Family Responses to Youth Who Have Engaged in Deliberate Self-Harm: A Qualitative Constructive Grounded Theory Study in Sri Lanka

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Abstract

Like in the global context, suicide and deliberate self-harm (DSH) among youth are critical public health concerns in Sri Lanka. However, studies have mainly focused on the risk factors of suicide and deliberate self-harm with limited attention to examining the family responses to youth who have engaged in deliberate self-harm, which is vital in developing aftercare plans for prevention. This study, derived from the constructive grounded theory methodology and thematic analysis, aimed to explore how the immediate family responds to youth who engage in deliberate self-harm. A total of 40 qualitative interviews, 20 with affected youth and 20 with their family members, were analyzed. This qualitative analysis derived four themes: (1) the family's aftercare role, (2) family accusation and reduced conversation, (3) recalling of unpleasant memories on occasions, and (4) withdrawal of family support. Findings revealed that though family plays a vital caregiver role, negative responses of the family would buffer the psychosocial well-being of the affected youth in the post-discharged period, informing us of the importance of the family's role in helping the affected young people following deliberate self-harm. Thus, health professionals, social workers, and social service providers can contribute to minimizing the family's negative responses through enhancing family relationships and psychoeducation.

Keywords

Aftercare role; deliberate self-harm; family responses; negative responses; youth

Introduction

According to the World Health Organization (WHO) (2019), suicide accounts for over a million deaths worldwide each year. Globally, 77% of deaths by suicide occur in low- and middle-income countries (LMIC), of which 29% are within South Asian countries (World Health Organization [WHO], 2021). Also, it has been counted that 10–20 deliberate self-harm (DSH) incidents occur for each death by suicide, contributing to approximately four million DSH incidents every year in South Asia (WHO, 2014). Though the highest suicide rates were reported in the older populations earlier, in the recent past, global youth suicide rates have increased unexpectedly (Standley, 2020). Along with traffic accidents and interpersonal violence, suicide mortality was identified as one of the three leading causes of death for both boys and girls aged 15 to 29 in 2016 (WHO, 2019). Because of the challenges associated with social embeddedness in roles and relationships, some researchers have identified younger age as a risk factor for suicide (Beautrais et al., 2006; Nock et al., 2008). Some think that rapid psychological, biological, and social changes in youth and adolescence, known as developmental stress, contribute to growing suicide and mental illness (Standley, 2020).

In the global suicide context, Sri Lanka, a small country in South Asia, recorded the world's highest suicide rate in 1995, with 47 deaths per 100,000 people (Sri Lanka Medical Association [SLMA], 2019). Despite the decline in the overall suicide rate during the last few decades, the country still reports a high suicide rate in the world, with 17.5 deaths per 100,000 population (Knipe et al., 2019). At the same time, DSH remains the leading cause of severe injury and death among adolescents and youth in Sri Lanka (Pushpakumara et al., 2018; Sørensen et al., 2019; Widger, 2015).

The concepts related to the phenomenon of suicide are ambiguous in meaning due to the biological, psychological, ecological, and cultural complexities involved (De Leo et al., 2006). Then, based on the presence or absence of suicidal intent, suicidal behavior and self-harm behavior are distinguished (Krug et al., 2002). Accordingly, in the relevant literature domain, self-harm is often categorized into two: nonsuicidal self-injury (NSSI) and deliberate self-harm (DSH). Nonsuicidal self-injury is used to describe the deliberate damage to one's body tissue without suicidal intent. In contrast, DSH is used to refer to nonfatal outcomes caused by self-injurious behaviors, both with suicidal and nonsuicidal intent (Muehlenkamp et al., 2012). Drawing from Muehlenkamp et al. (2012), in this study, we use the term DSH as any deliberate injury to oneself resulting in a nonfatal outcome, irrespective of the intent of injury, which is often death. The concept of 'youth' has been defined inconsistently in the international suicide and self-harm literature. Many researchers have considered the age of 15–24 in defining the concepts, while some studies have considered the age of 10–24 (Gould et al., 2003; Posner et al., 2011). However, aligning with the national youth policy in Sri Lanka, 'youth' is defined in this study as a person aged 15–29 years, and we have used the terms 'youth' and 'young' interchangeably.

Like the global literature, studies carried out in Sri Lanka have found that the presence of depression, high levels of hopelessness, childhood physical abuse, and emotional abuse or neglect increased the risk of suicide and DSH in adulthood (Knipe et al., 2018; Rajapakse et al., 2014). However, some studies argued that, unlike in the West, long-standing depression does not contribute much to DSH among Sri Lankan youth, but it often contributes to explosive anger, frustration, and humiliation (Marecek & Senadheera, 2012; SLMC, 2019). In the local context, youth suicide and DSH have been normalized as a socially accepted means

or problem-solving method for everyday difficulties (De Silva et al., 2012; Marecek & Senadheera, 2023). Distress related to unwanted pregnancies, unhappy sexual relationships, and sexual assault are frequent risk factors for DSH among adolescents and youth in Sri Lanka (Hewamanne, 2010; Marecek & Senadheera, 2023; SLMA, 2019; Widger, 2015). More specifically, young girls and women are vulnerable to DSH due to the mismatch of social change and traditional values related to the gender and intimacy roles of women (Hewamanne, 2010; Rajapakse & Tennakoon, 2016).

Among many other possible risk factors, family-related matters critically contribute to DSH among young family members in Sri Lanka. A child growing up in a household with violence, a mentally ill or suicidal household member, and experiencing parental death/separation/divorce increases the risk of DSH (Knipe et al., 2019). Among family-related matters, alcoholism and domestic violence acts of men are frequently cited (Knipe et al., 2018; Sørensen et al., 2017). Also, conflictual family relationships, more specifically conflict between parents and young children, increase DSH vulnerability among young people (Rajapakse, 2014; SLMA, 2019). However, most of the existing studies in Sri Lanka have attempted to discover the risk factors of DSH in the general population, creating a gap in the literature on the contribution of familial factors to DSH among young people.

Global studies found that low levels of intimacy, child maltreatment, weak socialization, low interactions, low family cohesion, and conflictive family environments may increase the risk of DSH in young family members (King & Merchant, 2012; Michelson & Bhugra, 2012). Brent et al. (2013), reviewing the intervention studies, found that family adaptability and cohesion prevent adolescents from DSH, while family conflicts may increase the risk of self-destructive behaviors in this group. Also, the decline in the quality of parent-child relationships (McKinnon et al., 2016) and low cohesion and flexibility in the family contribute to the development of DSH ideations (Gouveia-Pereira et al., 2014).

A family that has a low level of contentment in family relationships, parents' emotional support, school-related parental support, and a high degree of authoritarian-repressive father's parenting style and permissive-neglectful mother's parenting style increases the risk of DSH (Xing et al., 2010; Zaborskis et al., 2016). Moreover, problematic family structures, emotional invalidation, and suicide history of the family contribute to suicidal behavior among young people in the family (Wagner, 2009; Wagner et al., 2000; Zaborskis et al., 2016). Structural changes in families, such as the increase in nuclear families, changes in household composition, increased number of divorces, and alienation of family members, have reduced the family's ability to control some addictive behaviors of the children, such as smoking, alcohol, and drugs thereby increasing the risk of suicidal and self-harm vulnerability among adolescents and young children (Sweeney, 2007).

Though the family factors that increase the risk of DSH in young family members are well established, literature that explores the experience of family members of those who deliberately self-harmed in youth is lacking. Buckmaster et al. (2021) carried out a systematic review of the literature on family relationships in adults who engaged in DSH and found twenty-seven studies, of which only one study has been carried out on the perspectives of family members of those who self-harm. Lindgren et al. (2010) explored the experiences of six parents of adult children who have engaged in self-harm in the context of their daughter's professional help-seeking. When their daughters were receiving professional care, parents were seen to feel invisible at times. However, experts also accused parents of putting undue pressure on their daughters.

The participants also mentioned the phenomenon of 'walking on eggshells' around their daughters to appease them and not upset them. Buckmaster et al. (2021), exploring the experience of family members of those adults who self-harm, found that family members demonstrated an inner struggle in terms of their reactions to their loved ones' self-harm. Instead of love, support, and care roles, many family members initially experienced instinctive reactions of anger towards the affected adult. However, with time and growing understanding, love and empathy developed in family members, and they supported the loved one to overcome the crisis. Ferrey et al. (2016a) conducted qualitative interviews with 37 parents of young children who had self-harmed and found that parents' reactions often depended on how they conceptualized it: as part of adolescence, as a mental health issue, or as "naughty behavior." Also, after the self-harm of their young child, parents saw changes in their parenting behavior to become more effective parents, such as learning to avoid blaming themselves or their child for the self-harm and developing new ways to communicate with their child.

In the local literature regarding family responses to young people who have engaged in DSH, to the best of our knowledge, only the study by Marecek and Senadheera (2023) can be found. They interviewed 22 mothers of girls who engaged in DSH and found that young girls receive negative family responses, including blame and beating. Young women would receive adverse reactions from their families since young girls' DSH behaviors are mainly undertaken due to family conflicts regarding feminine propriety and sexual respectability in the cultural context. Thus, a detailed account of family responses to young people who engage in DSH must still be discovered. Existing literature has focused more on the causation of family risk factors to DSH. Even the existing limited studies that have found family responses have mainly focused on one perspective: the reaction of people who engaged in DSH or parents/family members. This one-sided method may involve subjective bias in responses.

Therefore, the present study uses constructive grounded theory (CGT) to explore the subjective experience of young people who had DSH and their family members to explore the family responses/reactions, allowing us to understand family responses more comparatively and critically. This comparative understanding would provide better inputs in developing support mechanisms for affected young people and their family members. Also, using CGT will allow us to explore the lived experiences, perceptions, attitudes, and reactions of both family and young people in the local culture, which will provide a new theoretical framework for the phenomenon for future research. To reach this aim, this study attempts to explore the research question of how the immediate family responds to youth who have engaged in DSH.

Methodology

Research team

This study involved a group of Sri Lankan researchers with sociological and social work backgrounds. After gaining ethics approval, the primary researcher formed a qualified research team of three research assistants who had a good relationship with the primary researcher by engaging in several previous research projects, including a study on suicide among the older population in Sri Lanka. Two research assistants had completed their bachelor's and master's degrees in Sociology. They possessed extensive knowledge in qualitative research and at least four years of working experience as research assistants and

data analysts. The other research assistant had completed a bachelor's in sociology and a master's in social work and had over six years of qualitative research experience.

Context and setting

The research setting of this study cannot be defined straightforwardly, as it was not limited to a particular geographical area, community, or organization. The study used pre-existing social contacts of the research team with various service providers who work in the field of mental healthcare and suicide prevention as the entry point in data collection. Therefore, the study participants come from different parts of Sri Lanka, including Kandy, Kurunegala, Matale, Anuradhapura, Polonnaruwa, and Hambanthota districts. Among these districts, Anuradhapura, Polonnaruwa, Kandy, and Hambanthota are areas in which suicide rates are ranked high in the country's suicide profile (Whittall et al., 2018).

Study design

This paper is part of a larger doctoral research project on the psychosocial well-being of youth who have engaged in DSH in the post-discharge period in Sri Lanka, employing a qualitative constructive grounded theory (CGT) methodology. Fundamentally, the CGT proposed by Charmaz (2006, 2014) is an extension of the former grounded theory (GT), used as a significant qualitative research methodology to understand and explore new social processes, especially when there are no adequate previous theories and literature on a selected research topic, grounded theory is used as an exploratory research methodology.

Sample strategy

Deliberate self-harm (DSH) is a sensitive topic, making identifying the participants challenging. Approaching the participants through social contacts of the service providers who work in the field of mental healthcare and suicide prevention allowed us to build on an already trustworthy relationship with prospective participants. Therefore, the sampling strategy was convenient. We sampled both men and women aged between 15 and 29 who had been admitted to the hospital after a recent DSH and one of their family members who were competent to speak about the incident recommended by the affected young person. The participants were interviewed after six months of returning from the hospital.

Participants and data collection

The research team conducted 40 interviews, including 20 in-depth interviews with young people who have engaged in DSH (ten men and ten women) and 20 interviews with their family members. The primary researcher arranged one day of training for research assistants on data collection and research ethics and supervised them throughout the process.

In the interview process, the primary researcher interviewed the first two young people who had engaged in DSH without a pre-fixed interview guide in an open-ended manner, asking questions such as "What did you feel when you faced the family after the incident? How did your family members help you after coming from the hospital?" These questions were insightful and created a thorough discussion on the overview of the study topic and identified necessary 'initial codes' (Charmaz, 2014) or 'emerging theoretical ideas' that guide the

subsequent interviews (Carmichael & Cunningham, 2017). In the next step, based on the initial theoretical ideas/codes from those two initial interviews, the primary researcher prepared an interview guide to conduct the following interviews with other participants. Then, the primary researcher met with the research assistants and discussed the interview guide in depth. Some modifications were made based on our previous research experience and general consciousness. Aligning with the principles of CGT, when a new code/theoretical idea came out, we often modified the interview guide until the end of the interview process. For example, in the third interview, the participant described that his family had performed some local healing practices after returning from the hospital to enhance the psychological well-being of the affected young person. Thus, we added this new code to the guide for consecutive interviews. The same protocol was used to conduct interviews with parents.

Data collection was performed from January to September 2022. The interviewer visited the participants at their homes with prior consent (n = 14), while other interviews were conducted in the service providers' offices for logistical reasons (n = 6). All the family members were interviewed at their homes. The average time was 80 minutes per interview. All interviews were conducted in Sinhala, recorded with the participant's consent, and saved on password-protected personal computers. Table 1 presents the essential sociodemographic characteristics of the study sample and the risk factors of DSH.

Table 1: Sociodemographic Characteristics of the Participants and Risk Factors of DSH

Self-harm occurrence (Pseudonyms)	**Age**	**Gender**	**Education**	**Civil Status**	**Method used**	**Risk factor**	**Family member interviewed**
1 Renuka	29	Female	Up to O/L (Ordinary Level)	Married	Pesticide ingestion	Shame caused by pregnancy from a relationship after the death of the husband	Mother
2 Nimesh	27	Male	Up to A/L (Advanced Level)	Unmarried	Knife Stab	Unemployment and family pressure to find a job	Elder sister
3 Nethramali	27	Female	Up to O/L	Unmarried	Pesticide ingestion	Shame caused by premarital pregnancy	Mother
4 Jagath	19	Male	Up to O/L	Unmarried	Pesticide ingestion	Breaking up of a love affair	Mother
5 Anil	29	Male	Up to O/L	Married	Medicinal overdose	Mental illness (Delusion)	Spouse
6 Aravinda	25	Male	University student	Unmarried	Pesticide ingestion	Breaking up a love affair	Sister
7 Nirosha	21	Female	Up to A/L	Unmarried	Medicinal overdose	Exam depression	Mother
8 Prasad	29	Male	Up to O/L	Married	Pesticide ingestion	Alcohol addiction and depression	Spouse

Self-harm occurrence (Pseudonyms)	Age	Gender	Education	Civil Status	Method used	Risk factor	Family member interviewed
9 Chamila	25	Female	Graduate	Married	Medicinal overdose	Husband's extramarital relationship	Mother
10 Varuni	15	Female	Grade 10	Unmarried	Medicinal overdose	Breaking up of a love affair	Grandmother
11 Asha	16	Female	Grade 11	Unmarried	Medicinal overdose	Suicide threats of the boyfriend after ending their relationship	Mother
12 Amith	26	Male	Up to A/L	Married	Pesticide ingestion	Wife's rejection to have sex	Spouse
13 Bandara	29	Male	Up to A/L	Married	Pesticide ingestion	Extramarital affairs	Mother
14 Dishna	28	Female	Up to A/L	Unmarried	Pesticide ingestion	Breaking up of a love affair	Elder brother
15 Kasun	24	Male	University Student	Unmarried	Medicinal overdose	Breaking up of a love affair	Sister
16 Iresha	17	Female	Up to O/L	Unmarried	Pesticide ingestion	Shame caused by the family's accusation of a premarital sexual relationship	Mother
17 Priyangi	21	Female	Up to A/L	Married	Medicinal overdose	Fear of breaking a love affair	Mother
18 Nissanka	20	Male	Up to A/L	Unmarried	Pesticide ingestion	Conflict with the father	Sister
19 Chamali	26	Female	Up to A/L	Married	Medicinal overdose	Problem related to a job transfer	Spouse
20 Gihan	26	Male	Up to O/L	Married	Pesticide ingestion	Household debt	Spouse

Of the 20 participants, six were between 15 and 20 years old, one was in the 21 to 24 age category, and ten were between 25 and 29 years. The mean age of the study group was 24. When considering the level of education, seven participants had studied up to G.C.E. O/L (General Certificate of Education Ordinary Level), and eight participants followed G.C.E. A/L (General Certificate of Education Advanced Level). Three (two in grade 10 and one in grade 11) were secondary school students, and three had university-level education.

Regarding civil status, 11 were unmarried, while nine participants were married. Six participants came from single-parent family backgrounds due to divorce of parents (n = 2), separation of parents (n = 2), or the death of the father or the mother (n = 2). Only ten families were identified as nuclear families where the participant lived with both parents or the spouse and children.

In terms of the method of DSH, pesticide ingestion was involved in 11 incidents. Eight participants took a medical overdose. One person had self-stabbed using a knife. Based on the description given by the participants to the question, 'Can you tell us what actually happened?' we identified the risk factors of self-harm of the study sample. Further, we crosschecked their answers through interviews with family members. Accordingly, in total, 13 people have engaged in DSH due to intimacy-related issues, including unwanted pregnancy (2), breaking up of a love affair (5), fear of breaking a love affair (1), threats of a boyfriend after ending the relationship (1), sexual rejection of a wife (1), extramarital relationship problems (2), and family accusations on a premarital sexual relationship (01). Four other people have engaged in DSH due to the stress caused by different social stressors, including unemployment and family pressure to find a job (1), conflicts with the father (1), problems related to a job transfer (1), and household debt (1). Among the family members of the affected youth, nine mothers, five spouses, one grandmother, and five siblings were interviewed.

It must be noted that mental problems and alcohol addiction were involved in only three occurrences (3). Two participants showed clinical records highlighting how their DSH was associated with a diagnosable mental illness. However, the reason for DSH was not used as an inclusion or exclusion criterion in recruiting the study participants, but it emerged in data analysis.

Data analysis

Interviews were transcribed and carefully checked with recordings. Then, transcribed interviews were uploaded to NVivo12 (QSR International) to identify initial codes and focused codes to identify emerging themes in the theory-building process using thematic analysis. After generating the bulk of initial codes, they were categorized into clusters or 'analytic categories' (Charmaz, 2008) based on the type of information and the relationship among codes. Analytical memo writing was the next step of data analysis (Charmaz, 2008). Memo writing reflects the researcher's critical thinking about codes and categories, the link between them, the usefulness of categories, and the practical implications (Charmaz, 2008, 2014). This memo writing is the sketch or 'framework' (Charmaz, 2008) of the future theory. Thus, based on the initial codes and categories, the primary researcher tried to develop brief notes on the themes that emerged relating to the research question. Table 2 shows the major themes identified and codes in thematic analysis.

Table 2: Themes Emerged and Codes in Thematic Analysis

Emerged Theme	Codes Grouped Under Themes
Family's aftercare role	Providing basic welfare; avoiding isolation, loneliness, and the risk of repeat DSH; managing negative responses; altering the environment; performing local healings; supporting future plans
Family accusations and reduced conversation	Shame and dishonor caused to the family; stigma; setting a bad example to the young counterparts; being irresponsible; girls' sexual misbehavior
Recalling the unpleasant memory	Argumentative situations; situations of disagreements; lack of dialogue about the incident; father's alcoholism; self-isolation; deterioration of relationships with family members; excessive use of mobile phones

Emerged Theme	Codes Grouped Under Themes
Withdrawal of family support	Continuation of problematic behavior; distant attachments

Ethical considerations

Before data collection, we obtained ethics approval from the Research Ethics Committee of the Faculty of Arts of the University of Peradeniya, Sri Lanka (No: Arts/Ethics/2022/01/14.1). Further, we obtained written and verbal consent from the participants before beginning the interviews. Further, the research team contacted one psychiatrist, clinical psychologist, and counselors to get their support if any emergency occurred during the data collection. Moreover, before beginning the interviews, participants were informed that their participation was voluntary and that they could skip some of the interview items or leave the interview or study. This paper uses pseudonyms to ensure anonymity in cases with DSH.

Results

The analysis derived four themes: the family's aftercare role, family accusations and reduced conversation, recalling unpleasant memories, and the withdrawal of family support. These themes have been developed based on the perspectives of affected young people and their families.

'I was always alert about her'; Family's aftercare role

In addition to providing basic welfare, many families have made efforts to avoid the loneliness and isolation of the young person who has engaged in DSH after returning from the hospital. Further, the family was vigilant about possible repeat risk behaviors immediately after coming from the hospital. For instance, Chamali's husband stated, "*I did not go to work for a few days and stayed with her.*" Nethramali said, "*My mother did not go anywhere after that, leaving me alone at home. My mother asked my sister to sleep in my room.*" Chamila stated, "*They always watched me because they feared I would do something again*."

Six families have altered the environment as an alternative method to avoid unwanted memories and possible shame reactions. Jagath stated, "*My mother changed my room because my previous room was near the kitchen. Otherwise, I would have heard what the neighboring females discussed about this incident with my mother when they visited us.*" Similarly, Dishna's family supported her in finding a rented place to avoid possible negative responses from society and negative memories attached to her home because she treated her boyfriend when he was ill, keeping him at her home before the relationship broke. She stated, "*They* [brother and sister-in-law] *helped me find an apartment in town; staying home in the village means I must always stay with the pain*." Further, Jagath's parents have brought him to visit relatives in faraway places as a method of helping him forget the painful memories, and refreshing his social relationships. Jagath's mother said, "*To change his mind, we went with Jagath to visit some of our relatives in faraway places. […] My brother has similar-age boys. Staying with them will help Jagath to forget about the incident a little.*"

We found four families that have attempted to manage negative family responses. Coming to a mutual agreement among family members to stop discussing the incident at home has been one method of avoiding negative family responses. The other method was the involvement of a senior member to control the rest of the family members' negative responses. "*I asked my mother and sister not to ask about the incident again and again. Please help him to forget the incident and look at the problem from his side. We agreed not to discuss this incident at home*," said Nimesh's elder sister. "*My sister managed everything at home,"* said Aravinda and Kasun.

Further, we identified five families that have performed local healing practices for the well-being of the young persons who have engaged in self-harm. Conceptualizing the self-harm act from supernatural and spiritual points of view, families have checked the horoscopes of the person involved in DSH and performed rituals such as bodhi pooja, *thovil* [a ritualistic treatment for demonic possession], charms, and wearing amulets for their well-being. Prasad's wife said, "*We performed a Bali Thovil to stop his drunkenness and self-poisoning*."

Moreover, three families have expressed their support to the affected young person for their plans. Nimesh's sister said, "*Now, he says he is going abroad. I said, 'Yes, it is good. I will help*." Jagath's mother said, *"We advised him to do a vocational training course and find a job then, but he says he wants to go to Korea. We said, 'Yes, we will help as we can'. I, too, think he must leave here for some time to change his mind*." Jagath's mother's statement further describes that leaving the village would help him to get back to normal.

Family accusations and reduced conversation

Despite the family's caregiver role, over ten participants have experienced family blame, accusations, reduced conversation, some aggressive responses, and sometimes even beating. For example, Renuka said, "*My mother did not talk to me much after I came home."* Prasad noted, "*Nalani* [wife] *did not talk to me in those days. Even my kids did not come to me."* Priyangi said, "*My mother did not talk to me nicely for maybe up to two months since I came from the hospital."* Another woman said, "*My brother behaved like an evil creature. Blamed me and one day beat me."*

We found a few reasons why the family has responded accusingly. The major underlying factor is shame and dishonor brought about by the DSH of the young family member. For instance, Nimesh's sister said, "*We were so ashamed after this incident. I did not go for teaching around one week. My mother also did not leave home."* Jagath's mother expressed, "*I could not tolerate this. I felt it would be good if I died before him. It was painful and shameful to that extent."*

Young women who have engaged in self-harm due to the distress caused by their sexual misbehaviors received more negative responses than young males as such behaviors are socially and culturally unaccepted, bringing enormous shame and dishonor to the person engaged as well as the family. The following are sample extracts by family members on how they responded to girls' DSH due to sexual misbehaviors. Renuka's mother said, "*She had no other option other than dying after doing these types of disgraceful things*." Iresha's mother said, "*Who can erase the black mark? This is a disgrace to everyone*." Nethramali's mother said, "*She disgraced all of us. I felt her father would drink poison. He was that upset."*

In these three incidents, Renuka and Netramali engaged in DSH due to problems related to unwanted pregnancies. At the same time, Iresha did so due to a premarital sexual relationship with her boyfriend. However, except for the use of "*it was shame*" or "*it was shameful*," we did

not find the expressions that included the words *disgrace* or *disgraceful* by family members in the interview transcripts related to the young male's DSH.

We noticed that the participants from families with government teachers, business backgrounds, and relatively prestigious family backgrounds received more negative responses. "*Now village people tell us 'Panadol house* (local name of Paracetamol)*.' How can we tolerate this type of insult? We were a respectable family in this village,"* said Priyangi's mother, who came from a business background and a prestigious family. Kasun also engaged in self-harm after ending his love affair. Kasun's sister said, "*My elder brother was unhappy about the incident because he is a teacher. Some other teachers had asked about this incident, and he was ashamed."*

Further, family members see the participants' self-harm acts as irresponsible behavior or a method of escaping problems without a sense of social responsibility. Chamali said, "*They* [husband and mother] *asked what would have happened to the children if I died."* Anil said, "*Everybody blamed me. Why didn't you think about children, at least?"* Gihan's wife said, "*He could have thought about our daughter before doing this."*

Another reason the family has negatively responded to the participants is because the parents feel that they have been a bad example to the younger counterparts of the family. Parents fear that their younger counterparts will imitate the self-harming acts of their elder counterparts. Therefore, the person engaged in DSH will likely be considered a person who sets a bad example in the family. Priyangi said, "*My mother advised my younger sister and younger brother not to even think about following the elder sister's path*." Nethramali said, "*My mother told my sister one day, do not accept your sister's advice. I felt so sad, but I was helpless at that time."*

These two extracts reveal that Priyangi and Netramali have experienced a sense of exclusion from love and care within their family, especially from their mother.

Recalling the unpleasant memories

We found that almost all the interview transcripts highlighted that the participants dealt with feelings of shame, upset, and guilt about their self-ham behavior except in very few incidents. Their concern was that the family members were ashamed in the community because of the incident. For example, Nimesh said, "*Now I am sad about what I did. I felt that my mother and sisters were so ashamed because of me."* Prasad said, "*I feel guilty now because everyone at my home was ashamed after this incident*." Kasun mentioned that they were all ashamed because of this incident. I worry about it. Gihan said, "*They couldn't face society because of me*." Similar data segments were found in 16 of 20 incidents, indicating that they worry about their act and that it is an unpleasant memory.

However, the participants described that among the family's negative responses, reintroducing the unpleasant memory occurs intentionally or unintentionally in the relationship context of the family. In five incidents, we found that family members had recalled unpleasant memories when some relationship-level conflicts or disagreements happened among family members. For example, Renuka stated, "*Even for smaller matters, she* [her mother] *reminds me of that incident. Then I worry about saving my life. My elder sister advised my mother not to do so, and then she quarreled with my sister."* Prasad said, "*When they always recall the same thing and blame me, I feel I should die or leave home*." Asha said, "*After coming from the hospital, every day, they blamed me, reminding me again and again. […] I keep dying and coming to*

life every day. I constantly felt guilty." Iresha stated, "*My father always quarreled with me, telling this story after drinking*." Priyangi mentioned, "*She passed hints. If I did something mistakenly, my mother blamed me, saying that the only thing that you know is how to die."*

According to these extracts, the participants are worried, disappointed, and upset when their family members recall unpleasant memories. Parents would recall the unpleasant memory just as a method to express their emotions and anger in argumentative relationships rather than a deliberate effort to put down the mental state of the young person. However, some young participants have reduced conversations with family members to avoid this type of negative response from the family. For example, Asha said, "*After school, I mostly use the phone and stay in my room."* Iresha stated, "*After that, I did not talk to my brother*." Priyangi said, "*At last, I eloped with Ayya* [boyfriend]. *I did not like to stay at home anymore."*

Withdrawal of family support

Three participants described that family support would be reduced if the affected young person did not show behavioral improvement or change problematic behaviors that led to DSH. For example, Prasad engaged in self-poisoning four times during the last two years after drinking alcohol. He has realized that his problematic behavior has created an unhealthy family environment. He said, "*I know that my drinking is the cause of everything. Another thing, since I drank vaha* [poison] *four times, it has become a shameful thing for my family. That may be a reason why they don't like me now."*

Prasad demonstrated a few problematic behaviors, including heavy drinking, beating his wife, and repeating self-poisoning. Due to these problematic behaviors, his wife, parents, and even children are disappointed and unhappy and show a distant attachment to him. For example, his wife mentioned,

> *[…] He never changes his uncivilized mannerisms. How do we face society now that children are grown? They can't face society. This is the karumaya* [karma] *that we all have done in our previous lives. After the first time of self-poisoning, we all helped him to recover. I excused him. But now it is like a habitual thing. I tolerate everything because of my children. Otherwise, I feel like dying before him. My parents asked me to divorce him.*

In another place of the interview, his wife said, "*Last time, his mother asked others not to bring him to the hospital and let him die."* These chunks of data indicate that the family members helped and excused Prasad after his first incident. However, gradually, they reduced support due to the continuation of his problematic behaviors.

In the study sample, Bandara also received little family support during his crisis due to his problematic connections with a few other women, putting his legally married wife under stress. Finally, his wife left him. In his incident, only his mother supported him after he came from the hospital. Nonetheless, she is also not happy with Bandara's behavior. Five months later from the first occurrence, Bandara had tried to die by hanging. Luckily, his mother rushed and protected his life without injury. She said,

> *[…] I do not say he is correct, though he is my son. […] I was not going to tell him anything after he came from the hospital. It is useless to tell*

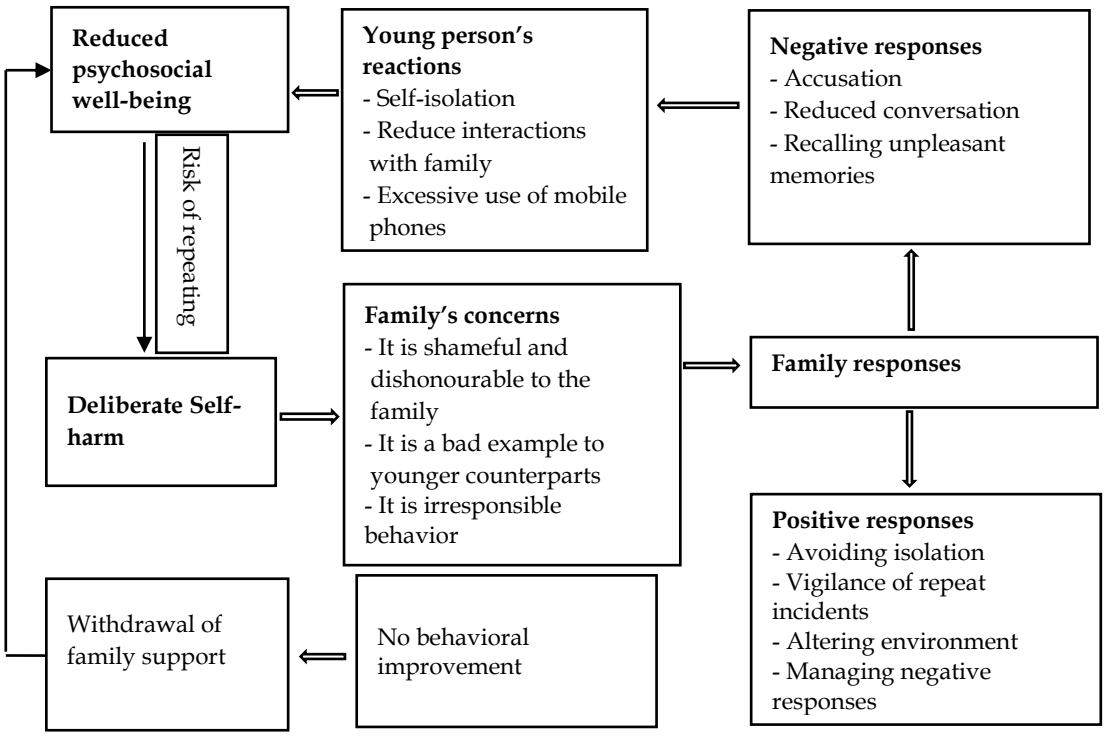
> *him. I advised him previously and tried to change him. However, he did not accept anything that I said. He still maintains those connections. Now, I am not going to be involved in his things. I cannot allow him to die as a mother. Therefore, I tolerate and keep silent.*

As this extract demonstrates, Bandara's problematic relationship with other women has been the underlying factor that caused him to receive little support from the family. His mother says she supports him; being the mother, she cannot morally allow him to die, but she is not happy with Bandara's behavior.

Discussion and conclusion

This study explored how the immediate family responds to youth who have engaged in DSH through data gathered from youth who have engaged in DSH and their family members. Four major themes emerged from data analysis that answered the research question: (1) family's aftercare role, (2) family accusation and reduced conversation, (3) recalling unpleasant memories, and (4) withdrawal of family support. In the following, the findings are discussed according to these four themes. Figure 1 illustrates the process of family responses to the young person who self-harm and their impacts.

Figure 1: Thematic Map of Self-Harm and Family Responses



Accordingly, the immediate family played a vital aftercare role in ensuring the psychosocial well-being of young people engaged in DSH. The study participants have encountered both negative and positive family responses. Among positive responses, avoiding isolation, being alerted to avoid another risk, altering the environment, managing negative responses, performing local healing practices, and supporting their plans were highlighted. Indeed, these

positive responses by the family would create a sense of belongingness, care, and love in the young person, which is an essential psychological resource in returning to effective social functioning following a DSH act. However, the family would not further support or withdraw support if the young person does not show a progressive change of maladaptive, problematic, or unacceptable behaviors during the post-discharge period, affecting the psychosocial well-being of the person, which may lead to repeat DSH.

However, except in a few occurrences, we found that there is no peaceful and effective family environment for the affected young person to return to normalcy in the post-discharge period due to the negative responses by the family. Buckmaster et al. (2021) found that family members experience an inner struggle resulting in instinctive anger towards the affected person instead of love, support, and care roles. Nevertheless, they have not described why the family demonstrates instinctive reactions. Our interviews describe that the family's negative responses are likely to be developed by three major concerns of the family members. Firstly, it is considered shameful and dishonorable to the family. Secondly, parents believe that young people who engage in DSH set a bad example to their younger counterparts. Thirdly, it is regarded as 'irresponsible behavior' because they have engaged in a self-harm act without considering their family and social responsibilities as a method of merely escaping from immediate problems. Among negative responses, many participants have experienced family accusations, blame, reduced speech, sometimes beating, and recalling unpleasant memories on certain occasions. These negative responses may aggravate the young persons' self-isolation, deteriorate relationships with family members, and lead to excessive use of mobile phones, reducing the psychosocial well-being of the person. Eventually, it would increase the risk of repeat DSH.

Some scholars pointed out that though suicide and self-harm behaviors are predominantly conceptualized as psychiatric problems in the West, in Sri Lanka, the contribution of psychiatric factors in suicide and DSH is not significant compared to situational factors. In this regard, suicidal and DSH behaviors are seen as extreme responses and problem-solving methods related to everyday social and interpersonal discourses such as family disputes, domestic violence, poverty, social disarticulation, gender role, alcohol abuse, love, sex, virginity, pregnancy, etc. (Marecek & Senadheera, 2012; 2023; Widger, 2015). Our study findings also align with this argument because we found only three participants who have engaged in DSH with borderline mental problems. In contrast, intimacy problems were involved in 12 out of 20 incidents. Therefore, issues relating to partner relationships seem to be prominent stress factors in youth DSH behavior in the study sample.

Concerning family responses, Ferrey et al. (2019b) found that parents' responses after a young person's self-harm are shaped by three factors associated with how parents conceptualize the young person's self-harm act: as a mental health issue, a problem of adolescence, and naughty behavior. However, in the local context, our findings stress that the family responses towards young self-harming persons are widely influenced by embodied sociocultural meanings and interpretations of causes of DSH. As Ferrey et al. (2019b) pointed out, parents' conceptualization of self-harm as a mental problem or as a problem of adolescence may not be highly applicable to our study sample as our study sample was not limited to adolescents and self-harmed persons with mental issues. Our findings suggest that sociocultural stressors have contributed to DSH among the participants than mental problems. Thus, socially unjustifiable and unacceptable causes have brought more negative family responses than justifiable and tolerable reasons. For instance, we found that the young persons who have engaged in DSH due to exam distress and mental problems have received fewer negative family responses than people who had issues with sexual misbehaviors and unwanted

pregnancies. Further, the family's educational and social status are also likely to be critical factors that influence the family's responses.

Marecek and Senadheera (2023) found that young girls receive negative family responses, including blame and beating after a DSH act, due to the value attribution of *læjja-baya* [shame and fear] in the local cultural context. The term *læjja-baya* is a social expectation that encompasses 'ideas about honor, status, loss of self-esteem, ridicule, vulnerability to slights, deference [and] prestige' (Obeyesekere, 1984, p. 79). Therefore, in Sri Lankan society, especially in the Sinhala-Buddhist community, men and women are subjected to demonstrate a good, decent, and respectable public life. However, it has a gendered entitlement as well. For women, *læjja-baya* entails a value of modesty and a sexually controlled life. It is a way of regulating women's behavior (Abeyasekera, 2019). Similar to Marecek and Senadheera (2023), our study findings reveal that young women receive negative responses from their families since young girls' DSH behaviors are mainly due to family conflicts regarding feminine propriety and sexual respectability in the cultural context.

This CGT exploration of perspectives of affected young people and their families brings new theoretical insights to the phenomenon of DSH in the local culture. Most existing studies have popularly investigated the perspectives of young people after SDH to identify the risk factors. In contrast, limited studies have focused on the perspectives of affected young people and their families (Marecek & Sendheera, 2023), but why the family negatively responds is little known in the relevant literature domain. According to this study, family members' perspectives highlighted that the codes, including shame and stigma, dishonor caused to the family, being irresponsible, and setting a bad example to the younger counterparts, generate the family's adverse reactions. Buckmaster et al. (2021) revealed that though parents demonstrate instinctive reactions of anger towards the affected adult initially, with time, a growing understanding, love, and empathy develop in family members and support the loved one to overcome the crisis. Our participants also revealed that family members returned to normalcy after some time of the occurrence, though they initially responded emotionally and aggressively. However, in some incidents, data gathered from family members revealed that there is a risk of withdrawal of family support during the post-discharge period if the affected person does not show a positive change in their problematic behavior, increasing the psychosocial vulnerability of the affected young person, perhaps reoccurrence of DSH.

The theme of withdrawal of family support derived from this study seems to be a novel theoretical contribution to the existing qualitative research on the phenomenon. Also, the theme of recalling unpleasant memories, generated from both affected and family members' perspectives, provides a new lens through which to theorize the family reactions after the DSH of the young family member in the local culture. Especially data received from both family and affected youth revealed that recalling unpleasant memories by family creates an unfavorable environment for young women to interact with family in the post-discharge period due to the involvement of feminine and sexual properties in DSH. A sizable number of previous studies have discussed the participation of sexual misbehaviors and feminine values in suicide and DSH in the local culture (Abeyasekera, 2019; Hewamanne, 2010; Marecek & Senadheera, 2023; Widger, 2014). However, family reaction to young women after a DSH is a relatively untouched topic. Thus, the theme of recalling unpleasant memories that occur in argumentative situations in family relationships adds a new gender dimension to the phenomenon for future research.

Though the family plays an essential aftercare role, the study findings imply that negative responses of the family challenge the psychosocial well-being of affected young people. Thus,

aftercare plans must be developed focusing on both young people who self-harm and their family members concerning gender dynamics. In this effort, social workers and social service providers can actively participate with relevant stakeholders in developing postvention plans for persons who engage in DSH and their families. As such, enhancing the family's psychoeducation, helping the self-harmed person to change their problematic behaviors, and developing healthy relationships are essential in preventing future self-harm in the recovery process. Further, suicide and self-harm survivors often receive adverse reactions from others, such as social avoidance, lack of social support, stigma, and shame, creating a stressful social environment during the bereavement period (Andriessen et al., 2015; Logan et al., 2018). According to our findings, the family's negative responses mainly derive from the social shame, stigma, and adverse reactions of neighbors and the community. Therefore, the social workers' role is vital in providing service for both young persons who have engaged in DSH and their families to overcome these adverse social reactions in the aftermath of self-harm.

We identified two limitations of the study. First, since we used pre-existing social contacts to identify the study participants, the inclusion of the cultural and ecological diversity of the study sample needed to be improved. However, Sri Lanka is predominantly a multiethnic and multi-religious society. Most participants hailed from Sinhala Buddhist communities and a few ecological areas. The second limitation was that most family members who participated in the interviews were females, primarily mothers, as the family member for interviewing was introduced by the participant who engaged in DSH. Thus, the study sample's representation of male family members was limited. Therefore, future studies must consider these limitations and follow a more inclusive cultural and ecological procedure when researching this topic.

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References

Abeyasekera, A. L. (2019). Embodied shame and gendered demeanours in young women in Sri Lanka. *Feminism & Psychology, 29*(2), 157–176. https://doi.org/10.1177/0959353518803976

Andriessen, K., Draper, B., Dudley, M., & Mitchell, P. B. (2015). Bereavement after suicide: Disentangling clues to better help bereaved adolescents [Editorial]. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 36*(5), 299–303. https://doi.org/10.1027/0227-5910/a000339

Beautrais, A. L., Wells, J. E., McGee, M. A., & Oakley Browne, M. A. (2006). Suicidal behaviour in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry, 40*(10), 896–904. https://doi.org/10.1080/j.1440-1614.2006.01909.x

Brent, D. A., McMakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. (2013). Protecting adolescents from self-harm: A critical review of intervention studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*(12), 1260-1271. https://doi.org/10.1016/j.jaac.2013.09.009

Buckmaster, R., Guerin, S., O'Leary, T., & McNulty, M. (2021). Exploration of family dynamics in adults who self-harm: A multi-perspective approach. *Journal of Family Therapy, 43*(4), 665-686. https://doi.org/10.1111/1467-6427.12314

Byrne, S., Morgan, S., Fitzpatrick, C., Boylan, C., Crowley, S., Gahan, H., Howley, J., Staunton, D., & Guerin, S. (2008). Deliberate self-harm in children and adolescents: A qualitative study

exploring the needs of parents and carers. *Clinical Child Psychology and Psychiatry, 13*, 493–504. https://doi.org/10.1177/1359104508096

Carmichael, T., & Cunningham, N. (2017). Theoretical data collection and data analysis with gerunds in a constructivist grounded theory study. *Electronic Journal of Business Research Methods, 15*(2), 59–73. https://academic-publishing.org/index.php/ejbrm/article/view/1357

Charmaz, K. (2008). Constructionism and grounded theory. In J. A. Holstein & J. F. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 397–412). The Guilford Press.

Charmaz, K. (2014). Constructing grounded theory. In R. Barbour (Ed.), *Introducing qualitative methods* (2nd ed.). SAGE Publications Inc.

De Leo, D., Burgis, S., Bertolote, J. M., Kerkhof, A. J. F. M., & Bille-Brahe, U. (2006). Definitions of suicidal behavior: Lessons learned from the WHO/EURO Multicentre Study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 27*(1), 4–15. https://doi.org/10.1027/0227-5910.27.1.4

De Silva, V. A., Senanayake, S. M., Dias, P., & Hanwella, R. (2012). From pesticides to medicinal drugs: Time series analyses of methods of self-harm in Sri Lanka. *Bulletin of the World Health Organization, 90*(1), 40–46. https://www.scielosp.org/pdf/bwho/2012.v90n1/40-46/en

Ferrey, A. E., Hughes, N. D., Simkin, S., Locock, L., Stewart, A., Kapur, N., Gunnell, D., & Hawton, K. (2016a). Changes in parenting strategies after a young person's self-harm: A qualitative study. *Child and Adolescent Psychiatry and Mental Health, 10*, Article 20. https://doi.org/10.1186/s13034-016-0110-y

Ferrey, A. E., Hughes, N. D., Simkin, S., Locock, L., Stewart, A., Kapur, N., Gunnell, D., & Hawton, K. (2016b). The impact of self-harm by young people on parents and families: A qualitative study. *BMJ Open, 6*, Article e009631. https://doi.org/10.1136/bmjopen-2015-009631

Gould, M., Shaffer, D., & Greenberg, T. (2003). The epidemiology of youth suicide. In R. King & A. Apter (Eds.), *Suicide in Children and Adolescents* (Cambridge Child and Adolescent Psychiatry, pp. 1–40). Cambridge University Press.

Gouveia-Pereira, M., Abreu, S., & Martins, S. (2014). How do families of adolescents with suicidal ideation behave? *Developmental Psychology, 27*(1), 171–178. https://doi.org/10.1590/S0102-79722014000100019

Hewamanne, S. (2010). Suicide narratives and in-between identities among Sri Lanka's factory workers. *Ethnology, 49*(1), 1–22. https://ethnology.pitt.edu/ojs/Ethnology/article/view/6075

King, C. A., & Merchant, C. R. (2012). Social and interpersonal factors relating to adolescent suicidality: A review of the literature. *Archives of Suicide Research, 12*(2), 181–196. https://doi.org/10.1080/13811110802101203

Knipe, D. W., Bandara, P., Senarathna, L., Kidger, J., López-López, J., & Rajapakse, T. (2019). Childhood adversity and deliberate self-poisoning in Sri Lanka: A protocol for a hospital-based case-control study. *BMJ Open, 9*(8), Article e027766. https://doi.org/10.1136/bmjopen-2018-027766

Knipe, D. W., Gunnell, D., Pearson, M., Jayamanne, S., Pieris, R., Priyadarshana, C., Weerasinghe, M., Hawton, K., Konradsen, F., Eddleston, M., & Metcalfe, C. (2018). Attempted suicide in Sri Lanka: An epidemiological study of household and community factors. *Journal of Affective Disorders, 232*, 177–184. https://doi.org/10.1016/j.jad.2018.01.028

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *Lancet, 360*(9339), 1083–1088. https://doi.org/10.1016/S0140-6736(02)11133-0

Lindgren, B.-M., Åström, S., & Graneheim, U. H. (2010). Held to ransom: Parents of self-harming adults describe their lived experience of professional care and caregivers. *International Journal of Qualitative Studies on Health and Well-Being, 5*(3), Article 5482. https://doi.org/10.3402/qhw.v5i3.5482

Logan, E. L., Thornton, J. A., & Breen, L. J. (2018). What determines supportive behaviors following bereavement? A systematic review and call to action. *Death Studies, 42*(2), 104–114. https://doi.org/10.1080/07481187.2017.1329760

Marecek, J., & Senadheera, C. (2012). 'I drank it to put an end to me': Narrating girls' suicide and self-harm in Sri Lanka. *Contributions to Indian Sociology, 46*(1–2), 53–82. https://doi.org/10.1177/006996671104600204

Marecek, J., & Senadheera, C. (2023). Gendered antecedents and consequences of young women's suicidal acts in Sri Lanka. *International Journal of Environmental Research and Public Health, 20*(4), Article 2885. https://doi.org/10.3390/ijerph20042885

McKinnon, B., Gariépy, G., Sentenac, M., & Elgar, F. J. (2016). Adolescent suicidal behaviours in 32 low- and middle-income countries. *Bulletin of the World Health Organization, 94*(5), 340–350. https://doi.org/10.2471/BLT.15.163295

Michelson, D., & Bhugra, D. (2012). Family environment, expressed emotion, and adolescent self-harm: A review of conceptual, empirical, cross-cultural, and clinical perspectives. *International Review of Psychiatry, 24*(2), 106–114. https://doi.org/10.3109/09540261.2012.657613

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent nonsuicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10), Article 10. https://doi.org/10.1186/1753-2000-6-10

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiological Review, 30*, 133–154. https://doi.org/10.1093/epirev/mxn002

Obeyesekere, G. (1984). *The cult of the goddess Pattini*. The University of Chicago Press.

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry, 168*, 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Pushpakumara, P. H. G. J., Thennakoon, S. U. B., Rajapakse, T. N., Abeysinghe, R., & Dawson, A. H. (2018). A prospective study of repetition of self-harm following deliberate self-poisoning in rural Sri Lanka. *PLOS ONE, 12*, Article e0199486. https://doi.org/10.1371/journal.pone.0199486

Rajapakse, T., Griffiths, K. M., Christensen, H., & Cotton, S. A. (2014). Comparison of non-fatal self-poisoning among males and females in Sri Lanka. *BMC Psychiatry, 14*, Article 221. https://doi.org/10.1186/s12888-014-0221-z

Rajapakse, T. N., & Tennakoon, S. U. B. (2016). Gender differences in suicide in Sri Lanka – What does it tell us? *Ceylon Medical Journal, 61*, 139–141. https://doi.org/10.4038/cmj.v61i4.8377

Sørensen, J. B., Agampodi, T., Sørensen, B. R., Siribaddana, S., Konradsen, F., & Rheinländer, T. (2017). 'We lost because of his drunkenness': The social processes linking alcohol use to self-harm in the context of daily life stress in marriages and intimate relationships in rural Sri Lanka. *BMJ Global Health, 2*(4), Article e000462. https://doi.org/10.1136/bmjgh-2017-000462

Sørensen, J. B., Pearson, M., Andersen, M. W., Weerasinghe, M., Rathnaweera, M., Rathnapala, D. G. C., Eddleston, M., & Konradsen, F. (2019). Self-harm and suicide coverage in Sri Lankan newspapers: An analysis of the compliance with recommended guidelines. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 40*(1), 54–61. https://doi.org/10.1027/0227-5910/a000534

Sri Lanka Medical Association (SLMA). (2019, December). *Suicide prevention in Sri Lanka: Recommendations for action*. https://slma.lk/wp-content/uploads/2020/10/Suicide-Prevention-in-Sri-Lanka-Recommendations-for-Action-final.pdf

Standley, J. C. (2020). Expanding our paradigms: Intersectional and socioecological approaches to suicide prevention. *Death Studies, 46*(1), 224–232. https://doi.org/10.1080/07481187.2020.1725934

Sweeney, M. M. (2007). Stepfather families and the emotional well-being of adolescents. *Journal of Health and Social Behavior*, *48*(1), 33–49. https://doi.org/10.1177/002214650704800103

Wagner, B. M. (2009). *Suicidal behavior in children and adolescents*. Yale University Press.

Wagner, B. M., Aiken, C., Mullaley, P. M., & Tobin, J. J. (2000). Parents' reactions to adolescents' suicide attempts. *Journal of the American Academy of Child and Adolescent Psychiatry*, *39*(4), 429–436. https://doi.org/10.1097/00004583-200004000-00011

Whittall, J., Sumner, A., Ravindran, A. V., Rodrigo, A., & Walker, Z. J. (2018). Evaluating sociodemographic and psychiatric contributors to suicide in Sri Lanka: An ecological survey. *International Journal of Noncommunicable Diseases, 3*(2), 49–55. https://www.ijncd.org/text.asp?2018/3/2/49/235212

Widger, T. (2014, May 28). Suicide in Sri Lanka: Understanding the crisis. *Forum for Suicide and Culture Research.* https://suicideandculture.wordpress.com/2014/05/28/suicide-in-sri-lanka-understanding-the-crisis/

Widger, T. (2015). *Suicide in Sri Lanka: The anthropology of an epidemic.* Routledge.

World Health Organization. (2014). *Preventing suicide: A global imperative.* https://iris.who.int/handle/10665/131056

World Health Organization. (2019). *Suicide in the world: The global health estimates.* https://apps.who.int/iris/bitstream/handle/10665/326948/WHO-MSD-MER-19.3-eng.pdf

World Health Organization. (2021, July 16). *Suicide rate estimates, crude, 15–19 years: Estimates by country [Data set].* https://apps.who.int/gho/data/node.main.MHSUICIDE1519?lang=en

Xing, X.-Y., Tao, F.-B., Wan, Y.-H., Xing, C., Qi, X.-Y., Hao, J.-H., Su, P.-Y., Pan, H.-F., & Huang, L. (2010). Family factors associated with suicide attempts among Chinese adolescent students: A national cross-sectional survey. *Journal of Adolescent Health, 46*(6), 592–599. https://doi.org/10.1016/j.jadohealth.2009.12.006

Zaborskis, A., Sirvyte, D., & Zemaitiene, N. (2016). Prevalence and familial predictors of suicidal behaviour among adolescents in Lithuania: A cross-sectional survey 2014. *BMC Public Health, 16*(554), Article 554. https://doi.org/10.1186/s12889-016-3211-x