichtweis, 2015; Singh & Behmani, 2018). Adolescents with lower parental care are more likely to progress from suicide ideation to attempted suicide (Saffer, Glenn, & Klonsky, 2015). Authoritative parenting and a positive family climate are protective against suicide ideation (Consoli et al., 2013). In sub-Saharan Africa, risk of suicide planning and attempts in adolescents is higher among those with adversities such as parental death, abuse, and violence (Cluver et al., 2015).

The emotions parents experience after a child's suicide attempt are described in multiple studies. Parents find themselves in a state of emotional turmoil characterised by sadness, anxiety, guilt, fear (Greene-Palmer et al., 2015), shock, surprise and anger (Asare-Doku, Osafo, & Akotia, 2017). They experienced a sense of failure, rejection, isolation, incomprehension, and feelings of helplessness and powerlessness, as if they were losing control (Lachal, Orri, Sibeoni, Moro, & Revah-Levy, 2015). Similar feelings of frustration, anxiety and helplessness were reported by parents of adolescents with a diagnosis of depression, who blamed themselves for the child's condition (Stapley, Midgley, & Target, 2016). Helplessness might be associated with hopelessness. Parents in a study by Brown (2018) who responded with low-hope to their adolescents' mental illness, put their lives on hold and remained focused on the child's problems without making changes to their parenting interactions. Parents who

view the problem as biological in nature and expect professionals to find a solution, might be reluctant to do self-discovery (Brown, 2018).

Morgan et al. (2013) linked the psychological distress of the parents with the magnitude of difficulties encountered by the child. There is a clear relation between successful suicide and feelings of shame and guilt in surviving family members (Hastings, Northman, & Tangney, 2002; Van Der Pol & Pehrsson, 2016). What requires more exposition though, is the role of shame and guilt in attempted suicide. Little is known about the needs of parents after a child's attempted suicide. A study conducted in the United States showed that parents have unmet needs with regards to ensuring the safety of the child (Hickey, Rosetti, & Musker, 2019) The psychosocial needs of South African parents of adolescents who attempted suicide have not been addressed by research studies.

Barriers in the mental healthcare system that hinder family involvement in the care of a relative who is at risk for suicide, exacerbate parents' feelings of caregiver burden and powerlessness (Grant et al., 2015). When parents perceive the healthcare system as useless, futile, or rejecting, feelings of helplessness are reinforced (Lachal et al., 2015). On the other hand, when parents were treated with empathy, concern and positive regard by healthcare professionals, they responded with more empathy and understanding towards their children with depression (Moran & Diamond, 2008). The mental health treatment gap and shortage of public mental health resources that exist in South Africa, may make it even more difficult for parents to obtain psychosocial support after a child's suicidal attempt (Bantjes, 2017).

Goal of the study

We sought to explore the psychosocial support needs of South African parents of children who attempted suicide. Increased awareness of the effects of suicidal attempts on families and the support required by the affected parents, may strengthen collaboration between family

members and mental healthcare providers (Morgan et al., 2013; Hickey, Rossetti, Strom, Bryant, 2015; Grant et al., 2015). This study was guided by the research question: 'What are the psychosocial support needs of parents of adolescents who attempted suicide and were admitted to a district hospital in South Africa?'

Method

Research design

We employed a descriptive phenomenological approach. Phenomenological research involves a rich description of lived experiences, where the researcher adopts an open phenomenological attitude and refrains from importing external frameworks and sets aside judgements about the research phenomenon (Finlay, 2009). We aimed to understand the psychosocial support required by parents through exploring their lived experiences of how they made sense of their adolescents' attempted suicide.

Participants and setting

We selected a purposively sample of 10 female parents of children who attempted suicide and received services from a public district hospital in a rural area in South Africa. This area housed 21345 people, of whom 38.8% lived in informal settlements due to the high unemployment rate (33%) (City of Tshwane, 2015, Statistics South Africa, 2016). Potential participants were identified by nurses working in the psychiatric unit of the hospital. The nurses introduced the parents to the researcher, who explained the aim of the research. The participants were all females aged between 29 to 59 years. Three were from the Tsonga culture group and seven from the Tswana group. Their educational levels ranged from Grade 7 to one participant with tertiary education. Only two were employed at the time of the study.

Data collection

The participating parents completed semi-structured individual interviews on experiences with regard to their adolescent who has attempted suicide. We asked follow up questions on the parents' thoughts and feelings about their adolescents' suicide attempt, as well as the support parents would like to receive following their adolescents' suicide attempt. For credibility and trustworthiness of the data collection, we kept field notes and worked to achieve data saturation, which we reached after the tenth interview.

Procedure

The Ethical Committee of the Faculty of Health Sciences, University of Pretoria approved the study. Participants consented for study. We informed them that they may experience emotional discomfort while they were sharing sensitive information and also that we had a counsellor to debrief then should they require assistance with any psychological needs from the study participation.

Data analysis

We employed Braun and Clarke's (2006) method of thematic analysis to analyse the transcribed interviews. In doing so, we read through the data to obtain a general sense of the information, reflected on the overall meaning and checked for general ideas verbalised by participants. We then generated initial codes and coded all transcripts followed by labelling the emerging themes and sub-themes.

To ensure trustworthiness of interpretations, we had an independent researcher experienced in qualitative data analysis to go through the data applying the same thematic analysis we engaged. To ensure the accuracy of the findings, we discussed any discrepancies in interpretation with the independent researcher to reach consensus on the themes.

Results

Under the theme, psychological needs, three sub-themes emerged, namely, (1) post-traumatic experiences, (2) regret, self-blame and guilt, and (3) fear and anxiety. The social needs were reflected in two sub-themes, namely, (1) disturbed family relationships and (2) coping mechanisms. The findings are substantiated with verbatim quotations, indicating the participant's number and age in brackets.

Theme 1: Psychological needs

Participants expressed their psychological needs in terms of the emotional turmoil from the post-traumatic experience following attempted suicide by their child. They also reported experiencing feelings of regret, self-blame, guilt, fear and anxiety for which they needed mental health services.

Post-traumatic experiences

Parents experienced the suicide attempt as a traumatic event. Some participants experienced symptoms of post-traumatic stress disorder such as re-experiencing the event, avoidance, numbing and arousal. One participant said to vicariously re-experience the suicide attempt as if she were present, although she was not:

> *After the incident I could not stay alone in the house, I had a feeling as if what happened I was present…I could not sleep with the lights off… At times I could experience this big fear as if I was on the scene…* (Participant 9, 54 years).

Another parent re-experienced disturbing emotions when she visualised the suicide attempt:

> *The method that she used, hanging herself, marked the most hurtful and I cry every time I imagined it* (Participant 10, 59 years).

Like with a traumatic event, Participant 4 (39 years) stated that she will never forget the image of her daughter in the intensive care unit:

> *I heard the doctor saying if she doesn't respond she will be taken to ICU [intensive care unit]. I became crazy, I thought she won't survive because my mom died in ICU. I had flashbacks…if something have happened to you it leaves a mark. I will still have her picture whilst in ICU and that day will always be remembered*.

Another participant avoided talking about the incident and did not want to be reminded about it:

> *It was difficult; she was on drips until she was discharged. I felt very hurt inside, I did not want to talk about it…I felt very hurt (Tears filling in her eyes).*

Numbing is illustrated in the next quotation. The participant felt as if her life was on hold with no reason to plan for the future:

> *And then everything came to a standstill, there was nothing I was thinking about except him. I had plans for life and family. I am a traditional person, I was supposed to perform some rituals [cultural rituals] but I stopped…This has affected me so much in my life. Everything stopped; I did not have a plan anymore…* (Participant 2, 29 years).

Participant 8 (50 years) experienced arousal symptoms and was so watchful and alert that she left her work at times and rushed home to check on the adolescent:

> *I'm working and he is attending school. He comes back earlier than me because I knock off late …sometimes when I look at the time I would say he is already home and what*

if he thinks of killing himself again. I would leave what I was doing, pack my stuff and go home…I have to go and see what is happening.

Although all participants did not display symptoms of post-traumatic stress, they all experienced the event as traumatic and required support to overcome the disturbing experiences and emotions.

Regret, self-blame and guilt

The parents experienced regret, self-blame and guilt related to the adolescent's suicide attempt. Participant 1 (30 years) wished she could have reversed the experience:

I felt as if I could reverse that day, it was very painful to me and I was thinking something that is not possible: reversing it and not seeing what has happened now.

Parents tried to find a reason for the suicide attempt and Participant 4 (39 years) blamed herself for what happened. She could not think of anything she did wrong, but reasoned that because she was with her daughter most of the time, she must be to blame:

I blamed myself that as a parent maybe I didn't do enough for her. I asked myself that maybe she had long standing problems and not knowing with whom to share with. I keep asking myself who made her sad, is it me or what, l kept asking myself questions. Initially if I failed somewhere, she could tell me that I have disappointed her or send me an SMS. Her boyfriend is in military training and I said she is with me most of the time so it's me who had bothered her.

Later during the interview, Participant 4 (39 years) revealed that her divorce might have contributed to the suicide attempt:

At some stage everybody has her own problems, I have just divorced…so I thought that she thinks that I no more have space for her and her brother and I also thought that maybe she didn't tell me her problems because she thought I also have my own burdens.

The guilt feelings were exacerbated by a remark one of the nurses made in hospital after the suicide attempt:

When the sister asked me: 'What did you do to the child?' then I told myself that it means there is a negative role that I have played.

One of the parents was of the opinion that disciplining the child prior to the incident could have caused the suicide attempt:

I don't feel good at all…sometimes I blamed myself for shouting at her and punishing her. But I had no choice because she could sometimes stay in the bedroom the whole day without washing the dishes or cooking…. (Participant 9, 54 years)

Another participant experienced frustration and responded with verbal aggression towards the adolescent. She and her husband felt guilty about their angry responses, which might have worsened already tense relationships:

…his behaviour made us to be short tempered and shout at him when we are not supposed to… (Participant 8, 50 years).

The parents blamed each other for the suicide attempt. Participant 6 (40 years) felt that '*my husband is partly to be blamed…'*, while Participant 8 related the incident to the way they disciplined the child prior to the attempt:

...we are blaming each other. His father is blaming me for shouting at him; I'm also blaming him for using strong words.

Participant 5 (49 years) explained felt that growing up without a father figure contributed to her daughter's wish to take her own life:

I thought that maybe the fact that they grew up without their father contributed to this.

Participants did soul searching into their own behaviour and social circumstances, attempting to understand their adolescents' self-destructive behaviour. This led to guilt feelings and self-blame which affected marital and parent-child relationships.

Fear and anxiety

Participants felt tense and anxious and some anticipated another suicide attempt. Participant 4 (39 years) explained that she still did not know what caused the attempt and feared that it might happen again:

I have fear that something might happen again because it is still early and the fact that I don't know what pushed her to do that.

Participant 7 (42 years) was scared by her child's disturbing profile image that might have indicated that she had planned another attempt:

Her profile picture on her phone shows her hanging and I don't know if she took it before or after the incident, that scared me and that was the reason I asked my neighbours to check on her.

Parents felt a need to constantly check on their children, even at night, to the extent of one parent following the adolescent to the bathroom for fear that he might retry suicide by using a more lethal method:

> *I started wondering why he was taking long inside the bathroom. I thought that maybe he has thought of doing something else. I went to check on him and I found him standing…I'm thinking that maybe I'm disturbing him psychologically and he would kill himself with something very powerful because the tablets failed* (Participant 8, 50 years).

> *…we think that he might attempt again, even at night I feel as if I could go into his room to enquire if he was okay or whether he had killed himself or what…* (Participant 9, 54 years).

Parents became alert and overprotective to the extent of watching and accompanying the child everywhere:

> *…so what happened was a shock and was going to change my life completely…. I also have a fear of putting cough mixtures anywhere, so as of now I am traveling with them inside the car...she is going to live like a prisoner because I have to take her to school and fetch her* (Participant 4, 39 years).

Participant 2 (29 years) so much feared another attempt that she anticipated and experienced the pain of the loss she could have been exposed to:

> *Death is not a child's play, there is you won't see him anymore, I'll miss him and his deeds. Every time I would say if he was here he could be doing this and that. He is a clever boy, able to fix household stuff, people from the tavern broke my gate, so*

remember if he was not there, who was going to fix the gate… when I remember all these that is what hurt me, it would leave a scar for the rest of my life and I don't think that I would forget…It was painful because every child is important to his mother especially if you have seen his doing… that's why I felt pain when I think that he wanted to commit suicide, who would replace him?

It is clear from the quotations that parents need help to deal with the constant fear and anticipatory grief. Some of them realised that their intrusive behaviour might affect the adolescent in a negative way, but they fell short of more effective ways to deal with the situation.

Theme 2: Social needs

Participants' social needs revolved around the disturbed family relationships, more effective coping mechanisms and a need for professional support.

Disturbed family relationships

In this theme parents described changes in the parent-adolescent relationship and other family relationships, after the suicide attempt. These included changes in parenting and disciplining the adolescent and the ways in which they tried to support the adolescent.

In some cases the disturbed family relationships were already present before the suicide attempt, for example, Participant 5 could not even reach out to her daughter immediately after the suicide attempt:

I felt hurt that I even cried when I looked at her inside the car to hospital, I cried that even the words that I said will not help her because she doesn't listen to me. I was heartbroken as any parent in my situation… (Participant 5, 49 years).

Participant 4 explained that 'there is tension between the two of us…it frustrates me and I have million questions for her…' Participant 7 (42 years) also experienced communication difficulties because her daughter avoided discussions about the incident: '*She is always busy with school work and keeping distant…*'

Parents described how their adolescents' suicide attempts affected other family members who were filled with fear by what happened:

> *My other two kids are also affected in so much that we had to sleep at a friend's place because they were fearful* (Participant 10, 59 years).

The families experienced tension and the incident affected their daily living and communication patterns:

> *…there is this tension in the family after the incident, we don't talk as we used to, she just say hello and went to sit in her bedroom* (Participant 4, 39 years).

Parents reported feeling ambivalent about discipline, they knew they were responsible for guiding their children, but following the suicide attempt, they were unsure about how to discipline their adolescents, or even afraid to do so. Some parents even felt that they should not discipline the child at all:

> *I now don't know how am I going to try and guide because I can't leave her to do as she wishes, as a parent I might not know how is she going to take it…* (Participant 1, 30 years).

> *I think it is my responsibility to show her the correct way, but if she does this, what am I supposed to do?* (Participant 3, 32 years).

In the next quotation the parents tried to avoid serious discussions with their son, feeling afraid that the confrontation would upset him:

> *…last night he came home late and I was very worried about that. I then told his father that when he comes back, we must call him and talk to him about his behaviour because he promised us to change. His father is also scared and he said we must not make serious meetings with him as they will make him feel scared. He said we must just tell him in passing and not seriously. That is the life that we are living now (tears flowing down her cheeks)…even if he has made mistakes we cannot reprimand him…* (Participant 8, 50 years)

This theme illustrated the strained family relationships after the suicide attempt. Although the families experienced tension and fear, they did not feel comfortable enough to reach out and comfort each other.

Coping mechanisms

Coping mechanisms is discussed as a sub-theme under social needs as most participants regarded effective coping as coping that occurs within the context of the relationship with the adolescent who attempted suicide.

Although parents realised that they had to support their children in one or the other way, many were unsure how to go about showing their support. Some participants did not realise the extent to which their children required support until after the suicide attempt. Participant 7 (42 years) described her willingness and commitment to support the adolescent (and other children in the family) after the suicide attempt: '*I'm going to allocate my time to be with them. I should also start to listen to them the same time they want to see me…*' Participant 2 (29 years) explained that the whole family was willing to support the adolescent. The intrusive

methods that she intended using to get to know her child better, might have been less effective though:

> *We are there to support him, if he can't talk to me, his brother is there or any other family member or even his father, he could explain to him his challenges and he could help and guide him… every parent should know his child…I should try being next to him every time. This means I must try to do secret investigations where I see any deviations, I must force to know what it is that is troubling him, and so that when he needs help I can help to reassure him…*

Some parents wanted to help their children, but were unsure about what to do and felt powerless to manage the situation:

> *I am trying to satisfy him but I really don't know what to do. He was discharged on Wednesday and Thursday I started assisting him with his homework so that he can go back to school…* (Participant 8, 50 years).

Another participant tried to accept the situation that precipitated the suicide attempt, and attempted to get her child to do the same:

> *As a parent I accepted because in life no situation is permanent, and then I was looking for success, but if he loses the job he should just accept it, God will help him to find another job in order to pursue his dreams. I sat him down and told him how life is and its ups and downs* (Participant 2, 29 years).

Participant 4 (39 years) also tried to accept the suicide attempt, but through using self-talk and viewing it as something that can happen to any person:

But sometimes if things like this happen you tell yourself that if it doesn't happen to me, who else was it to happen to?

Some of the parents were unable to seek support from their social networks as a way of coping. This is related to the stigma attached to suicide, as illustrated in the next two quotations:

…it is important for you to keep your family sensitive issues confidential so as to avoid frustrations to your family, because they will end up talking many things that you don't even know as a family (Participant 7, 42 years).

When we arrived at the clinic it was 9h30 and the clinic was full with people from our area and also our neighbours and everybody was looking at us. It was not nice at all… This incident had hurt me a lot. Even at work I did not tell anyone but it has hurt me… (Participant 8, 50 years).

The participants attempted to cope with the trauma of the suicide attempt, but the quotations highlight their needs for some form of assistance to facilitate effective coping. Some participants felt relief simply by talking to the researcher as Participant 1 acknowledged*: 'as I'm talking to you I feel relieved so I need it…'* Participants expressed a need for individual and family counselling, support groups, and a desperate need for advice on how to manage the situation:

…I need help to reassure me and advise me on living with an adolescent who has attempted suicide, what am I supposed to do? (Participant 2, 29 years).

…I need counselling, if it can be done individually and again as a family by a professional, I think it can be very helpful for all of us… (Participant 8, 50 years).

…a support group or something to empower us and this can make me feel better because other parents, their children didn't make it… (Participant 4, 39 years).

Parents realised that coping needs to happen within the troubled relationship with the adolescent who attempted suicide. They felt a supportive relationship with a helping professional or others in the same situation, will enable them to develop coping mechanisms.

Discussion

Symptoms of post-traumatic stress experienced by parents after a child's suicide attempt are mentioned in some studies, for example, parents described the attempt as traumatic and displayed hypervigilance to the extent of invading their children's privacy (McDonald, O'Brien & Jackson, 2007; Buus, Caspersen, Hansen, Stenager, & Fleischer, 2014). The possibility of these parents developing post-traumatic stress, is though not fully explored in research.

Similar to the findings of this study, Buus et al. (2014) indicated that parents struggled with the unpredictable character of suicide attempts and subsequent fear of another attempt. Parents' sense of responsibility to safeguard the adolescent manifested in behavioural and relational changes such as hypervigilance and being attentive of the suicidal child. They wanted to understand why the suicide attempt happened in the first place, engage in suicide prevention activities and establish communication and trust (Hickey et al., 2015). During a suicide crisis of a loved one, family members strongly desire the needed knowledge (and perhaps power) to prevent suicide from happening (Grant et al., 2015).

However, parents doubted their ability to protect their adolescents, recognize suicide warning signs and obtain their adolescent's commitment to refrain from suicide. Professionals have to address these concerns before continuing with other therapeutic interventions. Parents need support to implement suicide prevention strategies, as their low confidence in their

capacity to influence their adolescents' behaviour may undermine their efforts (Czyz, Horwitz, Yeguez, Foster, & King, 2017).

The trauma of the suicide attempt negatively affected family relationships and communication. Parents' efforts to support their children following the suicide attempt, were sometimes futile and left them with feelings of powerlessness. Adolescents with suicidal tendencies tend to feel alienated from others and a burden to others. Parents should be assisted with interventions that will lessen these perceptions and promote close and supportive family relationships (Czyz, Berona, & King 2015). Relationship problems, particularly with parents, are a common suicide antecedent (Consoli et al., 2013; Sheftall et al., 2013) and parents who respond in angry, hostile, or argumentative ways, may increase the risk of recurrent suicide attempts (Greene-Palmer et al., 2015). Pre-existing family problems and stressors associated with the child's behaviour combine with the stress of the suicide attempt and affect the family's well-being and ability to function (Morgan et al., 2013).

In this study parents responded with guilt to their children's emotional pain. Shame, guilt and embarrassment may withhold parents from seeking much needed support to cope after an adolescent's suicide attempt (McDonald et al., 2007). Shame invokes a desire to withdraw and escape from others (Hastings et al., 2002). Social withdrawal is evident in cultural contexts where suicide is stigmatised and considered a taboo, as illustrated in a study conducted in Ghana (Asare-Doku et al., 2017). Parents in the current study did not feel comfortable to reveal the suicide attempt to community members. Goldstone (2017) found that people who attempted suicide in South Africa endure considerable rejection and stigmatisation attributed to conservative beliefs about suicide.

Healthcare professionals should address potential barriers towards family centred care, and when clinically appropriate, involve the family in the care of the adolescent at risk for suicide (Grant et al., 2015). Programs to support families after a suicide attempt are proposed

in the literature. The COPE Program facilitates parents' sense of self-efficacy by training them to deal with suicide threats and the distress surrounding the threat-interaction (Grant et al., 2015). The SAFETY Program is a cognitive-behavioral family intervention designed for integration with emergency services to increase safety and reduce suicide attempts (Asarnow, Berk, Hughes, & Anderson, 2015). The Resourceful Adolescent Parent Program reduces suicidal behavior and associated psychiatric symptoms, through interventions aimed at family functioning (Pineda & Dadds, 2013).

Support programs for parents of children with suicide attempt history should be tailored to address the needs of the individual, family and community. Individual psychotherapy (specifically cognitive behavioural therapy) may help parents to manage the complex feelings they experience. Family members should be involved in the adolescent's mental healthcare programme through family interventions and psycho-education to prevent future attempts. Community programs need to address the stigma attached to suicide and inculcate life skills such as coping and problem solving to prevent suicide ideation and behaviour. Mental health professionals should establish and facilitate support groups to help parents enhance their coping mechanisms, parenting skills and self-awareness when faced with problematic and suicidal behaviour in adolescents. The researchers identified a need for implementation research to adapt and implement one of the mentioned support programmes for parents in the research context.

Limitations of the study and suggestions for further research

A limitation of the study was that the participants came from a specific rural area and represent only two of the many cultural groups in South Africa. Parents who come from other areas or belong to different cultural groups may experience attempted suicide differently. Moreover, parents who elected not to participate in our study might report differently on their experiences.

Conclusion

Parents of adolescents who attempted suicide experienced symptoms of post-traumatic stress and feelings of regret, self-blame, fear and anxiety. Their social needs manifested wanting supports to mend their disturbed family relationships and to work through their feelings of fear, guilt and helplessness. The parents reported a sense of guilt that motivated them to make amends while they still had the opportunity to do so, while some parents allowed their adolescent special privileges or could not confront the child. What stood out, was that some of the parents felt guilty despite knowing what they did wrong, and others felt powerless and unequipped to repair the strained relationships.

To meet the psychosocial needs of parents after adolescents' suicide attempts, mental healthcare professionals need to consider two aspects. Firstly, symptoms of post-traumatic stress and underlying guilt and shame might be unexpressed and masked; and secondly fear of stigma might prevent parents from using their usual social support networks.

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