EXPERIENCES AND SUPPORT STRUCTURES OF HOUSEHOLD MEMBERS OF SUICIDE ATTEMPT SURVIVORS PRESENTING AT AFRICA INLAND CHURCH LITEIN HOSPITAL

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A Thesis Submitted to the Institute of Postgraduate Studies of Kabarak University in Partial Fulfillment of the Requirements for the Award of Master of Medicine in Family Medicine Degree

KABARAK UNIVERSITY

NOVEMBER, 2025

DECLARATION

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This thesis entitled: **‘Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church Litein Hospital** and written by **Ekisa Loraine Idionyi** , is presented to the Institute of Postgraduate Studies of Kabarak University. We have reviewed the research thesis and recommend it acceptable in partial fulfillment of the requirement for the award of the degree of Masters of Family Medicine.

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DEDICATION

This work is dedicated to the Mental Health Department at Africa Inland Church Litein whose members work tirelessly to support survivors of suicide attempts and their families as well to families affected by suicide attempts in Kenya, who are key members in suicide prevention.

ABSTRACT

Suicide is a serious public health problem, with a previous suicide attempt being the greatest risk factor for repeat and completed suicide. Household members of a person who attempts suicide, who are greatly affected by a suicide attempt, are key gatekeepers in prevention of suicide, hence their experiences and support needs cannot be ignored. However, there is a paucity of data on the effects of a suicide attempt on household members in Kenya and their support needs have not been explored or exhaustively included in existing local mental health policies. This study's objectives were to describe the experiences of household members following a suicide attempt presenting at Africa Inland Church (AIC) Litein Hospital and to explore the existing and desired support structures following the event. A qualitative phenomenological study design was used, with the study participants being household members living of suicide attempt survivors presenting at AIC Litein Hospital recruited using a purposive sampling technique. Following an informed consent, in-depth interviews were conducted using a semi-structured interview guide. Interviews were audio recorded, transcribed verbatim, and thematically analysed. 16 in-depth interviews were conducted. Participants experienced a range of negative emotional and psychological responses and relationships within households were either strengthened or weakened while others experienced social isolation and stigma from community. Physical harm during rescue attempts was sustained and participants reported additional responsibilities including financial burden and reduced work productivity. Support structures available included good healthcare provision, practical support from family and community including rescuing the survivor and financial support. Spiritual and moral support from religious leaders and community was reported. Household members desired mental health and professional support and expressed the need for education and information on suicide which could be relayed both at the hospital and community level. Community support financially, materially and through formation of support groups was desired and participants expressed the role of community leaders in addressing suicide triggers and advocating for the needs of affected households. Considering the crucial role of household members and the adverse effects of a suicide attempt, addressing their needs is not only the mandate of healthcare workers but also the clergy, the government, community leaders and the larger community working collaboratively. Healthcare institutions must institute well structured counselling services for these individuals, and support groups need to be initiated at community level. The role of community and religious leaders in supporting these households needs to be well defined in the Kenya Mental Health policy and access to mental health services at community level improved in line with the World Health Organization's call for de-institutionalization of mental health services to cater for the mental health needs of these households.

Keywords: *Suicide Attempt, Household Members, Support Structures, Mental Health*

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LIST OF ABBREVIATIONS AND ACRONYMS

CDC	Centres for Disease Control and Prevention
CHP	Community Health Promoters
HCP	Health Care Professional
KNBS	Kenya National Bureau of Statistics
LMIC	Low- and Middle-Income Countries
MHC	Mental Health Clinic
NACOSTI	National Commission for Science, Technology and Innovation
SEM	Social-Ecological Model
SHIF	Social Health Insurance Fund
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Suicide: Harmful actions done by an individual that result in one’s own death

Suicide Attempt: Potentially dangerous actions done by an individual with an intention to die.

Suicide Attempt Survivor: An individual who has performed a potentially harmful action with a goal to die but did not die.

Household Member: Individuals aged above 18 years living in the same household and sharing the resources of the household, whether related by blood or not.

Stigma: Negative and unfair attitudes beliefs or actions held or done by members of a society toward a particular subject, person or group of people.

CHAPTER ONE

INTRODUCTION

Suicide, a global health menace, refers to harmful actions done intentionally that result in one's own death (World Health Organization, 2014). Not only does it result in an untimely death of the individual but also greatly affects friends, families and the society at large (World Health Organization, 2014).

Suicide cannot be fully addressed without an understanding of suicide attempts. Suicide attempt refers to potentially dangerous actions executed by an individual with a goal to die (Bengoechea-Fortes et al., 2023). These acts, however, do not always result in fatality. Suicide and suicidal attempts have many risk factors, including individual factors, familial factors, psychological factors, and larger societal factors (World Health Organization, 2014). Personal factors include age, whereby higher rates have been established in the youth and in older individuals above 70 years, and sex, with higher rates of completed suicide in men and suicide attempt rates up to 4 times higher in women (Bengoechea-Fortes et al., 2023). Presence of mental illnesses including depression, schizophrenia, bipolar mood disorder, and substance abuse among others have been associated with an increased risk of suicide and suicide attempts (Bengoechea-Fortes et al., 2023; Carballo et al., 2020).

Social factors have also been implicated, including family conflicts, social isolation, and marital status. The divorced and those whose spouses have died being at a higher risk (Bengoechea-Fortes et al., 2023). Conversely, a good social support system is considered a protective factor (Edwards et al., 2021). Out of the many risk factors for suicide and suicide attempt, a previous suicide attempt is considered the strongest risk factor for repeat attempts or successful suicide (Bengoechea-Fortes et al., 2023; Greenfield et al., 2021).

Because family factors are greatly implicated as a cause of suicide and suicidal attempts, the family has an important role in preventing suicide through support of the suicide attempt survivor (Edwards et al., 2021). This makes it important to understand what families go through as they live with and support individuals who have attempted suicide. This Chapter will delve deeper into the background of this problem and elucidate the relevance of this study to the problem.

1.1 Background of the Study

Individuals who die by suicide are believed to have gone through episodes of extreme psychological pain and despair, resulting in a loss of desire to live (Bengoechea-Fortes et al., 2023)It is postulated that there are stages these individuals go through before the actual suicide which begin with the having suicidal thoughts, followed by making actual plans to die, then a suicide attempt. The plan is executed but may or may not be successful (Bengoechea-Fortes et al., 2023). In line with the United Nations Strategic Development Goals, the World Health Organization (WHO) aims to achieve a reduction in suicide mortality rates by one third by the year 2030(World Health Organization, 2021). Being that suicide attempt is the single most important risk factor to a completed suicide, suicide attempts must be well addressed if this goal is to be achieved.

About 700,000 deaths by suicide are recorded every year, with up to 77% of these occurring in Low- and Middle-Income Countries (LMIC) where most of the world's population lives (WHO, 2021). According to WHO (2021) suicide is currently the 4th leading cause of death in the age group 15-29 years, with the global age standardized rate of 9.0 per 100,000 compared to the higher rate in Kenya which stands at 11.0 per 100,000 deaths.

The prevalence of suicide attempts in LMIC is not well-established due to lack of data on suicide. However, several studies have attempted to estimate this with a meta-analysis investigating the prevalence of suicide attempts in various population groups in different African countries estimating the prevalence to be 9.9% (Babajani et al., 2024). Quarshie et al. (2020)in his review of data in Sub-Saharan Africa concludes that the lifetime prevalence of self-harm both with and without intent to die among adolescents is 3.0% in Western Africa, 15.5% in Southern Africa and 6.6% in Eastern Africa. However, the inclusion on non-suicidal self-harm in this study may have resulted in a higher prevalence. In Kenya, the prevalence of suicide attempt in former Nyanza province is estimated to be 2% (Jenkins et al., 2015). This differed greatly with a study done in rural coast that estimates the lifetime prevalence of suicide attempt is 19% among females and 15% among males. (Ongeri et al., 2018). The prevalence of suicide attempt in Kenya may be different from region to region and although the overall prevalence in Kenya is not well established it is a problem worth addressing.

Families whose members have attempted suicide may have many other challenges to deal with, including pre-existing mental illnesses, physical diseases, substance abuse, grief and loss, financial strain among other challenges prior to and after a suicide attempt as established by risk factors that culminate to suicide attempts and completed suicide. Having a family history of suicide in a first degree relative for instance, will increase the risk of suicide and suicide attempt by up to 10 times (Bengoechea-Fortes et al., 2023). Thus, it may be apparent that families experiencing a suicide attempt may have either experienced the same before or have a family history of a completed suicide. In Sub-Saharan Africa family issues including conflict, violence, separation, poor communication, sibling rivalry and poor family bonds have been implicated in studies as causes of suicide attempt (Akotia et al., 2019; Quarshie et al., 2020). These

issues that eventually lead to a suicide attempt may not be resolved immediately after the incidence and thus adds onto the family strain.

Shame, fear, guilt, and stigma are common feelings experienced by families of patients who attempt suicide in many places around the world (Juel et al., 2021). Parents of children who attempt suicide experience traumatizing emotions and strain in their family relationships (Buus et al., 2014). Studies done in Western countries have reported dissatisfaction by the level of involvement by healthcare professionals following suicide attempts by loved ones (McLaughlin et al., 2016). Family members have reported feeling resentful towards offering care, owing to the burden it comes with, whereas others become too protective and do not offer the affected individual freedom of individuality, both of which have a negative impact towards recovery (Reupert et al., 2015). Conversely, offering emotional support, linkage to support groups, economic support, and unconditional love aids in the recovery process (Reupert et al., 2015). In addition to these emotional experiences, other societal factors also complicate the experience of families following a suicide attempt.

High levels of stigma exist around the subject of suicide all over the world. Criminalization of suicide in many LMIC has contributed greatly to the stigma around suicide with resultant under-reporting of suicide attempts and death (Ochuku et al., 2022). Furthermore, it has acted as a barrier to individuals seeking help for suicidal behaviour and their families seeking support thus causing a barrier to prevention strategies (Ochuku et al., 2022). Criminalization of suicide and the resultant stigma has likely contributed to the paucity in knowledge of family experiences following a suicide attempt and affected the available support structures in such countries. In Kenya, where suicide is still illegal and stigma is high, the already complicated path to care has been

made more difficult with fear of being discriminated or facing legal charges for attempting suicide.

Like most Africa countries, Kenya is highly religious. Most religions consider suicide sinful, while it is considered a taboo in the African traditions with dire consequences including banishment of suicide attempt survivors, punishment for the individual and their families among others (Mugisha et al., 2013; Ongeri et al., 2022). Whether these strong religious affiliations in Kenya have influenced how families experience a suicide attempt of a loved one and the subsequent support they receive has not been fully explored in the Kenyan context.

Although studies around the world, mostly from Western countries, have endeavoured to explore the experiences of family members, and their support needs, there is a dearth of knowledge surrounding this topic in Africa and particularly in Kenya. The specific support structures in Kenya may differ from those in western countries due to differences in culture, beliefs of the people and resource availability among other factors. As an example, shortage in psychiatrists, psychiatric nurses and psychologists is one of the factors that may deter the reduction of suicide rates especially is low and middle income countries, where the number of psychiatrists is 170 times lower, while that of nurses is 70 times lower than high income countries (Ministry of Health, 2015). These same professionals are expected to attend to both the suicide attempt survivors and their affected relatives and offer them professional support. However, there is an obvious disparity in the availability of human resource in the high-income countries compared to LMICs.

Family and community support is a critical component in suicide prevention strategies especially in LMIC and their role cannot be understated (Fleischmann et al., 2016). Survivors of suicide attempts have expressed the need for social support from their

family members. In a qualitative study, suicide attempt survivors expressed that how a family responded to disclosure of a suicide attempt or ideation influenced future disclosure and engagement by the survivor (Oexle et al., 2019). These survivors reported that experiencing blame and being shamed by family members had a negative influence on the survivors. Suicide attempt survivors have expressed experiencing difficulty in communication with family members and further have suggested that seeking professional help may have helped enhance their knowledge concerning suicide and perhaps made communication easier (Binnix et al., 2018).

Family members are important in suicide prevention and can offer support in the care of the suicidal individual in various ways including participating in their healthcare by offering valuable information to healthcare professionals that can help in their management, offering open channels of communication, involvement in making and implementing safety plans for the individual and encouraging adherence to treatment and follow-up following an attempt (Edwards et al., 2021; Fleischmann et al., 2016). Since the family plays a crucial role in the recovery of individuals who attempt suicide, their experiences and needs while providing this care cannot be ignored as it will inform their ability to play this role efficiently.

1.2 Statement of the Problem

Suicide is among the leading causes of death in the world, with more than one in every 100 deaths resulting from suicide (WHO, 2019). These rates remain higher in Africa compared to the global rates at 11.2 per 100000 deaths compared to 9.0 per 100000 deaths respectively (WHO, 2019). The number of suicide attempts far supersedes the actual completed suicides with an estimate of more than 20 suicide attempts for every one completed suicide (Centre for Disease Control and Prevention (CDC), 2022). A few studies have estimated the prevalence of suicide attempts in Kenya with differing

prevalence in different regions from 2% to as high as 15%(Jenkins et al., 2015; Ongeri et al., 2018). The overall prevalence in Kenya however is not known due to lack of data.

Research has been done to determine the prevalence of suicidal behaviour in East Africa and in Kenya, to understand the determinants of suicidal behaviour while some qualitative studies have been done in Africa exploring the causes of suicide attempts, perspectives and experiences of survivors, and socio cultural perspectives on suicide (Akotia et al., 2019; Asare-Doku et al., 2017; Fleischmann et al., 2016). Other studies have attempted to compare what survivors think were the causes of the attempt to what their families thought (Asare-Doku et al., 2019). However, there is a dearth of studies in Africa exploring experiences of family members following a suicide attempt, with only one study published in Ghana by Asare-Doku et al., (2019) which does not fully explore the support structures of these families following an attempt. Studies addressing this subject are lacking in East Africa and particularly in Kenya.

When an individual attempts suicide, those closest to them are most affected, which is usually the family and those living with and caring for the individual. The family constitutes the smallest and basic unit of a society. Thus, the wellness of a family contributes to the general wellbeing of a society. However, the experiences and needs of this greatly affected group is not fully understood in the Kenyan context. Ignoring the experiences and needs of this population will weaken what is considered a crucial support structure to individuals attempting suicide hence hampering efforts towards suicide reduction. Hence is it imperative to address the needs of these households to ensure a healthy family and eventually a healthy society. In effect, reduction of suicide rates will not only meet the global targets of suicide reduction but also preserve the

country's population and income, as suicide rates are highest among the younger population.

1.3 Justification of the Study

Insufficient data on suicide and suicide attempts in LMIC have made development of prevention strategies a difficult task (Fleischmann et al., 2016). With the high suicide rates in LMIC and in Kenya, all effort needs to be focused on what can be done to reduce these rates.

Family support, a great factor in suicide prevention can only be realized if the family is healthy and capable of providing this support. Understanding the experiences of families following a suicide attempt and exploring what support structures they have and what they desire is crucial as it provides a basis of specific interventions to these families. In effect, this will ensure a strong and healthy support system for individuals who attempt suicide and ensure they can effectively play their role in suicide prevention.

Although studies exploring experiences of families following a suicide attempt have been done in other parts of the world, mostly in the western countries, regional, cultural diversity and resource availability may play a big role in how a similar event is perceived and experienced in the LMIC and will inadvertently influence the support structures available. Although the Kenya Mental Health Policy and the Kenya Suicide Prevention Strategy acknowledges the need to support families experiencing suicide attempts(Ministry of Health, 2015, 2022), they do not clearly acknowledge the effects of suicide attempts and specific and exhaustive ways in which they ought to be supported, perhaps owing to lack of local research on the subject. In view of all these factors, it is of vital importance to explore this subject in a Kenyan context.

A phenomenological study design was be used to explore this subject. This study design is best suited for the study as it seeks to explain the 'lived' experiences of individuals from their own perspectives as they undergo a particular phenomenon (Renjith et al., 2021). According to Renjith et al (2021) data is collected from participants who have in common an experience of a particular phenomenon mainly through interviews. In this case, individuals who have a shared experience of a suicide attempt within their households was considered.

1.4 Purpose of the Study

This study's aim was to understand the experiences of household members following a suicide attempt presenting at AIC Litein Hospital and to explore their existing and desired support structures.

1.5 Study Objectives

i. To understand the experiences of household members of suicide attempt survivors presenting at AIC Litein Hospital.
ii. To explore existing support structures of household members of suicide attempt survivors presenting at AIC Litein Hospital.
iii. To explore the desired support structures of household members of suicide attempt survivors presenting at AIC Litein Hospital.

1.6 Research Questions

i. What are the experiences of household members of a suicide attempt survivor presenting at AIC Litein Hospital?
ii. What are the existing support structures of household members of a suicide attempt survivor presenting at AIC Litein Hospital?

iii. What are the desired support structures of household members of a suicide attempt survivor presenting at AIC Litein Hospital?

1.7 Significance of the Study

Understanding experiences and the support structures of household members of individuals who attempt suicide is paramount in providing holistic care by involving the family and treating the family as a unit. Information gathered will be important to healthcare providers within AIC Litein Hospital as it will bring to light the experiences of the household members at the healthcare level and their subsequent follow up. It will also demystify what kind of support they would require from health care providers in a rural Kenyan context. This information will not only help improve the Mental Health Unit at the hospital of study which serves a vast region within the County but also that of other health facilities within the county through dissemination of information gathered.

At the community level, the results of this study shall be beneficial in enhancing community support towards households affected by suicide attempts by identifying exact ways in which these families wish to be supported. Community leaders including the clergy will use this information to strategize on ways to support affected households.

Policy makers at the county and national level also stand to benefit from this study. To date, this subject has not been explored in Kenya. Findings related to how larger societal factors including policies, resources and access to care influence experiences and supports structures of those affected shall be of benefit in the improvement of these structures at the county and national level and will give evidence to guide policies that will aid in both support of affected families and in general, suicide prevention strategies.

1.8 Limitations of the Study

Following the possible stigma around the subject of suicide, some participants were apprehensive about sharing their experience. To mitigate this, confidentiality was assured, and privacy maintained during the interviews. Participants were also given liberty to withdraw from the study at any point.

Secondly, language barrier was a limitation, this was identified and mitigated during pilot testing of the tool and mitigated by translating the interview guide to Kipsigis and further by having a research assistant well versed in English, Kiswahili and Kipsigis.

Third, being qualitative in nature, the study had a risk of researcher bias. To mitigate this, the researcher ensured validity and reliability of findings through personal reflexivity, and a second independent reviewer reviewed the generated codes and themes. Additionally, the data collection tool was pilot tested to ensure the questions were clear and appropriate.

Lastly, this study was done in one healthcare facility which is a faith-based organization. As such, some of the findings may limit applicability in a different setting, however, to improve this the sampling method used ensured participants were from diverse sociodemographic backgrounds.

CHAPTER TWO

LITERATURE REVIEW

Suicide and suicide attempts have a huge negative impact on those close to the suicidal individual. Studies around the world have explored the experiences of family members, some following self-harm whether with intention to die or not, while others more particularly following an actual suicide attempt. This chapter offers a review of literature on this subject and highlights the gaps in literature in the African and more specifically Kenyan setting.

2.1 Experiences Following a Suicide Attempt

2.1.1 Psychological and Physical Experiences

A meta-ethnographic study by Juel et al. (2021) which synthesized findings from different parts of the world found that families who experienced a suicide attempt had a complete change of their lives from normalcy after the attempt. These families described feeling helpless, hopeless and even responsible for the suicide attempt of their loved ones and this was made worse by implied accusations from health professionals especially on parents for failing to protect their children from harming themselves.

In a qualitative study done in Ghana amongst family members of individuals who attempted suicide, Asare-Doku et al. (2017) reports that victims were viewed as a source of grief, a burden and source of social injury to the family. Being highly shunned as a social taboo, suicide attempt was associated with shame to the family. As a result, family members kept secret the details of the event of a suicide attempt and did not share beyond their nuclear family which led to social isolation (Asare-Doku et al., 2017). Similarly in another study among relatives of suicidal individuals done in Northern Ireland, due to stigma, whether imagined or real, carers felt the need to keep

the incident private, some out of shame while others having been compelled to do so by their relative who had attempted suicide(McLaughlin et al., 2014).

Suicide attempts are often met with great shock from family members (Asare-Doku et al., 2017; Krysinska et al., 2020; Spillane et al., 2020). Asare-Doku et al. (2017) describes that the disbelief experienced by the families was made worse by the notion that having provided to the victims all that they needed, they could not understand why they still wanted to die. In contrast, Buss et al.(2014) following a qualitative study done in Denmark, reported that most parents were not entirely shocked by the events as they viewed the attempt as a result of a long mental illness their children were facing. However, several participants interviewed by Buss et al. (2014) had experienced their children harming themselves, issuing suicide threats and facing other mental health challenges prior to the suicide attempt and this could explain why they were not entirely shocked. It is not clear whether participants who experienced great shock in the other studies had gone through similar experiences in the past.

Fear and anxiety have been described as predominant emotional experiences following suicide attempts. Parents of children who had attempted suicide have expressed fearing a repeat attempt which would be more fatal, causing them to be on constant alert and worried about their safety (Buus et al., 2014; Ferrey et al., 2016; Krysinska et al., 2020).

In addition to the emotional effects of a suicide attempt, physical symptoms including palpitations, nausea and vomiting, chest pains, panic attacks and physical fatigue have been reported, while others have reported getting diagnosed with diseases such as hypertension around the same time the incident occurred (Ferrey et al., 2016; Spillane et al., 2020).

2.1.2 Social Experiences and Stigma

Suicide and suicide attempt, even without the accompanying stigma, affects the social functioning of affected families. In his study among parents of children who had attempted suicide in Denmark, Buss et al.(2014) reports that parents struggled to learn how to discipline their children following the event and the relationships between the parents and children were greatly strained by these events. Not only did these events lead to a strain between the caregivers and the suicidal individuals, but they also caused strain between parents due to the high levels of stress, and threatened the stability of their marriages(Buus et al., 2014; Ferrey et al., 2016).

Parents have also reported a strain in their relationship with the other children owing to difficulty in balancing the attention and care needed for the other children (Buus et al., 2014; Ferrey et al., 2016).However another study reported that caregivers worked together to support the survivor of the attempt and overall they were united (Nygaard et al., 2019). In the rural Kenyan setting, the family may consist of more members than the nuclear family members, with a greater number of children compared to the developed countries. The effect on the social functioning of the family unit following a suicide attempt in this setting is not clear.

McLaughlin et al. (2014) reports that young caregivers whose parents had attempted suicide had difficulty relating to peers and were afraid to have them find out about their parents' suicide attempts. Engagement in leisure activities was curtailed, children had to be taken to foster homes, and their education and school performance negatively affected. Siblings had to take up the role of protecting their siblings after a suicide attempt and to shield them from public shame (Ferrey et al., 2016).

Stigma around mental health issues and particularly suicide still exist all both in the developed and developing countries. A qualitative study done in Britain among people bereaved by suicide showed greater levels of stigma compared to those bereaved by natural causes. Participants in this study expressed isolation and a sense of social uneasiness, coupled with comments from the public that implied they were to blame for the suicide, making them feel stigmatized (Pitman et al., 2018). Similarly in Italy, increased levels of stigma were experienced by suicide survivors and had a positive association with increased levels of distress among these individuals (Scocco et al., 2017). Social stigma was similarly reported in a study done in India among family members of survivors of a suicide attempt (Vivekanandhan et al., 2024). In Ghana, different levels of stigma were described among patients and carers of people with mental disorders including social , economic and psychological with 72% being social stigma (Tawiah et al., 2015).

Similarly in Kenya, there is still stigma surrounding the subject of suicide. While there are no published studies done among families of those who have attempted suicide in Kenya, Ongeri et al. (2022) in an exploratory study among community members on their perspectives of suicide in Coastal Kenya revealed this continuing stigma. This community perceived those who attempted suicide as weak, deserving punishment, and such punishment should include their family members to serve as a warning against further attempts. Additionally, they believed that those who died by suicide did not deserve to be buried decently and thus would be buried at night and away from those who died naturally. However, this aspect of stigma has not been fully explored in Kenya from the perspective of individuals caring for those who have attempted suicide. Exploring stigma from the perspectives of those directly affected may perhaps reveal bigger issues and gaps that need to be addressed.

2.2 Support Structures

Families have expressed a desire for support in different ways including social support, practical support, informational support, psychological support among others forms of support following a suicide attempt of a loved one (Krysinska et al., 2020; McLaughlin et al., 2016; Spillane et al., 2020).

2.2.1 Social Support

Suicide and suicidal behaviour are a serious mental health problem and often associated with other severe mental health disorders. Studies on families that have experienced suicide attempt have not fully explored the aspect of social support. However, with its close relationship with severe mental disorders, this can also be deduced from studies that explore social support for caregivers of those with severe mental disorders.

A mixed study done in Iran among relatives of mentally ill patients demonstrated a great need for social support in various ways. A need for emotional support and positive social interactions without social stigma were among the key needs highlighted. Moreover, the emotional toll that comes with an unpredictable future and financial strain called for a desire for financial and practical support in this regard, and a need for social security (Amini et al., 2023).

A quantitative study by Chang et al. (2016) done in Singapore found that caregivers between the age group 35-49 years were more affected by interruptions in their schedules possibly due to greater responsibility among this age group. The more distressed carers felt, the more their health and schedules were negatively impacted. Poor family support was likewise associated with greater distress (Chang et al., 2016).

While some studies report good support from friends and other family members after a suicide attempt (Buus et al., 2014; Krysinska et al., 2020), others report receiving

unsatisfactory support and judgement from family and friends (Spillane et al., 2020). In a study done in Ireland, social workers, counsellors and other support services were reported to offer good support to these families with the police ensuring that the suicidal individual got to hospital and received care and this was of great help to the family (Spillane et al., 2020). Studies in Africa and particularly in Kenya have not explored such support structures as family and friends, counsellors, social workers or police services for families affected by suicide attempts.

2.2.2 Involvement in Care and Professional Support

Those closest to individuals who attempt suicide, mostly family, are the ones who bring them to hospital following an attempt. They will often be the ones taking care of them at the hospital, taking them home following discharge and ensuring their safety and possibly ensuring they are followed up. McLaughlin et al. (2016) in his qualitative study in Northern Ireland reports that relatives of these patients craved involvement in their care but instead felt excluded. He reports that, citing confidentiality, some health care professionals (HCP)refused to divulge any information to the relatives causing them to feel inadequate and at a loss as they were the same people expected to care for and protect them at home. The relatives acknowledged the devastating effects that caring for their suicidal loved ones had on their mental health and needed an outlet, someone to turn to, however they mostly felt ignored at the hospital (McLaughlin et al., 2016).

Further, McLaughlin et al. (2016) explains that fragmented healthcare made it more difficult for the relatives and a better organization would have been appreciated. Similarly, in a qualitative study done in Australia, caregivers expressed desire to be included in discharge plans and a need for acknowledgement of their crucial role by HCPs and yet felt that their emotional and practical preparedness for discharge was

scarcely considered (Wayland et al., 2021). McLaughlin et al. (2016) reported that in as much as these relatives felt that the HCPs were not resourceful to family, they were helpful to the patients and the relatives appreciated that. In contrast, Spillane et al. (2020) found that the care towards the suicidal individuals at the hospital was poor and those who attempted suicide were viewed as "another suicide attempt". Follow up for both the patient and their family members was deemed unsatisfactory and families had no one explaining to them what had happened (Spillane et al., 2020).

In Kenya, the level of involvement of the family by healthcare workers in the care of their loved one after a suicide attempt has not been studied. With few mental health professionals across the country, it is unclear whether these families feel supported by HCPs or what kind of support they would desire from them.

2.2.3 Informational Support

Parents of children who attempted suicide expressed a great desire to support their children but felt inadequately equipped and lacked knowledge on how to best do so (Buus et al., 2014; Spillane et al., 2020).Two studies done in Australia highlighted the need for access to information which would not only help them recover and know what to do in the face of the crisis, but also help them know how best to engage and communicate with their loved ones and help challenge stigma (Krysinska et al., 2020; McGill et al., 2019). A review of ten studies, all from Western countries, showed that careers valued information that would help them ensure safety of their loved ones following an attempt including educational programs and resources. (Branjerdporn et al., 2023).

A preference for online sources, crisis lines, public discourse and information from professionals has been reported with less preference for information from people with

similar experiences of a suicide attempt (French et al., 2023). This need has not been well studied in Africa. With lower literacy levels and less access to the internet especially in the rural areas of Kenya, delivery of the informational needs for this population may be different.

2.2.4 Spiritual Support

Spiritual support and needs have not been fully explored in the context of suicide attempt, however, can be deduced from studies that have explored spiritual needs of caregivers of mentally ill patients.

Casaleiro et al. (2022) in his systematic review of 26 studies from all over the world explores spiritual aspects of families of people with severe mental illness who are in the community, with only three of these studies done in Africa. This review brings to light as a spiritual need, the need for hope and a search for a greater meaning to life among caregivers of people with mental illness. He reports that caregivers have resorted to spiritual practices that have helped them cope including prayers, visiting traditional healers and temples, herbal medication and having increasing faith in God. In search of the meaning of life, caregivers have described their experiences as a test from God or as an experience meant to strengthen their faith (Casaleiro et al., 2022) .

Similarly in Sub-Saharan Africa, caregivers have resorted to prayers and other religious practices when faced with mentally ill relatives or suicide attempts within the family as a means to cope (Asare-Doku et al., 2017; Daliri et al., 2024; Verity et al., 2021). In Nigeria, mental illness has been viewed by caregivers as a spiritual attack and so the hospital was the last place to seek help, and their initial resort was spiritual help and traditional healers (Jack-Ide et al., 2013). The same has been described in Coastal Kenya, where traditional medicine is the first resort for suicidal individuals (Ongeri et

al., 2022). In Kenya however this has not been explored from the perspective of those living with and caring for the suicidal individual.

In Uganda, some Christian communities will punish suicidal behaviour by refusing to conduct burials for victims and banishment of survivors (Mugisha et al., 2013). Although Africa is highly religious, religion could equally act as a propagator of stigma around suicide, hence religious institutions may fail to offer support to families affected by suicide and suicide attempts. In contrast, churches have been a source of support in other stigma-related illnesses such as HIV/AIDS. A review of literature from Sub-Saharan Africa, highlighted the role of the church not only in HIV prevention strategies but also in providing support to people living with HIV and providing a safe environment for disclosure despite the associated stigma (Campbell et al., 2011).

From experience at the institution of study, survivors of a suicide attempt and their families get support from the chaplaincy at the hospital including prayers and encouragement, which has acted to instill hope to both the suicidal individuals and their families. However, it is not clear whether they receive the same from their religious groups in the community, where the religious leaders may not have the same understanding and attitudes concerning suicide as those working within a hospital setting.

2.3 Theoretical Framework

To understand the experiences of household members following a suicide attempt, and explore their existing and desired support structures, the family systems theory and the Social-Ecological Model (SEM) was used.

2.3.1 The Social-Ecological Model

Bronfebrenner (1977) developed the ecological theory to explain human development. He explained that a person's development, behaviour, and experiences were influenced by their immediate environment, which he termed the microsystem, by their relationships and interactions which he termed the mesosystem, then the larger environment in which these interactions occurred which he called the exosystem and finally the macrosystem which mainly constituted the society the individual lived in, their cultures and beliefs.

This theory has further grown into the Social-Ecological Model (SEM) which has been used to explain various phenomena and to formulate public health interventions. It has been used to explain the causes of violence including self-inflicted violence wherein suicidal behaviours are included (Krug et al., 2002). Health promotion studies have also used this model to explain the various factors influencing health and to formulate strategies aimed at promoting health at individual and community levels (Golden & Earp, 2012).

This study employed this model to understand this topic better as it provides a wider exploration of all the possible domains that could contribute to the experiences of a family member following such a life-changing event as a suicide attempt of a loved one and to explore all possible sources of support both present and desired for these families. The model entails four main domains which include individual factors, relationship factors, community, and societal factors.

Individual factors include age, gender, occupation, educational levels, knowledge, and perception of a phenomenon. The younger participants for instance may experience the event of a suicide attempt by a parent differently from an adult or an older individual

who must care for a spouse, an adolescent, or a sibling who has attempted suicide. Similarly, their support needs may also differ. Factors such as their education level, their knowledge and perception of suicide may influence their ability to seek out useful information and professional help when needed. Previous experiences of a suicidal attempt or a completed suicide in the family may also influence how one experiences the current event.

The immediate environment includes family bonds and dynamics, spousal relationships, and friends. These relationships will influence the family experience of the suicide attempt and form a source of support to affected families and by extension, the survivor of the suicide attempt as shown by various studies (Buus et al., 2014; Spillane et al., 2020).

The third domain in this model is the community, which includes the individual's workplace, school, neighbourhood, their places of worship and any other place in which their social interactions take place. In relation to the experience of a suicide attempt of a loved one, these communities may become a source of support or stigma. The attitudes and knowledge of the community pertaining suicide will influence their ability to be a source of support to the affected individuals. Health seeking behaviours of a community will also determine whether the household members will seek professional support when overwhelmed or not as shown by Jack-Ide et al. (2013) and Ongeri et al. (2022) who report the hospital being last place of resort for mentally ill patients.

Societal factors, the fourth domain in this model include the cultural norms, religious beliefs, resource availability, and educational, health and economic policies. Religious beliefs in African countries have been shown to have an influence on how suicide is viewed and dictates what should happen to individuals and their families after a suicidal attempt and their bodies if they die of suicide (Mugisha et al., 2013; Ongeri et al.,

2022). Low- and Middle-Income Countries(LMIC) have a shortage in mental health professionals required to take care of suicidal individuals and their families(Ministry of Health, 2015). This undoubtedly affects the support of affected families as care will likely be more focused on the suicidal individual. Having a healthcare system that facilitates involvement of relatives in the care of the suicidal individual has been expressed as a support need by affected individuals (McLaughlin et al 2016; Spillane et al, 2020) Laws that criminalize suicide have resulted in increased stigma associated with suicide and complicated the care of affected individuals and their families (Ochuku et al., 2022). Therefore, an exploration of the effect of these larger societal factors on the experiences of families affected by a suicide attempt is important.

2.3.2 Family Systems Theory

Family systems theory was first described by Bowen in the 1960s to explain the interactions of family members within the family unit. This theory explains that the family forms one emotional unit, where members are so profoundly connected such that the emotions, thoughts and actions of one member of the family greatly affects other members of the family (Bowen, 1966). According to this theory, when one member of the family experiences a change in functioning, other members of the family equally experience changes in their functioning. Bowen (1966) explains that periods of heightened stress in one individual of the family results in reciprocal stress in other family members. He further postulates that the family member who seems to absorb the stress and tension will be more prone to psychological problems including depression, anxiety, and even physical illness. Conversely, strong positive emotional interdependence can result in cohesion in the family (Bowen, 1966).

In relation to this study, this theory was used to understand how the family might be affected by a stressful situation such as a suicide attempt of a loved one. The family

being one emotional unit, will undergo emotional turmoil during such an event. Based on this theory, it can be postulated that if a family can successfully navigate this stressful event, it can emerge as a healthy emotional unit that is able to offer support to the suicidal individual ensuring restoration of the family unit and of the suicidal individual to normalcy. However, if this stressful event is not handled well, the effects of the event on the family members affects the suicidal individual who is part of this emotional unit even more, slowing down their healing process and may even result in a repeat attempt as they become prone to more depression, anxiety, and other psychological problems.

2.3.3 Integration of the SEM and Family Systems Theory

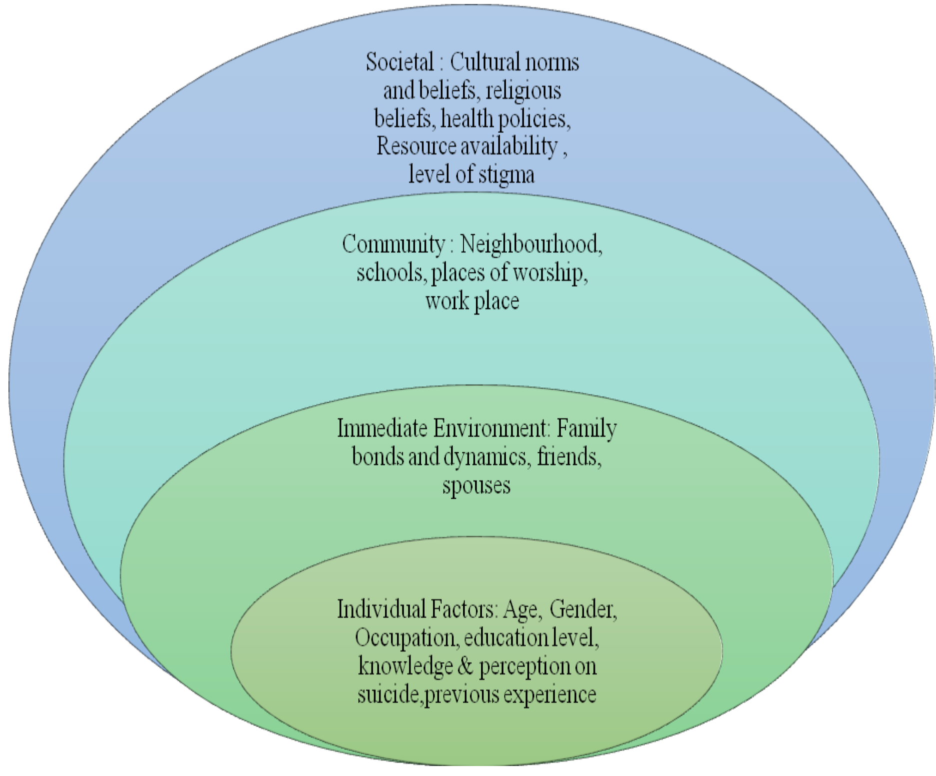
The family systems theory is partly captured in the social-ecological model under the social relationships, which is the second domain of the model. However, the inclusion of the Family Systems Theory in this study was important as it is aimed at providing a better understanding of how a suicide attempt within the family affects the entire family as members of one emotional unit and to explain further how these effects on the family may result in corresponding effects on the suicide attempt survivor which will affect their recovery process. The effect of the family experiences on the survivor’s recovery process may not be fully captured and explained without the inclusion of this theory.

The SEM on the other hand incorporates other factors that can potentially influence the affected families and provide support to them. These other factors are external to the family and not captured in the Family Systems Theory. It also highlighted the various need which may be addressed following the same domains as used in the model to create interventions that will promote the health and well-being of the families and by extension, that of the survivor of the suicide attempt.

Below is a diagrammatic representation of the integration of the SEM and the Family Systems theory (Bowen, 1966; Bronfenbrenner, 1977).

Figure 1

Integration of Socio-ecological Model and Family Systems Theory



CHAPTER THREE

METHODOLOGY

The study methodology is elaborated in this chapter under the following sub-sections: Research design, location and population of the study, sampling and sample size, inclusion and exclusion criteria, data collection tools and procedures, data management including reliability and validity and ethical considerations.

3.1 Research Design

The objectives of this study were to understand experiences of household members of suicide attempt survivors and to explore their existing and desired support systems from their own perspectives. To meet these objectives, a phenomenological study design was employed in this study. A phenomenological study design seeks to explain the lived experiences of individuals. It seeks to understand the individuals' experiences of a certain phenomenon, and to explain what and how the phenomenon was experienced (Renjith et al., 2021). Thus, using this design ensured a clear and rich understanding of this subject from the individual's own perspectives as opposed to the researcher's perspective.

3.2 Location of the Study

The location of the study was AIC Litein Hospital, in Bureti Sub- County, Kericho County. The hospital is a Level 5Hospital serving the local population and acts as a referral hospital to other sub-county hospitals within the county. Being a referral hospital with an intensive care unit the hospital receives referrals of critical suicide attempt cases needing intensive care. The facility recorded over 100 admissions due to suicide attempts in the past year, with suicide attempts being among the top ten causes of morbidity in the hospital. It has an established Mental Health Clinic (MHC) where

patients with mental health disorders including those who have attempted suicide are followed up. The MHC staff carry out home visits to families facing psychosocial issues that may affect the treatment process and offer clinical psychology services.

3.3 Population of the Study

The population of this study was household members of individuals who had attempted suicide and admitted at AIC Litein Hospital. According to the Kenya National Bureau of Statistics (KNBS) (2022), a household in Kenya refers to a group of people related by blood or not, living under one headship whether male or female and share common resources within the unit. The KNBS (2022) further acknowledges that in rural Kenya up to 26% of household in rural Kenya contain children whose heads of the households are not their biological parents. Cognizant of the fact that households in Kenya may not be limited to nuclear families or individuals directly related by blood, and that those assuming the role of headship may oversee children who are not biologically theirs; household members in this study included anyone who was living with and caring for the individual who attempted suicide at the time of the event.

3.3.1 Inclusion Criteria

The following criteria was used to determine was eligible for inclusion into the study:

i. Household members who were above 18 years of age.
ii. Household members who had been living with the suicidal individual at the time of the incident.
iii. Household members who continued to live with the suicidal individual following the event and/or participate in their care either at home or during the hospital admission and follow up visits.
iv. Household members who had experienced the incident within the past 2 years.

3.3.2 Exclusion Criteria

i. Household members who were unavailable for a physical interview.

ii. Household members who due to the traumatic experience were unable to undertake the interview. This was determined during the pre-interview phone call by emotional breakdown or verbal communication that they were emotionally not ready to discuss the events.

3.4 Sampling and Sample size

Participants were recruited using a purposive sampling technique using two approaches namely, typical case sampling and maximum variation sampling. Typical case sampling is a type of purposive sampling where the sample is selected with an aim to highlight what is typical or normal whereas maximum variation sampling aims to show what is similar across cases as participants are of a heterogenous nature(Palinkas et al., 2015). This study used these two approaches of purposive sampling as all participants had a shared phenomenon, that is, an experience of a suicide attempt within their household, thus making it typical case sampling. However, individuals recruited were of a heterogenous nature as they had different relations to the suicide attempt survivor in addition to having different socio-demographic characteristics including age, gender, and education level hence maximum variation sampling approach in this regard.

The sample size for this study was determined by the point of saturation. Guest et al (2006), describes data saturation point as the point at which there is no more new information collected from study participants while conducting in-depth interviews in a qualitative study. It has been estimated that about 12 interviews need to be conducted to reach this point (Guest et al., 2006). 16 interviews were conducted in this study. Data

saturation was achieved after 13 interviews and an additional three interviews conducted to ensure no new information arose.

3.5 Recruitment Procedure

Permission was sought from the hospital of study to access records of suicide attempt cases admitted to hospital within the past two years. Contacts of their next of kin were retrieved from their medical records and participants meeting the eligibility criteria sampled purposively. They were then contacted by phone, informed about the study and invited to take part in it. This was followed by an enquiry of where they would wish the interview to take place, whether at their homes or at the MHC. Upon acceptance a date for interview was set where a written consent was obtained. A maximum of two members per household with different relations to the survivor could be recruited for the study. This was done to ensure that different perspectives from members with different relations with the survivor were captured as their experiences and support needs may be different depending on their relationship and their role in the life of the survivor and that of the survivor in theirs.

There was no incentive provided to the study participants except for transport facilitation for those who had the interview done at the mental health clinic as opposed to their homes.

3.6 Data Collection

3.6.1 Data Collection Tools

Data was collected using a semi-structured interview guide. Demographic data was included in the interview guide to understand the characteristics of the participants recruited for the study. Open ended questions asked included the details of the suicide attempt, the immediate and subsequent experiences following the incident, the

experience of care at the hospital, an exploration of the existing support structures and what the participants would desire.

The interview guide was adopted from two studies by Asare-Doku et al. (2017) and McLaughlin et al. (2014) with additional questions formulated by the researcher to ensure a rich understanding of the subject. Questions that did not directly relate to or answer the researcher's objectives from the two guides mentioned above were omitted and some questions modified. The interview guides were initially in English and Kiswahili.

The data collection tool was pilot tested at Kapkatet County Hospital in Kericho County. Participants for the pilot test were recruited from admissions following suicide attempt, with the patients' next of kin contacted and invited to participate in the pilot test after seeking permission from the hospital administration to access records. After conducting five interviews the researcher realised a need to interpret the tool to Kipsigis as some participants were not conversant with English or Kiswahili. This was done by a translator who was well versed with the three languages. Questions in the interview guide were clear and answered the research question, thus, they were left unchanged. Details of the interview guide in English, Kiswahili and Kipsigis are found in Appendix I.

3.6.2 Data Collection Procedure

A research assistant was recruited to assist with the process of data collection. The assistant was well versed in English, Kiswahili and Kipsigis. Both the principal researcher and the research assistant were involved in the data collection process. The research assistant was well trained on data collection and on how to conduct the in-depth interview, with the process of conducting the interview supervised during the

pilot test to ensure full understanding. Recruitment of participants who met the inclusion criteria was done as previously described. After contacting eligible participants, the date, time and venue of the interview was set. Four interviews were conducted at participants' homes and 12 interviews conducted at the MHC in an enclosed room with privacy and minimal distraction.

Upon arrival at the interview venue, the participants who could read were handed the consent form to read, while those unable to read had the form read to them. They were given opportunity to ask questions for clarity after which an informed consent was obtained either by signing or by fingerprint for participants who are not able to write (See Appendix I). Consent to use an audio recorder was requested and then audio recorder switched on. To ensure confidentiality, there was no mention of names on both the consent forms and the audio recordings.

3.6.3 Validity and Reliability

To ensure reliability, the principal researcher practiced personal reflexivity. This type of reflexivity allowed the researcher to journal their personal beliefs, values, life philosophies thoughts and reflections concerning topic in questionenable them to be aware of and avoid personal bias during the research process. Additionally, regular reflexive discussions were carried out between the principal researcher, research assistant and the supervisors. Conducting a pilot test of the data collection tool ensured the tool was accurate and sufficient. Lastly, a second independent researcher reviewed the transcripts, codes and generated themes to mitigate researcher bias.

3.7 Data Analysis

Data was analysed by thematic analysis as described by Braun and Clarke (2006) using an inductive approach. This process of analysis involved six steps which included

familiarization with the collected data, coding of data, discerning themes, evaluating the discerned themes, determining the actual themes, and finally interpreting the findings. Familiarization with collected data entailed transcription of the data verbatim from the audio recorder. Manual transcription was done followed by translation from Kipsigis and Kiswahili to English for ease of analysis.

Dedoose data analysis software was used to facilitate organization of the data. Transcripts were uploaded to the software for the process of open coding. Following reading and re-reading of the transcribed data the researcher highlighted key areas and repeated words and phrases that seemed to have a similar pattern and generated codes for them. Following coding of data, the codes were organized to discern any arising possible themes. These were further be analysed and overall themes and subthemes were generated.

Evaluation of the themes developed was done then reviewed and refined. Data was then re-read to determine validity of the generated themes and to find any additional missed out codes. An independent researcher conducted an independent analysis of the data and further reviewed the codes and themes generated by the principal researcher to ensure validity and reduce researcher bias. A comprehensive analysis of the themes was then formulated including finding stories for each theme and showing how the theme fits into the main topic.

The final stage of the process entailed interpretation of the findings, discussing the findings considering the study objectives, existing literature and the theoretical framework employed in this study.

3.9 Data Storage

The consent forms and transcriptions were stored in a lockable cabinet with only the principal investigator having access to the cabinet. Audio recordings were transferred to an encrypted storage with a password only known to the principal investigator. After the analysis process voice distortion was applied to the audio recordings for anonymity. The data will be destroyed after at least ten years of being archived.

3.10 Ethical Consideration

The study was guided by important ethical principles including autonomy, respect, truthfulness, and beneficence. Thus, informed consent was obtained before carrying out any data collection and no participants were coerced. The participants were given liberty to withdraw from the research at any point of the study. The principal researcher and research assistant ensured utmost confidentiality. There was no mention of names of participants both on the audio recordings, the consent forms, the transcribed data, or the final document. Participants were de-identified, and transcripts labelled by codes.

Additionally, voice alteration applied to the audio recordings further concealed participants' identities and ensured anonymity. Because of the sensitive nature of this topic and possible ongoing stigma, participant's wishes as to where to conduct the study, whether at their homes or the hospital was respected, and privacy guaranteed. The study shall ensure beneficence by using the findings to better guide interventions towards this population. Moreover, participants who during the interviews were deemed to be needing further or immediate psychological interventions were linked to the hospital's Mental health clinic for appropriate services. Participants whose loved ones were lost to follow up were assisted to re-establish follow up with the MHC.

Ethical approval was obtained from Tenwek Hospital Institutional Ethics Review Committee, National Commission of Science Technology and Innovation (NACOSTI) permit obtained and set guidelines were strictly adhered to (See Appendix IV).

CHAPTER FOUR

RESULTS, DATA ANALYSIS AND PRESENTATION

This chapter includes details of the data analysis including socio-demographic data and themes generated according to the research objectives which were:

i. To understand the experiences of household members of suicide attempt survivors presenting to AIC Litein Hospital
ii. To explore existing support structures of household members of suicide attempt survivors presenting at AIC Litein Hospital
iii. To explore the desired support structures of household members of suicide attempt survivors presenting at AIC Litein Hospital

4.1 Socio-Demographic Data

This study had a total of 16 participants who fully participated in the study to completion, with 56% being male and 44% females. The 16 participants were from 11 households with 5 households having two members interviewed in each and the remaining 6 households had one member per household interviewed. Two interviews were carried out in Kipsigis, two in English and 12 in Kiswahili. Four interviews were carried at participants' homes while 12 were carried out at the hospital at the MHC in a private room. The longest interview took 58 minutes while the shortest interview took 30 minutes with an average duration of 32 minutes. Below is a table outlining the socio-demographic characteristics of the participants.

Table 1

Socio-demographic Characteristics of Study Participants

Variable	Frequency
Sex	
Male	9 (56%)
Female	7 (44%)
Age	
20-30	6 (37.5%)
31-40	2 (12.5%)
41-50	1 (6.3%)
51-60	5 (31.2%)
>60	2 (12.5%)
Relationship with survivor	
Sibling	5 (31%)
Mother	5 (31%)
Father	1 (6%)
Spouse	1 (6%)
Uncle	2 (13%)
Cousin	2 (13%)
Marital status	
Married	9 (56.2%)
Single	5 (31.3%)
Widowed	2 (12.5%)
Education level	
No formal education	2 (12.5%)
Primary school	3 (19%)
High school	5 (31%)
College	6 (37.5%)

The suicide attempt survivors whose household members were interviewed were aged between 19 years to 40 years of age with 9 being male and two female. The regency of the suicide attempt ranged from five months to 18 months from the time of the

interview. Three survivors had only attempted suicide once, two had attempted twice, two had attempted thrice and four had attempted suicide more than three times.

4.1.2 Experiences of Household Members

Four themes were generated under the experiences of household members following a suicide attempt with several sub-themes under some of the themes as outlined on the table below.

Table 2

Thematic Representation of Experiences of Household Members

Theme	Sub-Themes
Narrative sense Making	Life stressors
	Cultural beliefs
Emotional and psychological Responses	
Social dynamics	Relationship changes
	Social isolation and stigma
Physical and practical impact	Physical harm
	Additional responsibilities
	Effect on productivity

4.1.3 Narrative Sense-Making

This theme entailed the narrations given by the participants in a bid to make sense of the suicide attempt. Two sub-themes emerged from this theme including life stressors faced by the individuals who had attempted suicide and cultural beliefs held about the attempt as presented below.

Life Stressors. Participants attributed the suicide attempt to different life stressors that the survivors faced. While the majority expressed financial and relational issues as triggers, a few related the suicide attempt to mental health illnesses that survivors were

battling, and others drug and substance abuse. Financial issues ranged from being unable to cater for the family needs even when employed to the stress of unemployment as expressed by a participant:

> "*Whatever he raised was the issues of economic difficulties, so there's the issue of the economic crisis. My brother has a young family. But he's struggling with the current economic crisis" (Participant 3, Brother, 30 years).*

Relationship issues were mostly within the household, between spouses for some and for others between parents and their children. In addition, some participants attributed the attempt to alcohol and substance abuse by the survivors as expressed by the following participant:

> *"… but in my opinion, I think he is using alcohol and bhang and that is what is contributing to this suicide attempt." (Participant 6, Father, 75 years)*

In this particular case the son to participant 6 had significant issues with the father and would resort to excessive alcohol consumption. In a previous attempt he mixed alcohol with poison while in the most recent attempt, he was grieving his mother who had recently died.

Cultural Beliefs. Despite attributing the attempt to the stressors mentioned above, some participants attempted to make sense of the incidents using cultural beliefs, with many expressing beliefs in curses and family sins as possible causes, especially in households that had similar experiences in other household members and in cases of repeated attempts. Most of these households held interventions to atone for the perceived sins to lift what they perceived was a curse as expressed by the following participant:

> *"When we sat down together with our clan members, they thought that the root of all this is an incident which occurred with our great*

grandparents, there was a story that our great grandfather stole some a sack in a tea buying centre which was belonging to someone else, and that person later on committed suicide by taking poison ....they have made plans that they are going to approach that family to ask for forgiveness and they can give something as a form of compensation for that." (Participant 13, Brother, 25 years).

4.1.4 Emotional and Psychological responses

Household members reported experiencing a range of negative emotions and psychological responses following these incidences ranging from shock immediately following the incident, emotional pain, sadness, guilt, shame, fear, and anxiety. Others reported having confusion, disturbed and excessive thoughts.

A response of shock was mostly experienced immediately after discovering the attempt as expressed by a mother to a survivor who brought her son to hospital following a suicide attempt:

"*I got to casualty and then thought, and then looked around and thought the doctors are few. I don't know if it was my eyes. Maybe it was my eyes because I was very shocked. And then a little bit I saw ohh, the doctors are actually there. I was very, very shocked at that time." (Participant 4, Mother, 53 years)*

Emotional pain and grief were ongoing responses for most participants not only immediately after the attempt but also many months after the incidents. An example was a mother, whose daughter had had a tumultuous mental health journey coupled with many family difficulties including a mentally ill husband and previously lost two other children to physical illnesses. This participant described her experience as follows:

"It is so painful when your child wants to kill, wants to kill herself, it is so, so much painful. It hurts and it has been hurting for a long time. It deeply hurts." (Participant 2, Mother, 58 years)

Another participant whose husband had attempted suicide several times expressed a similar response:

"It feels very bad for my heart to hear that my husband has attempted suicide three times. It really hurts because since that time we have never had peace. But before then, we were living very well, so these suicide attempts have caused me a lot of pain." (Participant 11, Wife, 29 years)

Some participants reported feelings of guilt for not being present to help their loved ones immediately after the incident. This was for instance captured by the brother to a survivor who had left home for a family activity when the incident happened:

"It was very disturbing, you know, the feeling that now that I was away, my elder brother was away, the only person who could have rescued him was my only younger brother, so I could not imagine just one person rescuing him. You feel that? That discouraged me. You see, you left only one person at home now that situation has occurred. We feel like if there was no one, the situation could have worsened. We could have lost him." (Participant 3, Brother, 30 years)

In addition to fear, participants reported being anxious and in constant alert and or expecting bad news from people concerning their loved ones. This was mostly seen amongst household members whose loved ones had attempted suicide several times. Some had mental health illnesses that caused them to expose themselves to significant high-risk behaviours, in addition to suicide attempt which made it even harder for their caregivers. Such was the case with a mother to one survivor who expressed always expecting the worst from each phone call from home:

".... even me as a mother, I am always in constant fear because even as I'm here if anyone calls me from home, I'm always afraid that I'm going to be

told that he has done something bad. I am in constant fear. I don't have peace anywhere I go." (Participant 14, Mother, 49 years)

Another mother expressed a similar response following repeated attempts by her daughter.

"It's hard so much because I have lost two other children who are older than her. They became sick and died, and I'm so afraid that I'm going to lose another child by suicide." (Participant 2, Mother, 58 years)

Participants expressed ongoing psychological effects including experiencing high levels of stress for some due to additional burden of care and for others due to uncertainty concerning future attempts. A participant whose nephew was a survivor, abandoned by his parents to be cared for by the uncle expressed this:

"*...as I have told you, I also have my children in school, so sometimes it hurts me that sometimes he needs something, and I am not able to provide. So that really disturbs my heart." (Participant 8, uncle, 52 years).*

In expressing his stress and uncertainty about future attempts another participant whose brother had attempted suicide multiple times said:

"*...but if he decides another alternative like getting into a well then, we would not be able to save him. So that is what is really stressing me because suppose he decides to find another alternative of attempting suicide..." (Participant 5, Brother, 24 years).*

Participants expressed experiencing confusion, associated with memory loss for some and having excessive and disturbed thought interfering with their daily activities. For instance, a wife to a survivor expressed this:

"I am very confused. I keep forgetting things. I can make tea without putting sugar. I can go somewhere and leave my phone. I am seeing that my memory is very poor, and I am confused of late. I think I am confused because I have a lot of stress. I have been thinking a lot." (Participant 11, Wife, 29 years).

Emotional indifference was a unique response from one participant. This participant, a father to the attempt survivor had a disagreement with his son before the attempt and expressed that he had lived long and seen much in life and so was not affected by the incident:

> "*I was not very much affected...I do not see anything strange about someone dying" (Participant 6, Father, 75 years).*

Although this response was not experienced by other participants, some reported experiencing emotional indifference from other household members in all cases, fathers to the attempt survivors who in response to the attempt withdrew care from the affected individual and isolated them. An example was an experience narrated by a sister to a survivor concerning their father's response to the incidents:

> *"...dad tells Mum that my sister will never get well until she dies. So even when mum wants to go after my sister, when she has run away, wanting to commit suicide, my dad usually tells my mom, "Stop following her. She's not going to ever be well until she commits suicide."" (Participant 9, Sister, 20 years).*

4.1.5 Social Dynamics

This theme encompasses the relationship changes experienced in affected households following the attempt, both within the family and externally; and the reactions the community members had towards the incidence. It also includes the effects on the social lives of the affected households.

Relationship Changes. Households were affected by the incidents in diverse ways. Some experienced strengthening of their family bonds, uniting to help the survivor and offered support to each other, as expressed by a participant, whose family had to unite to help their brother and support his wife and children:

> "*...it made us think of several other ways, like when this thing happened, we had to come together more to bring a different bond from the one that we had built before now having seen him as the head of the family, we expect that he runs his family and all that. But when a situation like this happens, OK, fine, now that he has faced this and these challenges, we have to come together and support him at that period." (Participant 3, Brother, 30 years)*

Others experienced weakened family bonds and strain that acted as a source of additional stress to the survivor and the rest of the household. For some, the family strain seemed to be a trigger for the event and continued even afterwards and for others, the disunity resulted from the incident. One participant, whose son had a serious mental illness coupled with multiple suicide attempt expressed how these incidents had separated her family:

> "(Name) *sickness has really affected all the relationships within the family. Because even the other brother (name),they don't enjoy staying at home, so (name) decided to move away from home. He's currently not at home." (Participant 14, Mother, 49 years).*

Social Isolation and Stigma. Some participants reported facing judgmental comments from community members. An example was a mother to a survivor who said:

> "*We have not gotten any support from the community. They just see us. Some of them think that it's a curse." (Participant 2, Mother, 58 years)*

Others, especially who had experienced either repeated attempts in the same individual or other attempts in the family, or had serious mental illnesses experienced similar comments and speculation that their families were cursed. Such comments not only caused social isolation but also propagated stigma towards these households. Another participant similarly narrated:

> *"...some of our friends and some of our villagers have ended up avoiding us. They say that if your sister is mentally ill like that, it means even you can be mentally ill like that." (Participant 9, Sister, 20 years)*

This family had experienced stigma from the home with negative comments from the father of the survivor and he would further prohibit anyone from visiting this family due to this incident making them even more isolated socially in addition to the negative comments made by some of the neighbors:

> *"Her father has blocked any support from our family and our neighbours...This man has blocked everyone from coming to our family, even when he sees that I have two or three friends that I talk to, he comes and chases them away..." (Participant 10, Mother 60 years)*

4.1.6 Physical And Practical Impact

This theme includes the physical impact sustained by household members while taking care of the attempt survivors and the practical impact including additional care and responsibilities, financial burden and effect on productivity.

Physical Harm. Some participants reported experiencing physical injuries while attempting to rescue their loved ones from attempting suicide. This was mostly narrated by participants whose loved ones had concomitant serious mental illnesses. For instance, a mother describes how her son who tried rescuing her daughter from harm sustained injuries:

> "*They went and they put her on a motorbike, but she jumped off the motorbike, sustaining a lot of bruises in her abdomen. In her body, she was really hurt. Even the brother, who was trying to rescue her came home while having bruises all over his legs." (Participant 2, Mother, 58 years).*

In an extreme case a brother died while trying to rescue his brother from drowning in a well:

"My first born, now [name] also followed them... so fast and after noticing that his brothers have jumped into the well, he also jumped in into the well. At this point, all my three sons are inside the well. And after going in, [first son's name] didn't know how to swim. When he went into the well, he shouted at (Second son's name), "have you gotten hold of him?" and those were the last words, [first son's name] mentioned while inside the well." (Participant 14, Mother, 49 years)

Additional Responsibilities. Other participants described the impact of having to provide additional care. They already had responsibilities of caring for their own families, themselves and other needs but following the attempt had to provide care for their affected loved one and their children. For instance, a participant explains:

"*This has really affected my life because I have a sister, my elder sister, is sick and I am taking care of her in my own house. We keep bringing her here to (name) for checkup. Apart from that, here is another person who is trying to commit suicide." (Participant 7, Uncle, 69 years)*

Caring for affected household members led to household members experiencing a financial burden with many expressing difficulties clearing hospital bills, attending clinic and buying medications they needed after the incident, in addition to financial costs of taking care of them and their dependents. The following are some of the responses as narrated by participants.

"When it was time for him to be discharged, we were given the hospital bill, and it was really hard. We did not have any money because also me, I have two of my children who were in high school." (Participant 8, Uncle, 52 years)

Effect on Productivity. Many participants expressed reduced productivity as some had to reduce their working hours to offer care during the hospital admission and afterwards. Participants whose loved ones had repeated attempts or other mental

illnesses expressed repeatedly having to leave work to protect their loved one as expressed by the participants below.

> *"… But whenever [name], wakes up and starts saying that she's going to commit suicide and starts running away from home, we have to leave all our work and try to follow her around to make sure that she is safe. So that has really affected the work that we do at home." (Participant 9, sister, 20 years)*

> *"…it has also affected my work because when he is at home I do not go to school because I have to take care of him. Like for now I have not gone to school to teach for about three days because he has been at home and unwell…" (Participant 11, wife, 29 years)*

> *"…it reached a point where I left my job because I thought, if (name) was not able to teach, even me I cannot be able to teach…" (Participant 14, Mother, 49 years)*

4.2 Existing Support Structures

Three themes arose under the support structures that existed for household members following a suicide attempt and these are outlined on the table below.

Table 3

Thematic Representation of Existing Support Structures

Themes	Sub-Themes
Healthcare provision	
Practical Support	Rescuing the survivor
	Financial support
	Transport to seek care
Spiritual and Moral Support	

4.2.1 Healthcare Provision

Most participants expressed receiving good support from the hospital through medical care and mental health services provided for their loved ones following the attempt.

Many expressed being attended to promptly and appreciated the healthcare providers for assisting the survivor of the suicide attempt:

> *"He was taken care of very well in hospital from the time of admission to the time that he was in the ward, the nurses and the doctors were acting promptly whenever he could complain, even of a headache…" (Participant 3, Brother, 30 years)*

They expressed receiving hospitality from the hospital staff and some expressed receiving good communication and involvement by the hospital staff. The majority appreciated the follow up provided for the survivor through clinic appointments, while a few received phone calls follow up and one participant had a home visit from the mental health team which he reported encouraged their family.

> *"His follow up was good. He was given appointments after every two weeks …The hospital is really helping him" (Participant 13, Brother, 25 years)*

Some participants were taught how to care for and handle the survivor which they found as helpful information. Additionally, they received encouragement and for some, counselling by the mental health team offered both to the survivor and the family, as expressed by the following participants:

> *"And the family members, we were also well taken care of in hospital. We were encouraged not to shout at (name), not to be very offended because of her illness. We were encouraged to take care of her." (Participant 1, Brother, 42 years)*
>
> *"The Tumaini (Mental health clinic) team used to visit and do counselling to her. She was talked to well until we were discharged and even me I had a chance of being talked to by the Tumaini team, who encouraged me that this illness, there's hope that she's going to be OK. I was also encouraged to take care of (name's) child...." (Participant 10, Mother, 60 years)*

"Also, there's a time we came for a couples therapy where both of us was given guiding and counselling." (Participant 11, Wife, 29 years)

4.2.2 Practical Support

Participants expressed receiving different forms of practical support including assistance with rescuing of the attempted survivor, financial support and transport to seek care. This kind of support was experienced from different people ranging from household members, other extended family members, friends and neighbours.

Rescuing the survivor. Participants had their friends help to rescue the survivors and in some cases neighbours. In some instances, the household members were not at the vicinity and so the rescue was entirely done by the neighbours, as in the case of this participant:

"... so, when I came back from church, I found out that she had been rescued by her neighbour after trying to kill herself by throwing herself into a borehole... and was taken and was locked up inside the house." (Participant 2, Mother, 58 years)

In other cases, the participants were at the vicinity at the time of attempt but were unable to rescue them alone and so received assistance from the community.

"...several of the friends came now some of them are the ones who rescued him. Because some of our family members were away..." (Participant 3, Brother, 30 years)

Financial Support. Many participants received financial support from other family members, friends and community aimed to help in clearing hospital bills and to have follow up appointments and medications following discharge. This was done through online and physical fundraising. For instance, a participant recounts how neighbours were determined to assist them financially despite being barred by the father of the survivor:

"Our neighbours tried to organise for a fundraiser, but the father blocked all this. He refused that no fundraiser will be done in his home. And our neighbours decided to do a fundraiser through WhatsApp. That's the only way they can help us." (Participant 10, Mother, 60 years)

" ...so we have really received financial support from friends…we were having a fundraiser in our village, his friends came and supported, we were able to raise. Good amount of money…" (Participant 8, Uncle, 52 years)

Transport to seek care. Participants expressed receiving support to seek care through provision of means of transport. This provision of transport came from friends, community members, and in one case, the police service department providing a government vehicle to help transport the survivor to hospital.

"The OCS (Officer Commanding Station) gave me a Land Rover. And so, we took her to mission." (Participant 2, Brother, 30 years)

In other cases, other family members assisted in taking the survivor of the suicide attempt to hospital:

"There's a time this boy had attempted suicide and the some of the extended family members...One of them has a car. He's the one who came for him and took him to hospital. I was very thankful because I wasn't even aware of anything, but they're the ones who did everything and brought him here and they helped him." (Participant 4, Mother, 53 years)

4.2.3 Spiritual and Moral Support

Religious leaders, in this study pastors, and church members were a great source of spiritual support. Many participants reported that they would be visited at the hospital by pastors and received prayers and encouragement from them. Church members also visited them at the hospital and at their homes and this support continued long after the

incident. A participant whose husband had attempted suicide and experienced mental health problems mentioned:

> *"We always walk this journey with our pastor who prays with us. Even tomorrow, they are planning to pay us a visit at home with the other church members to fellowship and pray with us." (Participant 11, wife, 29 years)*

Although some participants experienced social isolation from community members, many recounted receiving moral support from neighbours, friends and community through visits at the hospitals and homes and through encouragement and company.

> *"Our neighbours have kept on visiting us even until now. They keep encouraging us and encouraging (name) brother. That he should not give up…" (Participant 2, Mother, 58 years)*

4.3 Desired Support Structures

There were five themes that arose under support structures that household members desired following a suicide attempt with several sub-themes as summarized on the table below.

Table 4

Thematic Representation of Desired Support Structures

Themes	Sub-Themes
Mental Health and professional support	Continued care and follow up
	Counselling services
Need for information and education on Suicide	Lack of information
	Handling the survivor
	Dissemination of information
Community support	Financial and material support
	Support groups
Family cohesion	
Community leadership intervention	

4.3.1 Mental Health and Professional Support

In as much as many of the participants reported experiencing good care for the survivor, hospitality by the staff and follow up for the affected individual, they still reported a need for more mental health and professional support. Sub-themes that arose in this theme included the need for continued care and follow up for the survivor and need for counselling services.

Continued Care and Follow Up. Participant desired that their affected loved ones would continue receiving mental health care as their well-being would greatly impact the well-being of the household. This continued care included offering medical treatment, identifying the root cause of the attempt, encouraging them and treating other concomitant mental health illnesses. An example is a cousin to a survivor who was experiencing depression and attempted suicide and was still having suicidal thoughts:

> *"I'm still requesting you people to really talk to him if there's a way you can help him to stop these thoughts." (Participant 15, Cousin, 37 years);*

while a mother whose daughter was experiencing bipolar mood disorder and had attempted suicide expressed:

> *"Another form of support which already is being done at the hospital. But I wanted to continue to continue talking to (name). Continue talking to her, encouraging her so that her healing journey can continue." (Participant 2, Mother, 58 years)*

Rehabilitation of individuals with severe mental illnesses who attempted suicide was also desired as expressed by a mother whose son had a severe mental illness characterized by aggression in addition to suicide attempts:

> "*The other support, which can really benefit everyone, including the family members, is if there are any programmes that can help to contain these people or to rehabilitate them. Until they are normal people.... If*

there are any programmes like that, it can really help everyone, including family members, because as you can see, the sickness does not affect only them, it affects the entire family." (Participant 14, Mother, 49 years)

Counselling Services. Counselling services from the mental health team was a desired support. This ranged from individual counselling because of the effects the incident had had on the household members to counselling of the entire family of the affected individual. Participants acknowledged the mental effects of the attempts and desired psychological help through professional counselling:

"I would want counselling also because this thing has really stressed me. It's really affected me because he's my only brother. I would want to be counselled, but not by people at home because I am not ready to disclose all my secrets to them." (Participant 5, Brother, 24 years)

Family therapy was desired for households that experienced disunity because of the suicide attempts and participants felt that counselling the aggrieved household members would benefit the entire household as expressed by these participants:

"If my dad had a chance to come here, it would be good. ...He has a lot of anger. He needs to be talked to go slow on (name). So that when he does something, he should not talk to him angrily…. Getting guidance would not be bad for the family. Dad and Mum, they should come and be talked to. The two of them together. To help Dad to reduce his anger." (Participant 5, Brother, 24 years)

"I would really have loved that we would have been talked together when his father is present to be talked on how to live together in peace and harmony, how to tolerate each other in this world. So that we can prevent recurrence of the suicide attempt." (Participant 8, Uncle ,52 years)

4.3.2 Need for Information and Education on Suicide

Several sub-themes emerged under this theme including lack of information, need for education on immediate interventions, handling a survivor of a suicide attempt and dissemination of information.

L***ack of Information.*** There was a general lack of information regarding suicide during the hospital admission and afterwards as expressed by most of the participants, ranging from information about causes of suicide attempts, discussing progress of the survivor, to handling the individual and preventing recurrence. Participants reported that although they were asked the events surrounding the suicide attempt, they were not given much information. An example is as expressed by the following participants:

> *"...when I made a visit there was a doctor who came and asked me of the incidents what happened, but there was no information given about the issue." (Participant 11, wife, 29 years)*
>
> *"We were not told how to prevent her from killing herself." (Participant 1, Brother, 42 years)*

Some participants hence sought information from different sources including the internet, and their friends.

> *"What I have learned from this is how to identify when he is stressed... I have learnt by myself, sometimes through Google. Yeah. Also, this is what I have learned through my experience living with him." (Participant 11, Wife, 59 years)*
>
> *"The only information that we have learned, but it's from just around our neighbourhood, is about the first aid measures for someone who has attempted suicide or who has taken poisoned that he should not be given water to drink." (Participant 12, Mother, 59 years)*

Handling the Survivor. There was need for education on how to handle the survivor including, how to identify triggers and warning signs. In expressing what information

would be important to someone caring for an individual who attempted suicide, an uncle caring for a suicide attempt survivor mentioned:

> *"They also need to be taught on the signs, which someone who is, for example, sick or depressed show so that they can prevent that suicide..." (Participant 8, Uncle, 52 years)*

Education on immediate interventions following an attempt was also desired.

> *"I just want to ask you can help educate me on the first aid measures which can be done when someone has attempted suicide as we are wait to arrive to hospital." (Participant 13, Brother, 25 years)*

Information on the causes of suicide attempt, how to relate to someone who has attempted suicide, how to prevent a recurrence and how to assist an individual who has attempted suicide was desired, as demonstrated in the following responses:

> *"...what we would wish to know is number one, what is this illness and what causes it? And the number two is how do we handle somebody when he has such an issue? And number three, when it is beyond family, what can we do about it when the situation like for example (name's) situation, we feel like it's beyond us. What can be done next so that we can help (name)?" (Participant 2, Mother, 58 years)*
>
> *"I would love to be educated on how to live with someone with mental illness like (name) I would also love to be told on how to support and how to relate with them." (Participant 10, Mother, 60 years)*

Dissemination of Information. Modes of dissemination of information on suicide to affected households were suggested by the participants and included dissemination through community outreaches and home visits by the hospital staff:

> "*...Hospital can get a team which will make visits to the villages and the local community to educate them on suicide attempts*." *(Participant 12, Mother, 59 years).*

Participants also desired affected households to have information passed by mental health staff during the hospital admission or by invitation to hospital for education:

> *"For other families they can be invited to come to hospital and then they are given the information." (Participant 9, Sister, 20 years)*

Others suggested dissemination through religious leaders, community leaders and trained community laymen through mass education as demonstrated by the following participant:

> *"The people who can help in teaching all this is, for example, the elders of the church, the chief.... Commonly in our area, when we have a meeting, we usually use our local tea buying centre, so when we do such a meeting there is always at least one representative from the families in the village. So, if you give information through such meetings, you can be sure that it is going to reach at least each and every family in the village. (Participant 8, Uncle, 52 years)*

4.3.3Community Support

Two sub-themes emerged under this theme including: Financial and material support and support groups.

Financial and material support. Financial and material support was a greatly desired support need from different participants including need for financial support to cater for their daily needs due to increased responsibility and material support including donations such as food.

> *"If the community members do the fundraising, that would really help, or if someone just came up to help. To help me financially, you know, my salary is not enough. It's not enough for all these things." (Participant 1, Brother, 42 years)*

Others required financial support to cater for the healthcare needs of the affected individual as they required several visits to the clinics after discharge and medication which were expensive.

"...sometimes we don't even have money for transport to go to hospital or money to pay for NHIF (National Health Insurance Fund). So if you can get financial support, especially so that you can be able to pay for NHIF to cater for the medications, it can really help because at this point I am getting old. I no longer have energy to do casual labour for money. So, it's becoming harder for our family with time to even get money for any child, for food, for transport to hospital..." (Participant 14, Mother, 49 years)

Others desired that the cost of healthcare would be lowered by the government for affected households to enable them to get treatment.

"If there can be help, even from the government, for such families, that would be good...the son was telling me every time he's told, bring 3000 bring 4000 shillings. Now, such families can even be treated for free." (Participant 1, Brother, 42 years)

Support Groups. Participants desired that community members who had faced similar experiences would meet and encourage each other as they understood each other's experiences much better than others. These would offer both moral support and an opportunity to learn from each other as expressed by the following participant.

"...Someone whose family has gone through the same problem as (name). Now, if you meet such a person, perhaps they may educate you. Now such a person, we may help each other and educate each other." (Participant 1, Brother, 42 years)

4.3.4 Family Cohesion

Household members desired that the affected families would be united to offer help to the affected individual and to support each other. They acknowledged the devastating

effects that disunity in the household had on the affected individual and the other household members and how that would hinder recovery.

> "*... families who have someone who has attempted suicide ...apart from the spiritual support, they need people who can just give them assurance they need people who can help them to stay together." (Participant 3, Brother, 30 years)*

Those household members who had experienced disunity following an attempt desired help from other family members to unite the family,

> *"The support we wish from other family members is to help us talk to our dad. So that our dad can be someone who protects and cares for his family." (Participant 9, Sister, 20 years)*

4.3.5 Community Leadership Intervention

Some participants expressed having approached community leaders for help during the crisis but received no help. They desired assistance from community leaders such as chiefs and village elders in resolving conflicts that either led to an attempt or resulted from the attempt as expressed by a participant, whose nephew, a survivor of a suicide attempt had been disowned by the father:

> *"I wanted our chief to help us, especially for the issues between (name) and his father." (Participant 8, Uncle, 52 years)*

Others desired support help in addressing what they believed were the triggers of suicide attempt especially in the cases of alcohol and drug use:

> *"Maybe the professionals, the chief, the village elders can give us help through counselling because as you have seen, the problem is in this alcohol... we can work together as the doctors and also as local authorities to get rid of this alcohol and bang in our village." (Participant 6, Father, 75 years)*

Advocating for the needs of the affected households was also a desired support from the community leaders:

> *"The Chiefs and the village elders also have to play a role in prevention of suicide attempts. They can be keen on those families which have needs and they are not able to provide their needs for themselves and urge community members to help that family." (Participant 12, Mother, 59 years)*

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter entails a detailed discussion of the findings of the study results in line with the objectives including a recap of the limitations of this study, conclusion and recommendations for policy and for further research.

5.1 Discussion

This study aimed to understand experiences of household members of suicide attempt survivors and to explore their existing and desired support structures. Majority of the participants (56%) were male while 44% were female. Notably, there were five mothers in this study and only one father and two uncles who played the role of fathers to the survivors and others were siblings and a spouse and a cousin. It was noted that during recruitment, most next of kin contacts indicated in patient files were mothers and attempts to recruit fathers at participants homes was met with resistance. A number of participants expressed strained relationships between the fathers of the survivors and the survivors and perhaps this contributed to their unwillingness to participate. The two uncles who played the role of fathers in the lives of the survivors also did so because the survivors had strained relationships with their biological fathers. This finding is worth exploring more as it may reflect need to strengthen fatherhood in the rural Kenyan setting as strategy to reduce suicide attempts and re-attempts.

Several themes arose under the experiences of household members, and these included: narrative sense making, emotional and psychological responses, social dynamics and physical and practical impact. The existing support structures as explored in this study included: healthcare provision, practical support and spiritual and moral support, whereas desired support structures included mental health and professional support,

need for information and education on suicide, community support, family cohesion and community leadership intervention. This section contains a detailed discussion on these findings.

5.1.1 Experiences of Household Members

Household members in this study used cultural beliefs to explain the suicide attempts with the beliefs revolving around family and generational curses. Other studies done in Africa have elicited similar beliefs concerning suicide (Mugisha et al., 2013; Ongeri et al., 2022).These studies however were from the perspective of community members and not from the perspective of those directly affected as in this study. A study done in the Coastal region of Kenya among community members showed that that suicide was believed to be caused by generational curses or a family or individual breaking taboos in the community (Ongeri et al., 2022). These beliefs held by household members in this study and by community members not directly affected in other studies shows the deep-rooted culture in African countries and its role in making sense of phenomena, especially those that may not be easily understood.

Relationship difficulties, financial crises and mental illnesses were viewed as major causes for suicide attempts in this study. These are among the common causes of suicide attempts as identified in Sub-Saharan Africa (Akotia et al., 2019; Quarshie et al., 2020). All participants in this study had identified a possible cause of the attempt as shown by their narrations, which is in contrast with a study done in Ghana comparing reasons for suicide attempt between families and survivors of the attempt, where several families were totally unaware of possible causes of the attempt and missed the warning signs (Asare-Doku et al., 2019). Although not measured in this study, this may be due to differing levels of stigma in different contexts which may affect knowledge on suicide and identification of suicide warning signs.

Emotional and psychological responses experienced in this study, ranging from immediate response of shock, to emotional pain and grief, anxiety and hyper vigilance are similarly reported in several other studies (Asare-Doku et al., 2017; Krysinska et al., 2020; Vivekanandhan et al., 2024).

Viewing this in the lens of Bowen's Family Systems theory (Bowen, 1966), a suicide attempt by one family member caused immense emotional disturbances on other family members, as described by this theory which postulates that the family is one emotional unit. Additionally, in line with this theory, it was clear that those household members who seemed to be bearing much of the burden of caring for the affected individual, ensuring their psychological well-being and providing for them financially and practically experienced more psychological problems and elicited depressive-like symptoms.

The emotional responses seemed to be similar across individuals of different age groups, gender and relationship to the survivor. However, anxiety and hyper vigilance were more common in those who had experienced repeated attempts. Emotional indifference elicited by one participant but also experienced from other household members by participants in this study was a unique finding and may reflect a defense mechanism where following a traumatic event, an individual detaches themselves emotionally to avoid the negative emotions that may result(Bailey & Pico, 2024).

Relationships within the household were affected in different ways with some strengthened and some weakened. A study done in Denmark among parents following a suicide attempt reported that parents worked collaboratively to ensure the well being of the child following an attempt and while some had differences in their strategies of supporting the child, the overall spirit was cohesion (Nygaard et al., 2019). This was different from the current study where families that experienced disunity had

disagreements stemming from poor understanding of what their loved one was going through with many having pre-existing conflict that contributed to an attempt. The differences in this finding may reflect the impact of knowledge on suicide and the importance of a stable family unit as a support system for the survivor of the attempt.

The differences seen in findings in different households in this study can similarly be explained by this study's theoretical framework that postulates that the ability of a family to navigate a stressful event determines their bonds and showing how family dynamics may impact an experience of a suicide attempt (Bronfenbrenner, 1977). Thus, households in this study that successfully navigated the stress of a suicide attempt emerged as one strong emotional unit while those that failed experienced disunity.

The experience of disunity has similarly been seen in another study where spouses experienced strain in how they related and parents had difficulty relating to the survivor and other children (Buus et al., 2014; Ferrey et al., 2016). These however were studies among parents of children who had attempted suicide hence they do not fully capture all family dynamics as the relationship with the survivor of the attempt is varied in the current study.

Social isolation in this study was experienced by a few participants, mostly those who had experienced multiple attempts, a family history or accompanying serious mental illness. This reflects ongoing stigma associated not only with suicide but also with mental illness (Ongeri et al., 2022; Scocco et al., 2017; Tawiah et al., 2015).

In view of the SEM framework used in this study, societal factors such as cultural beliefs and the level of stigma in a community greatly impacted the experience of household members following a suicide attempt as some community members had

judgmental views based on their cultural beliefs leading to isolation and propagating stigma towards affected households.

Other studies have reported stigma towards individuals affected by suicide as reported in a study done in the Coastal region of Kenya, although this study was from the perspective community members and not from affected individuals, while a study in Ghana provides the perspective of affected family members on stigma (Asare-Doku et al., 2017; Ongeri et al., 2022).In this study, household members who experienced social isolation and stigma also experienced poor social support from their families and community, showing how stigma may impact the ability of a community to support households experiencing a suicide attempt.

This study reports an experience of physical injury, additional responsibilities and reduced work productivity because of providing care to household members who had attempted suicide. Additional responsibilities were assumed when the survivor of the attempt had a family or was a provider in the affected household. This was similarly reported in other studies where participants had to take over the role of financial provision and providing care, and some had to stop working due to the burden of caring for their affected loved ones (McLaughlin et al., 2014; Vivekanandhan et al., 2024).

The financial burden and reduced productivity have not been explored in Sub-Saharan Africa as studies on this topic are limited. However, a systematic review done in Sub-Saharan Africa including 7 studies explores the economic burden of care giving for persons with mental illness (Addo et al., 2018). This is closely related as people with severe mental illnesses are more likely to have multiple suicide attempts. Direct costs were related to care giving and indirect costs majorly included inability to work and decreased output due to time consumed in care with up to 50% of careers being employed perhaps due to the burden of care giving (Addo et al., 2018). Output

reduction is a serious setback to economic growth not only for the affected individual but also to the larger community (Addo et al., 2018).In view of the theoretical framework of this study, the experiences of a suicide attempt in this study were affected by external factors including economic challenges faced by affected households.

5.1.2 Existing Support Structures

Healthcare provision was generally satisfactory in this study with good follow up of the survivor of the suicide attempt. Household members experienced hospitality and for some, good communication from the hospital staff. Other studies have reported unsatisfactory care at the hospital, poor and fragmented follow up, and others experienced blame from healthcare providers (Krysinska et al., 2020; Spillane et al., 2020). Some studies reported satisfactory follow up but relatives felt uninvolved in the care (McLaughlin et al., 2016). The high level of satisfaction with health care provision and follow up, coupled with hospitality reported in this study may reflect the role of faith-based institutions in offering compassionate and quality healthcare services. Patients have reported satisfaction in healthcare provision in faith-based hospitals compared to public institutions due to the respect to patient's dignity and empathy experienced in those institutions (Olivier et al., 2015). However, the findings of satisfactory healthcare may not be fully generalizable to other settings as this study was carried out only on household members of individuals admitted to a faith-based institution and thus the experience of healthcare provision may differ depending on the setting.

Following a suicide attempt, many household members experienced great support from family members, neighbours and friends in rescuing the survivor and getting them to hospital, and through financial support. However, the financial support seemed to be

limited to the immediate period after the attempt and household members still had ongoing financial struggles.

The support from community demonstrated in this study was not reported in a similar study done in Ghana (Asare-Doku et al., 2017). This could perhaps be due to higher levels of stigma on suicide in the setting of that study that pushed family members to secrecy with resultant isolation. Although a few participants in the current study reported social stigma, there was no report of secrecy hence the community was aware of the incident and provided the needed support.

Despite the cultural beliefs about suicide held by communities in African settings (Mugisha et al., 2013; Ongeri et al., 2022), the ability of the communities to support affected households and even the survivor perhaps against their beliefs signify that the community can be a great resource to individuals affected by a suicide attempt and thus should be empowered to continue providing this support.

The role of the church and religious leaders in supporting the affected households was a recurring and important theme in this study. Religious leaders, being highly respected in the setting of this study are an important resource in offering support to affected household, not only morally but also by-passing information both to the affected households and to the larger community, perhaps helping alleviate stigma towards affected households. Separation of religious attitudes concerning suicide from the person needing support has been reported to aid in reducing stigma (Osafo et al., 2013).

Moral support was provided by family, friends and church communities. This differed from a study done in India where moral support from friends and family was poor (Vivekanandhan et al., 2024). Prayers and encouragement in this study were done communally through home visits by church groups, a finding that differs from a similar

study done in Ghana where prayers were individualised and the role of religious leaders not captured attributed to existing stigma on suicide (Asare-Doku et al., 2017).

5.1.3 Desired Support Structures

Providing mental health care and follow up to the survivor of the suicide attempt was greatly desired in this study. Caregiver burden can possibly be reduced through provision of proper healthcare to the survivor of a suicide attempt(Lavers et al., 2022; Maple et al., 2023).

Additionally, counselling services were desirable both for the survivor and the entire household, both at individual levels but also at family level as expressed in other studies (McLaughlin et al., 2016). Household members of an individual who attempts suicide are immensely affected psychologically and thus offering them counselling services will enable them cope with the stressful incident. It is worth noting that families of those who have attempted suicide are at high risk of attempting suicide themselves and so psychological support through counselling may help mitigate this risk.

Other studies have reported desire for relatives to be included in the care of their loved ones following an attempt(McLaughlin et al., 2016; Wayland et al., 2021), however this was not reported in this study perhaps because many participants felt well involved in care at the hospital and follow up as shown by their satisfaction in the healthcare provision. Notably, the site where this study was undertaken has more mental health services and more investment in training than other peer hospitals in the same region and this may have contributed to this result. There is need to strengthen mental health services further in the facility and in the region as this is an important support structure to affected individuals. Other hospitals around the region should also benchmark with the mental health department in the site of study particularly regarding how they handle

patients and families following a suicide attempt and perhaps extend similar services in their facilities.

There is a general shortage of mental health professionals in Kenya required to offer these services both to affected individuals and their families(Ministry of Health, 2015). The findings of this study underpin the need for more mental health human resourcing and need to diversify ways of ensuring access to these services to affected households. In rural Kenya, where the shortage is even greater, Community Health Promoters (CHPs) may play a vital role in bridging this gap. The Kenya mental health policy acknowledges the need to train CHPs for mental health services, however the implementation and impact of this is unclear(Ministry of Health, 2015). Furthermore, their role in providing these services to households experiencing a suicide attempt is not included in this policy.

Lack of information on suicide by healthcare professionals was reported in this study and was consistent across different ages and educational levels. Even with repeated attempts there was still lack of information on what to do and how to assist the survivors and safeguard them. Other studies done in Western countries have reported similar findings where parents would wish to support their children following an attempt but lacked knowledge on how to do so(Buus et al., 2014; Spillane et al., 2020).

The dire need for information was reflected by some participants who reported seeking knowledge on suicide from neighbours and friends, which was not always correct and from online sources. A study done in England similarly reported that families who failed to get information concerning suicide from HCPs sought the information needed from the internet (Gorman et al., 2023).

With the general lack of suicide education on suicide, more information on how to handle the survivor, including identifying triggers and warning signs, immediate interventions during a crisis and how to relate after the crisis was greatly desired. Need for information on how to navigate an attempt has been reported by both the survivors of an attempt and the families caring for them (McGill et al., 2019). Offering education on what to do following a suicide attempt is important as it has been associated with reduced caregiver burden, and has been reported to be valuable in boosting the sense of skill in ensuring safety following an attempt (Branjerdporn et al., 2023; Maple et al., 2023).

Several methods of dissemination of information on suicide were suggested in this study including outreaches and home visits by health care professionals, through trained laymen, religious leaders and community leaders. These suggested methods differed from a study done in Ireland where online sources of information and crises lines were preferred, and another study done in Australia where a need for specialized training for those caring for survivors aimed towards ensuring safety was desired (French et al., 2023; Wayland et al., 2021). The literacy levels in the setting of the study compared to other studies may have informed the difference in desired dissemination of information.

A study done in the Coastal region of Kenya exploring strategies of suicide prevention from the perspective of community members highlighted the crucial role of community leaders in emancipation of the community about suicide through community forums organized by chiefs and at religious gatherings, similar to suggestions made in this study (Ongeri et al., 2023). Although this study was done among community members and not affected households, the similarities in methods of dissemination of information shows what is preferable and applicable in the Kenyan context and reflects the crucial role of the clergy and other community leaders in health education showing that this

responsibility is not only held by HCPs. Hence need for collaboration with all stakeholders to offer informational support to these households and the larger community.

Support groups formed by people with similar experiences was desired in this study and was similarly reported in a study done in India and was identified as a source of information through sharing of experiences by people in similar circumstances in an Australian study (McGill et al., 2019; Vivekanandhan et al., 2024). Due to isolation experienced , caregivers of individuals who attempted suicide in a study done in England similarly desired to have support groups for moral support (Gorman et al., 2023).

Ongeri et al. (2023) in their study done in Coastal region of Kenya reports the need for peer support, although this was suggested for the survivor of the attempt and those bereaved from suicide with participants suggesting that these support groups should be driven by religious leaders in the community. This may be similarly considered and useful for households experiencing a suicide attempt.

The desire for financial and material support from the community reported in this study may reflect economic difficulties faced and existing challenges in affordability of healthcare in these settings. Poverty rates in LMIC remain high and economic hurdles have been linked to increased suicidality (Bantjes et al., 2016). Hence, these households who are already at risk of suicide with the family history, are even more at risk with the financial challenges that increase due to additional care. According to the Kenya National Bureau of Statistics, the poverty rate in Kenya is 38.6%, and only 22% of Kenyans have health insurance cover(Kenya National Bureau of Statistics, 2022). This causes a heavy reliance on community help to raise finances for health care. These findings may reflect poor access and unaffordability of mental health services

hampering universal health coverage. Similar studies in Western countries although reporting reduced work productivity have not captured financial support for healthcare services as a need, perhaps due to better access to healthcare and health insurance. The new Social Health Insurance Fund (SHIF) in Kenya shall cover only 7 outpatient mental health visits per year (Ministry of Health, 2024).This is far less than the average survivor of a suicide attempt needs and thus is likely to put further financial strain on their already struggling household members to meet their medical needs through out-of-pocket payments. Hence, there is need to relook and increase funding for mental health services in the SHIF to reduce the financial burden of care on these households.

There is need to address larger social determinants of health including addressing unemployment, economic hurdles and fostering universal health coverage to reduce the burden faced by households experiencing a suicide attempt. Household members in this study acknowledged the need for family unity to enhance support to the suicidal individual andto mitigate risk for a recurrence in circumstances where disunity served as a trigger, reflecting an understanding of the importance of family support in suicide prevention strategies. Healthcare workers have reported difficulty in working collaboratively with families that were dysfunctional or contributing the mental health problems of the patient in preventing a suicide attempt (Gorman et al., 2023).Households experiencing lack of harmony need to be identified and supported for conflict resolution and restoration of unity to optimally support survivors of a suicide attempt.

Community leadership intervention was desired in addressing triggers of suicide attempts and to advocate for the needs of affected households. Community leaders are an integral part improving health in the Kenyan context. The Kenya Suicide Prevention Strategy acknowledges the role of community leaders including religious leaders and

administrative leaders, in suicide prevention through suicide education but does not capture their role in supporting affected household as desired by those with these experiences(Ministry of Health, 2022). This may be due to lack of studies in Kenya reflecting how these households desire to be supported by the leaders. Thus, beyond education on suicide, there is need for more exploration on how affected families desire to be supported by community leaders in a Kenyan context and inclusion of this into the strategic plan with clearly outlined roles.

As mentioned previously, this study had several limitations. There was a risk of researcher bias, however this was mitigated by having the transcripts, codes and themes reviewed by an independent reviewer in addition to personal reflexivity by the researcher and extensive discussions with the supervisors. Language barrier was a challenge for the principal researcher, however this was mitigated by having a research assistant conversant with English, Kiswahili and Kipsigis which was the local language. Additionally, while the data analysis using an inductive approach provided great depth to the codes and themes generated in this study, there is possibility that some important codes highlighted in literature done in the African culture may have been missed out which could potentially be generated using a deductive approach. Examples of these may be issues such as law and morality, and the view of suicide as a sin and how that may affect experience of household members.

5.2 Conclusion

Household members are adversely affected following a suicide attempt. Many have pre-existing family problems which worsen further after an attempt. While some households experience strengthening of bonds, these incidents generally have a negative impact on their mental health, social dynamics and increasing burden of care both physically and financially.

Community support and support from religious groups and leaders are vital in helping these households to cope. Even though healthcare provision to the affected individual, may be satisfactory, there is need to offer counselling services to these households to reduce the stress associated with the care. Education on suicide and support for support for affected households is important as household members are vital in suicide prevention and this mandate should not be limited to mental health professionals only but should include the clergy, community leaders and community at large.

5.3 Recommendations

5.3.1 Recommendations for Policy

i. Healthcare institutions should institute well structured counselling services for households experiencing a suicide attempt.

ii. Increased investment in mental health services in the facility of study and in the region.

iii. Trainings offered to CHP on mental health should include training on how to support households experiencing a suicide attempt within their community units.

iv. Support groups for affected households should be formed and conducted both at institution level and at the community level.

v. Clearly outlined roles for stakeholders including community leaders and the clergy in supporting households affected by suicide attempts should be included in the Kenya Mental Health Policy.

vi. The funding and number of visits covered for mental health services in the Social Health Insurance Fund in Kenya should be relooked and increased to alleviate the financial burden of care.

vii. Access to mental health services at community level should be emphasized in line with WHO recommendations to deinstitutionalize mental health services.

5.3.2 Recommendations for Further studies

i. Larger quantitative studies should be done to measure the level of support for affected households and improve generalizability of the findings
ii. A survey on whether public education as outlined in the Kenya Mental Health Policy has translated into improved knowledge among households experiencing a suicide attempt in rural Kenya should be conducted.
iii. Interventional or feasibility studies on culturally adaptable educational support for households experiencing a suicide attempt.

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APPENDICES

Appendix I: Data Instruments

Informed Consent

Name of Principal Investigator: Ekisa Loraine Idionyi

Organization: Kabarak University

Introduction

I am a student at Kabarak University pursuing a master's degree in Family Medicine and practicing at AIC Litein Hospital. I am conducting research study titled **"Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at AIC Litein Hospital".** You are invited to take part in this research. This form will contain information that will help you decide whether to take part in this study.

Purpose of the Research

The purpose of this study is to find out more about the experiences of individuals who live with and care for individuals who have attempted suicide and presenting at AIC Litein Hospital, what kind of support is available to them and what kind of support they would wish for. This information will help to provide the appropriate support and care for affected families and will enable them to care better for their loved ones who have attempted suicide.

Study Procedures

This research will involve face to face interviews that will take about 60 minutes conducted either at your home or at the Mental Health Clinic at AIC Litein Hospital in a private room whichever you are comfortable with. Only you and the interviewer will be present in the room during the interview. The interviews will be recorded on an audio recorder.

Risks

There is a risk that the information you share may affect your emotions. You are free to skip any uncomfortable question or stop the interview at any point if unable to handle it. Psychological counselling will be offered should you feel in need of this during the study.

Benefits

There will be no incentive offered for participation in this study.

Confidentiality

The information you share shall be kept confidential. There shall be no mention of names and the voice in the audio recorder shall be altered. Recordings shall be safely stored in a password protected folder and other documents stored in a lockable cabinet accessible to the principal investigator only.

Voluntary Participation

Your participation in this study is voluntary. Should your decision to participate change at any point during the process, you are also free to cancel your participation without giving any reason.

Contact information.

If you have any questions about this study, please feel free to ask now or later by contacting the principal investigator through this number: *0713586417* This proposal has been approved by the Tenwek Hospital Institutional Scientific and Ethics Research Committee and can be contacted for any questions via: *ierc@tenwekhosp.org/0728091900.*

Consent Certificate

I have clearly understood and voluntarily agree to take part in this study.

Initials of Participant: ______________________________________

Signature of Participant: ___________________________________

or

Thumb print of participant:

Statement by Researcher/Person taking consent.

I confirm that the participant has voluntarily given consent after reading or having this document read to them and has not been coerced in any way.

Name of person taking consent: ___________________________________

Signature of person taking consent: ______________________________

Date: ____

Kiswahili Translation

Jina la Mpelelezi Mkuu: Ekisa Loraine Idionyi

Shirika: Chuo Kikuu cha Kabarak

Utangulizi

Mimi ni mwanafunzi katika Chuo Kikuu cha Kabarak ninayesomea Shahada ya Uzamili katika Tiba ya Familia na kufanya kazi katika Hospitali ya AIC Litein. Ninafanya utafiti unaoitwa "Uzoefu na Miundo ya Usaidizi ya Wanakaya Kufuatia Jaribio la Kujitoa uhai kwa waliojiwasilisha katika Hospitali ya AIC Litein". Unaalikwa kushiriki katika utafiti huu. Fomu hii itakuwa na taarifa ambayo itakusaidia kuamua kama utashiriki katika utafiti huu.

Madhumuni ya Utafiti

Madhumuni ya utafiti huu ni kujua zaidi kuhusu uzoefu wa watu wanaoishi na kuwatunza watu ambao wamejaribu kujitoa uhai na kuwasilisha katika Hospitali ya AIC Litein, ni aina gani ya usaidizi unaopatikana kwao na ni aina gani ya usaidizi ambao wangetaka. Taarifa hizi zitasaidia kutoa usaidizi na utunzaji unaofaa kwa familia zilizoathiriwa na zitawawezesha kuwatunza vyema wapendwa wao ambao wamejaribu kujitoa uhai.

Taratibu za Masomo

Utafiti huu utahusisha mahojiano ya ana kwa ana ambayo yatachukua kama dakika 60 kufanywa nyumbani kwako au katika Kliniki ya Afya ya Akili katika Hospitali ya AIC Litein katika chumba cha faragha. Waweza chagua kati ya kumbi hizi mbili. Ni wewe tu na mhojiwa mtakuwepo kwenye chumba wakati wa mahojiano. Mahojiano yatarekodiwa kwenye kinasa sauti.

Hatari

Kuna hatari kwamba maelezo unayoshiriki yanaweza kuathiri hisia zako. Uko huru kuruka swali lolote lisilofaa au kusimamisha mahojiano wakati wowote ikiwa huwezi kulishughulikia. Ushauri wa kisaikolojia utatolewa ikiwa unahisi kuhitaji hili wakati wa utafiti.

Faida

Hakutakuwa na motisha itakayotolewa kwa kushiriki katika utafiti huu.

Usiri

Habari unayoshiriki itawekwa siri. Hakutakuwa na kutajwa kwa majina na sauti katika kinasa sauti itabadilishwa. Rekodi zitahifadhiwa kwa usalama katika folda iliyolindwa na nenosiri na hati zingine zitahifadhiwa kwenye kabati linaloweza kufikiwa na mpelelezi mkuu pekee.

Kushiriki kwa Hiari

Kushiriki kwako katika utafiti huu ni kwa hiari. Iwapo uamuzi wako wa kushiriki utabadilika wakati wowote wakati wa mchakato, uko huru pia kughairi ushiriki wako bila kutoa sababu yoyote.

Maelezo ya mawasiliano.

Ikiwa una maswali yoyote kuhusu utafiti huu, tafadhali jisikie huru kuuliza sasa au baadaye kwa kuwasiliana na mpelelezi mkuu kupitia namba hii: *0713586417*

Pendekezo hili limeidhinishwa na Kamati ya Utafiti ya Kisayansi na Maadili ya Hospitali ya Tenwek na linaweza kupatikana kwa maswali yoyote kupitia: *ierc@tenwekhosp.org/0728091900*

Cheti cha Idhini

Nimeelewa vyema na kwa hiari yangu nimekubali kushiriki katika utafiti huu.
Awali ya mshiriki: ______________________________
Sahihi ya mshiriki: ______________________________

Ama
Kidole gumba cha mshiriki: [ ]

Taarifa ya Mtafiti

Ninathibitisha kuwa mshiriki ametoa idhini kwa hiari baada ya kusoma au kusomewa hati hii na hawajashurutishwa kwa namna yoyote ile.
Jina la mtu anayekubali idhini: ______________________________
Sahihi ya mtu anayekubali idhini: ___________________________

Appendix II: Interview Guide

I would like to thank you for participating in this interview. The purpose of this study is to explore the experiences and support structures of household members following a suicide attempt.

Introduction

- Greet participant.
- Introduce the interviewer by name and the research assistant.
- Explain measures taken to ensure confidentiality and what happens after with the study findings.
- Explain the consent form and allow participant to read or read for those unable to, then obtain written consent.
- Request consent for audio recording and switch on the recorder.

1.Biodata

Initials:

Sex:

a.) How old are you?

b.) Where do you live?

c.) What do you do for a living?

d.) What is your marital status?

e.) What is your relationship to the suicide attempt survivor?

f.) When did the incident occur?

1. Questions on the experience

a. Could you please narrate the events leading to the suicide attempt of your loved one? (probe when, how, who,)

b. How does it feel to hear a close relation has attempted suicide?

c. Could you please describe how people reacted to the attempt?

d. How has your life been affected by this incidence?

Support Structures

a. How was the experience of care during the hospital admission and follow up?
b. What type of support did you and other member of the household have available at that time?
c. How better do you think the groups you have mentioned could have supported you?
d. What kind of information or education did you receive after the suicide attempt of a loved one? (Probes: who, how?)
e. What kind of information do you think would be helpful for people caring for suicidal individuals?
f. What other kind of support do you think would be useful for families of individuals who have attempted suicide?

Kiswahili Translation

Mwongozo wa Mahojiano

Ningependa kukushukuru kwa kushiriki katika mahojiano haya. Madhumuni ya utafiti huu ni kuchunguza uzoefu na miundo ya usaidizi ya wanakaya kufuatia jaribio la kujitoa uhai.

Utangulizi

- Msalimie mshiriki
- Mjulishe mhojiwa kwa jina na msaidizi wa utafiti
- Eleza hatua zitakazochukuliwa ili kuhakikisha usiri na kile kitakachotokea baada ya matokeo ya utafiti.
- Eleza fomu ya idhini na umruhusu mshiriki kusoma au kusoma kwa wale ambao hawawezi, kisha kupata idhini iliyoandikwa.
- Omba idhini ya kurekodi sauti na uwashe kinasa.

1. Takwimu za uhai

Herufi:

Jinsia:

a.) Una umri gani?

b.) Unaishi wapi?

c.) Unajishughulisha na nini?

d.) Hali yako ya ndoa ikoje?

e.) Je, una uhusiano gani na aliyenusurika katika jaribio la kujitoa uhai?

f.) Tukio hilo lilitokea lini?

1. Maswali juu ya uzoefu

a. Je, unaweza kusimulia matukio yaliyopelekea jaribio la kujitoa uhai la mpendwa wako? (chunguza: lini, vipi, nani,)

b. Je, ulihisije kusikia mtu wa karibu amejaribu kujitoa uhai?

c. Je, unaweza kueleza jinsi watu walivyochukulia jaribio hilo?

d. Je, maisha yako yameathiriwa vipi na tukio hili?

Miundo ya usaidizi

a) Uzoefu wa huduma ulikuwaje wakati wa kulazwa hospitalini na ufuatiliaji?
b) Ni aina gani ya usaidizi ambao wewe na wanakaya wengine mlikuwa nao wakati huo?
c) Je, unadhani vikundi ulivyovitaja vingekuunga mkono aje kwa njia bora zaidi?
d) Je, ni aina gani ya taarifa au elimu uliyopokea baada ya jaribio la kujitoa uhai la mpendwa wako? (Ni nani aliyekupa maelezo? Maelezo hayo yalipitishwa vipi?)
e) Ni aina gani ya taarifa au elimu unadhani inaweza kusaidia watu wanaojali watu wanaotaka kujitoa uhai?
f) Je, ni aina gani ya usaidizi unafikiri inaweza kuwa muhimu kwa familia ya watu wanaotaka kujitoa uhai?

Kipsigis Translation

Amwaun kongoi amun keyan iigu agenge en bik che kitepsen en chigilisyoninyon. Chigilisyoni kotoreti kenai toretosyek che terter chenyoru bikab korikab bik che kityem kobetenge sobet.

Kanamet

Kogotisyet

Komwage chito ne tepse en kainet and toretindenyin

Arorun kakwokoutik che kiibe si kobiit ungoteet en ngalalutik chuto ak ne neyaaksei ye kagobata chigilisyoni.

Arorun tuguk che mi chomchinet ne konu inendet ak igochi kasarta kosoman koyochinet ne kegochi. En icheg che momuche kosoman kogon chomchinet en siret.

Som kerekoden ak inaam rekoda.

Biodata

Kanwagikab kainet

Jinsia

a.) Ibo kenyisyek ata?

b.) Imenye ano?

c.) Iyoe kasi ne?

d.) Kigitunin?

e.) Ogurenge ne ak inendet ne kityem kobetenge sobet.

f.) Kiyaaksei au youtionito?

TebutikChebo Youtiet

a.) Kisome iaroru youtikab betunoto, tuguk che kiyaak en betut ne kimach kobetenge sobet (teb kasarta/sait? ngo? En or ne?

b.) Ikostoi ano en muguleldo inikas ile kamach kobetenge sobet chitongwong?

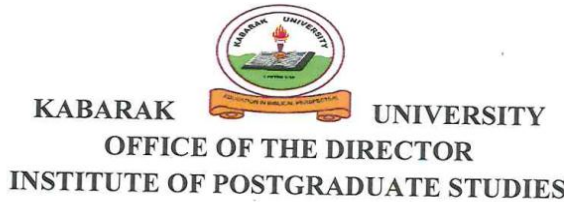
c.) Kisome iaroru ole kiipto biik youtyonito

d.) Kigoweleldoge ano sobengung kongeten kingoyaak youtyonito?

Tubutik Che Bo Toretoshek

a) Kiune ripset,toretet ak kanyoiset ne kionyoru en sipitali ak kosipeet kokaomande?
b) Toretet ne une ne kiotinye en kasarato?
c) Imuche kotoretok en orne kosiir kundisyek chekaimwa? Kanisosyek, kanyoik, bikab kokwet?
d) Konetisyet ainon ne kionyoru kingoyaak youtyonito? (teb ngo? En orne?
e) Ne konetisyet neibwotyini komuche kotoret ichek che ribe chito ne katyem kobetenge sobet?
f) Torete ne une age ne ibwotyini komuche kotoret korik/familia che bo chito ne kigotyem kobetenge sobet?

Appendix III: Letter of Introduction



KABARAK UNIVERSITY
OFFICE OF THE DIRECTOR
INSTITUTE OF POSTGRADUATE STUDIES

Private Bag - 20157
KABARAK, KENYA

Tel : 0773 265 999
E-mail: directorpostgraduate@kabarak.ac.ke

29th April, 2024

The Chairman,
Institutional Scientific and Ethics Revie Committee (ISERC)
Tenwek Hospital
P.O Box 39-20400 Bomet, Kenya

Dear Sir/Madam,

RE: REQUEST FOR ISERC CLEARANCE TO FACILITATE NACOSTI RESEARCH PERMIT APPLICATION

I am writing to formally request ISERC clearance for **LORAINE IDIONYI EKISA (GMMF/M/0334/01/21)**, currently enrolled in the Master's program in Family Medicine at Kabarak University. She is conducting research entitled ***"Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church Litein Hospital"***.

The student has successfully defended her research proposal and has been granted permission to proceed with field research. Kindly provide ISERC clearance to facilitate the application for the necessary NACOSTI research permit.

Thank You.

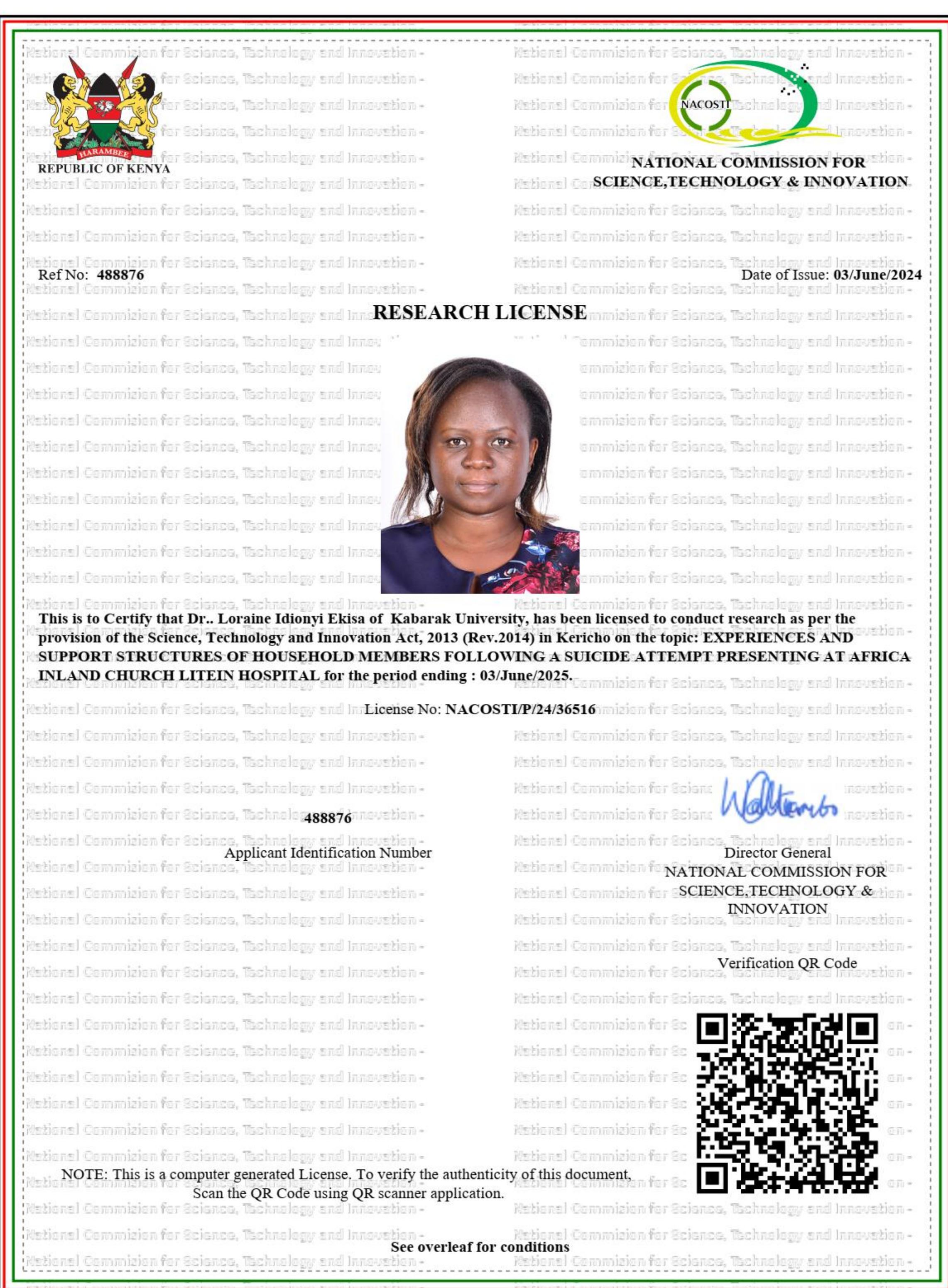
KABARAK UNIVERSITY
DIRECTOR
POST GRADUATE STUDIES
29 APR 2024
PRIVATE BAG -20157, KABARAK

Dr. Nehemiah Kiplagat, PhD
Ag. Director, Institute of Postgraduate Studies

Kabarak University Moral Code
As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Kabarak University is ISO 9001:2015 Certified

Appendix IV: Ethical Approval Letters



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **488876**

Date of Issue: **03/June/2024**

RESEARCH LICENSE

This is to Certify that Dr.. Loraine Idionyi Ekisa of Kabarak University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kericho on the topic: EXPERIENCES AND SUPPORT STRUCTURES OF HOUSEHOLD MEMBERS FOLLOWING A SUICIDE ATTEMPT PRESENTING AT AFRICA INLAND CHURCH LITEIN HOSPITAL for the period ending : 03/June/2025.

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See overleaf for conditions

Appendix V: Evidence of Conference Participation

NAIROBI CITY COUNTY
1ST NAIROBI HEALTH SCIENTIFIC CONFERENCE

CERTIFICATE
OF PARTICIPATION

THIS CERTIFICATE IS AWARDED TO

Loraine Idionyi Ekisa

for active participation in the 1st Nairobi County Health Scientific Conference themed **'Advancing Health Equity Towards Resilient and Sustainable People - Centered Primary Healthcare Systems for Nairobi'** held on 20th to 22nd November 2024 at Emara Ole Sereni - Nairobi, Kenya.

Dr. Irene Muchoki
Chief Officer - Medical Services

Suzanne Silantoi
County Executive Committee Member-
Health, Wellness and Nutrition

Appendix VI: List of Publications

JOURNAL OF CLINICAL CARE AND MEDICAL ADVANCEMENT

https://doi.org/10.58460/jccma.v1i1.124

ORIGINAL ARTICLE

MJ&M BIOLABS

Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church (AIC) Litein Hospital in Kericho County

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To read this paper online, please scan the QR code below:

ABSTRACT

Suicide is a serious public health problem, with a previous suicide attempt being the greatest risk factor for repeat and completed suicide. Household members of a person who attempts suicide are key gatekeepers in prevention of suicide; hence their experiences and support needs cannot be ignored. However, there is a paucity of data on the effects of a suicide attempt on household members in Kenya and their support needs have not been explored or exhaustively included in existing local mental health policies. This study's objectives were to understand the experiences of household members following a suicide attempt presenting at Africa Inland Church (AIC) Litein Hospital and to explore the existing and desired support structures following the event. A qualitative phenomenological study design was used and purposive sampling used to select 16 participants. In-depth interviews were conducted using a semi-structured interview guide, audio-recorded and analyzed thematically. Participants experienced a range of negative emotional and psychological responses with shifts in social dynamics at family and community level. Physical and practical impact including physical harm, additional responsibilities and financial burden was reported. Support structures available included good healthcare provision, practical, spiritual and moral support from religious leaders and community. Household members desired mental health and professional support and expressed the need for education and information on suicide at hospital and community levels. Support groups at community level was desired and role of community leaders in addressing suicide triggers and advocating for the needs of affected households expressed. Considering the crucial role of household members and the adverse effects of a suicide attempt, healthcare institutions must institute well-structured counseling services for these households. Moreover, addressing the needs of affected households is not only the mandate of healthcare workers but also the clergy, the government, community leaders and the larger community working collaboratively.

Keywords: Suicide, suicide attempt, experiences, support, household members

How to Cite this Paper: Ekisa, L., Horn, E., & Loftus, M. (2025). Experiences and Support Structures of Household Members Following a Suicide Attempt Presenting at Africa Inland Church (AIC) Litein Hospital in Kericho County. Journal of Clinical Care and Medical Advancement, 1(1), 74–83. https://doi.org/10.58460/jccma.v1i1.124

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