

Parasuicide at Ga Rankuwa Hospital

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Curriculum vitae

Dave Peiser was born in Pretoria, schooled at WHPS and St Alban's College and obtained the MB ChB from the University of Pretoria in 1983. After a year as houseman at Ga Rankuwa Hospital, he spent 2 years in the Department of Family Medicine (Medunsa) and is at present a medical officer in surgery (Ga Rankuwa). Dave is married to Leslie and they have two children. They plan to go to Manguzi Hospital in Kwa Zulu next year.

KEYWORDS: Suicide, attempted; Age factors; Sex ratio; Seasons

Summary

All patients presenting at the Emergency Unit at Ga Rankuwa Hospital over a period of one year with a history of self-injury or self-poisoning were studied. Daily and monthly variations are given, age and sex distribution as well as methods used and reasons given for the suicide attempts are shown and discussed.

Parasuicide can be defined as "acts which resemble suicidal acts where the person may or may not be attempting to kill himself"¹. Other authors such as Schlebusch feel that parasuicide differs from attempted suicide "in that the intent to die in parasuicide is far less and is more a plea for help than a real attempt on life"². For the purpose of this study the first definition will be used.

It is generally accepted that suicide and parasuicide is on the increase throughout the world, and in South Africa. "The national and international epidemic of parasuicide among adolescents seems to continue unabated"³. Much has been written about parasuicide throughout the world, but as far as I could ascertain nothing has been written specifically about black parasuicide in South Africa.

From the paucity of earlier articles a rise in suicide and parasuicide can be observed. In 1937 Laubscher wrote: "in an area containing a population of 869 944, according to the last census returns, there were 14 cases of suicide and 4 cases of attempted suicide during the last 2 years"⁴. In an article written by Walton in 1950, 252 cases of attempted suicide were described, of these only 2 were black.⁵ In his conclusion he wrote "The native rarely attempts suicide". In 1960 Klintworth published his findings of 141 suicide cases in the Johannesburg area, of these 32 were black⁶. In 1974 Studer and Kruger reported on black suicide rates between 1968-1973 in Pretoria; their findings revealed rather high figures (black males 22,2 per 100 000 compared to white males 20,4 per 100 000)⁷. Information from the Department of Statistics reveals an almost four-fold increase in reported suicide

S Afr Fam Pract 1987; 8: 250-3

cases between 1971 and 1981. Although these figures may be biased due to poor records and population census figures, it does show a significant rise in suicide and parasuicide cases among blacks.

It is the purpose of this study to demonstrate that parasuicide is a growing problem in the urban black.

Patients and methods

All patients presenting at the Emergency Unit at Ga Rankuwa Hospital (\pm 30 km north-west of Pretoria) over a period of 1 year (between 1.4.85 and 30.3.86) and who gave a history of deliberate self-injury or self-poisoning, were included in the study. A simple form was used which was filled in by the attending doctor or nurse. To ensure that all cases were identified, all the registers in the unit over the year were scrutinised and all files that were possibly positive, were drawn and studied. Over 100 files were drawn in this way and 14 proved positive and were included in the study. The form used included spaces for the date and time, name, patient number, sex, age, address, employment, ethnic group, reason for the attempt, the method used and how the patient was treated.

Results

Over a period of 12 months, 110 parasuicide patients were seen at an average of 9 per month; of these 65 (59%) were females.

The monthly variation can be seen in Table 1 and Graph A.

Table 1:

April 1985	7
May 1985	8
June 1985	10
July 1985	9
August 1985	10
September 1985	7
October 1985	9
November 1985	9
December 1985	12
January 1986	3
February 1986	14
March 1986	10

Graph A:

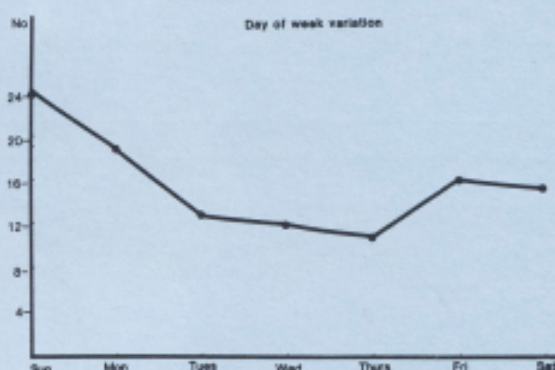


The daily variation is indicated in Table 2 and Graph B.

Table 2:

Sunday	24
Monday	19
Tuesday	13
Wednesday	12
Thursday	11
Friday	16
Saturday	15

Graph B

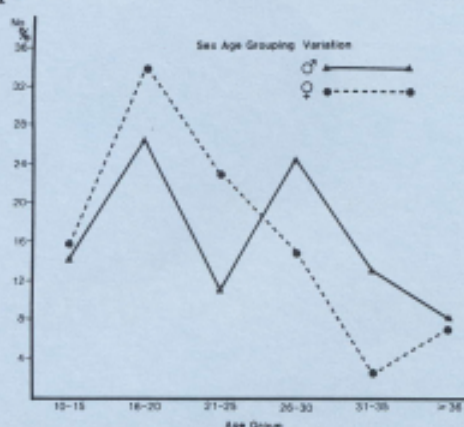


The age distribution was between 11 and 51 years with an average of 23,4 years. Average age of females was 22,3 and that of males 24,7.

Table 3:

Age Groups	Total	Females	Males
10-15 years	16 (14,5%)	9 (13,8%)	7 (15,5%)
16-20 years	34 (30,9%)	22 (33,8%)	12 (26,7%)
21-25 years	20 (18,2%)	15 (23,0%)	5 (11,1%)
26-30 years	21 (19,1%)	10 (15,3%)	11 (24,4%)
31-35 years	8 (7,2%)	2 (3,0%)	6 (13,3%)
> 36 years	9 (8,2%)	5 (7,7%)	4 (8,9%)

Graph C:



As can be expected by the area studied, the majority were Tswana-speaking and came from Soshanguve and Ga Rankuwa (two nearby townships).

Of the patients 39,1% were either scholars or students and 32,7% were unemployed.

Various methods were used in the suicide attempts and these are tabulated in Table 4.

Table 4

Methods	No. %	Ratio Female : Male
1. Various medicines	20 18,2	17 : 3
2. Jik, Javel, Bleach	18 16,4	13 : 5
3. Spirits (Benzine, etc)	12 10,9	2 : 1
4. Agricultural poisons	10 9,1	3 : 2
5. Glass	8 7,3	3 : 5
6. Acid	6 5,4	1 : 1
7. Attempted hanging	6 5,4	1 : 2
8. Rattex	6 5,4	1 : 1
9. Dettol	4 3,6	3 : 1
10. Glue	3 2,7	1 : 2
11. Disembowelment	3 2,7	All males
12. Various	3 2,7	2 : 1
13. Slit throat	1 0,9	Male
14. Unknown	10 9,1	2 : 3

The reasons given for the suicide attempts are listed below in Table 5.

Table 5: Reasons given in percentage:

1. Parent-child conflicts	29,1%
2. Husband-wife conflicts	20,0%
3. Boyfriend/girlfriend conflicts	10,0%
4. Work or school problems	10,0%
5. Conflicts with siblings	8,2%
6. Psychiatric or emotional disturbances	8,2%
7. Sickness	1,8%
8. Unknown	12,7%

Of the 110 patients seen 61% were admitted directly to a surgical, medical or psychiatric ward for further management.

Discussion

When one considers that 46 030 patients were seen at the Emergency Unit over the period of study, the number of parasuicide patients is small. However, I believe that this figure is the tip of the iceberg, as many parasuicide patients are probably seen at peripheral clinics, by general practitioners or are referred directly to psychiatry. It must also be noted that this study was conducted in a busy emergency unit where several cases could have been missed in comatose patients, or due to inaccuracies in the history given.

No significant variation can be seen in the monthly figures (Graph A and Table 1) in spite of tremendous socio-political changes in the country over this period. This is in agreement with the findings of Klintworth in 1960⁶. Other papers have indicated a rise in early spring and summer³. The usual drop in January cannot be explained.

The daily variation (Graph B and Table 2) shows a slight increase over weekends (especially Sundays). This could most likely be explained by an increase in personal contrast at home and increased leisure time.

... an almost four-fold increase in reported suicide cases between 1971-1981

The age/sex distribution (Graph C and Table 3) shows a predominance of young females which is most often reported in other parasuicide studies⁵.

The highest age percentage for both males and females is between 16-20, which is slightly lower than that reported among white parasuicide patients by Schlebusch⁸. Males show a small peak at the age grouping between 26-30.

There were few cases above 31, which once again shows that parasuicide is mainly seen amongst the young.

The high percentage (71,1%) of self-poisoning reflects availability (household chemicals and drugs) rather than specific choice. This is further illustrated by the fact that 87,7% of female attempts were self-poisonings. As can be seen in Table 4 males use more violent or aggressive methods in comparison to females. The percentage of toxic substance ingestion is slightly lower than that reported among Indians by Edwards et al⁹ which was 95% and Klintworth⁶ in Johannesburg, which was 82,6%.

It is difficult to assess the relevance of the reasons given, as these were given in a busy emergency unit

GPs need to recognise the early signs of the parasuicide patient and learn how to approach them

with very little privacy immediately after the attempt. The reasons given, therefore, may be superficial reasons, or rather the final straw that precipitated the event. In spite of this, however, the reasons given in Table 5 are very similar as those found in other studies. It is mainly interpersonal conflicts that are given as a reason for the attempt.

The fact that 39% of the patients were discharged immediately from the unit back to the environment which precipitated the crisis, without adequate counselling and intervention, reflects the inability of a modern overcrowded hospital to deal with an escalating problem in the Black society.

Conclusion

In conclusion this study demonstrates once again that it is most often a young female who, for interpersonal reasons, ingests toxic substances or drugs in an attempt to manipulate or draw attention to her interpersonal problems.

In spite of modern, well-equipped training hospitals and the emergence of crisis clinics, the burden of this ever-increasing problem will be borne by the primary care physician. His unique position and relationship with the family unit, creates the ideal setting for early detection and prevention as well as the continued management of the patient.

It is imperative, therefore, for those of us who are involved in Primary Health Care, to become fully

conversant with the early recognition and management of the parasuicide patient^{6, 8, 10}.

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