

THE EPIDEMIOLOGY OF PARASUICIDE
AT RK KHAN HOSPITAL

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SUMMARY

It was suspected that about 2 cases of parasuicide were admitted daily to RK Khan Hospital and this suspicion was confirmed by this study. Most of the cases were female, and in the 15 - 24 year age group. Patients were admitted mainly in the evenings and on Sundays. The majority earned less than R500 per month and were mainly manual-skilled and semi-skilled workers predominantly from Chatsworth.

Non-violent means were the common mode of parasuicide, the causes being family, marital and romantic problems. The hospital social worker dealt with the cases and referred patients to relevant organisations outside the hospital for management. Certain patients were referred to the Psychiatric Outpatient Clinic at the Hospital as there was no resident psychiatrist.

INTRODUCTION

The epidemiology of parasuicide cases presenting at RK Khan Hospital was examined in response to a request from the RK Khan Hospital Advisory Board, (1,2) in Chatsworth, Durban to the Department of Community Health, Faculty of Medicine, University of Natal in Durban.

There were two parasuicides per day in Chatsworth and this was alarming to the local community and medical personnel in Chatsworth (3) necessitating a study to be undertaken.

Bhana, (8) however, stated in 1981 that not much was known about the occurrence of parasuicides amongst Indian South Africans although the occurrence of suicides was known and that little work was performed in investigating Indian parasuicides in South Africa. Minnaar et al (6) indicated in 1980 that parasuicide was a public health responsibility.

Studies on parasuicide were conducted by the Department of Psychiatry of the University of Natal at the other two large hospitals in Durban, namely at King Edward VIII Hospital during 1978 to 1980 (4, 37) and at Addington Hospital during 1978 (5,6).

At RK Khan Hospital studies on parasuicide among Indian females admitted to RK Khan Hospital in 1981 were undertaken by the Department of Psychology of the University of Durban-Westville (8) and among scholars admitted to RK Khan Hospital in 1983 by the Faculty of Health Services of the University of Durban-Westville (7). However a complete comprehensive study was not undertaken at RK Khan Hospital and this study will complete a necessary sector requiring investigation of parasuicides in Durban.

OBJECTIVES OF THE STUDY

- 1 To determine the extent of the occurrence of parasuicide admissions to RK Khan Hospital.
- 2 To investigate the multiple epidemiological factors associated with the occurrence of parasuicide in respect of the person affected, the means used, and the social and cultural characteristics of the affected person's background.
- 3 To ascertain previous attempts at suicide and previous psychiatric care received.
- 4 To identify supportive services available in the community concerned and to ascertain the contribution made by these in respect of identified cases.
- 5 To determine multiple methods of interception of the various associated factors in respect of the reduction of the incidence of parasuicide.
- 6 To make recommendations in respect of (5) above.

DEFINITION OF CRITERIA

Suicide : Self inflicted violence with the apparent or stated intention to terminate the life of the person concerned.

Parasuicide : An unsuccessful attempt at suicide.

DATA SOURCES

- 1 RK Khan Hospital records from the Social Work Department, Medical Registry and Revenue and Statistics Section.
- 2 Annual Reports of welfare bodies operating in Chatsworth either voluntary or statutory organisations.
- 3 Annual Report of the Durban City Health Department and other records from the Durban City Health Department.
- 4 Unpublished works dealing with matters relevant to the study.
- 5 Theses of various researchers on relevant subjects.
- 6 Newspaper reports
- 7 Interviews with patients for the prospective study.
- 8 Literature review.

METHOD OF DATA COLLECTION

The study consisted of prospective and retrospective components.

Prospective Study : In the prospective sample all cases of parasuicide admitted from the 1 to 31 July 1984 to RK Khan Hospital were interviewed by the researcher and relevant information was recorded on the standardised questionnaire (Annexure B).

The ward sister in whose wards these cases were admitted filled in a notification form with the patient's name, ward, in-patient number, and the date and time of admission. These forms were then sent to a central point which was the duty matron's office from where the researcher obtained the notification.

Retrospective Study : All parasuicide cases admitted from the 1 January to 31 December 1983 were included in the retrospective sample. The cases were identified from the records of the Social Work Department at RK Khan Hospital. Relevant information was extracted on to the standardised check list (Annexure B). Further information was obtained from the Inpatient Hospital case notes from the Medical Registry. The revenue records were also examined.

Variables were eliminated by adhering to defined criteria and by the administration of the standardised questionnaire and check list by the researcher only.

Data was collated and analysed manually by the researcher.

RESULTS

Objective 1 : Of the total Durban Indian population of 417 254 (10), 545 cases (= 130 cases per 100 000 population) were parasuicides in 1983.

The total population of Chatsworth was 183 180 (9) in the 1980 census. There were 474 episodes of admission (250/100 000 population) in 1983.

There were 8 successful suicides at RK Khan Hospital in 1983 who were admitted as parasuicide due to drug overdose and then subsequently died in hospital. Four cases (50%) had ingested wintergreen; TCP in one case (12.5%); Codis in one case (12.5%); an unknown analgesic in one case (12.5%) and diabetic tablets in one case (12.5%) (Table 1). These 8 cases were not included in the sample of 648 cases for the retrospective study.

789 cases were admitted as drug overdoses and parasuicides to RK Khan Hospital in 1983. Of these 648 cases (82.1%) were due to parasuicides and 141 cases (17.9%) accidental overdoses of drugs. There were 54 parasuicides per month and 1.8 cases per day in 1983 (Table 2).

Total admissions to RK Khan Hospital in 1983 numbered 30 578 of which there were 648 cases (2.1%) of parasuicide.

Medical Inpatients numbered 6 119 of which 627 cases (10.3%) were due to parasuicide. The Surgical wards admitted 7 120 cases of which 21 cases (0.3%) were due to parasuicide (Table 3A).

In July 1984, of 587 Medical Inpatients, 62 cases (10.6%) were due to parasuicide. Total admissions were 2 738 cases of which 62 cases (2.2%) were parasuicides (Table 3B).

In 1983, 100 cases of parasuicides were admitted to King Edward VIII Hospital of which 79 cases (79%) were Indian (Table 4).

Objective 2 : In the prospective study 62 cases were admitted during July 1984 and in the retrospective component of the study 648 cases were admitted to RK Khan Hospital in 1983 as parasuicides. Of the 62 cases, 47 cases (75.8%) were female and 15 cases (24.2%) male. Of the 648 cases, 467 cases (72.1%) were female and 181 cases (27.9%) were male (Table 5). One male and one female patient in 1983 were Coloured while the remaining were Indian patients in both the prospective and retrospective studies.

Table 6 demonstrates the number and percent of admissions during each month of the year 1983. The average number of admissions per month was 54 cases and per day 1.8 cases (Table 2).

During January 57 cases (8.8%), February 58 cases (9.0%), March 68 cases (10.5%), April 52 cases (8.0%), May 60 cases (9.3%), June 44 cases (6.7%), July 37 cases (5.7%), August 59 cases (9.1%), September 66 cases (10.2%), October 46 cases (7.1%), November 47 cases (7.3%), December 54 cases (8.3%) were admitted.

With regard to the day of the week (Tables 7, 8) in the prospective study, on Monday 6 cases (9.7%), Tuesday 8 cases (12.9%), Wednesday 7 cases (11.3%), Thursday 9 cases (14.5%), Friday 7 cases (11.3%), Saturday 10 cases (16.1%) and on Sunday 15 cases (24.2%) were admitted.

During 1983, 103 cases (15.9%) were admitted on a Monday, 83 cases (12.8%) on a Tuesday, 86 cases (13.3%) on a Wednesday, 82 cases (12.6%) on a Thursday, 73 cases (11.3%) on a Friday, 85 cases (13.1%) on a Saturday, and 136 cases (21.0%) were admitted on a Sunday.

Concerning the time of day that the cases were admitted in the prospective study 26 cases (41.9%) were admitted between midnight to 16h59 and 36 cases (58.1%) between 17h00 to 23h59; while in the retrospective study 261 cases (40.3%) were admitted between midnight to 16h59 and 360 cases (55.5%) between 17h00 to 23h59 (Table 8).

Analysis of admissions due to parasuicide according to weekday for the month of July 1984 were as follows.

Between 17h00 to 23h59 for Monday there were 4 cases (66.7%), Tuesday 3 cases (37.5%), Wednesday 3 cases (42.9%), Thursday 6 cases (66.7%), Friday 5 cases (71.4%), Saturday 7 cases (70.0%), and for Sunday 8 cases (53.3%).

During 1983 there were on a Monday between 17h00 to 23h59, 53 cases (51.5%), Tuesday 45 cases (54.2%), Wednesday 45 cases (54.2%), Thursday 42 cases (51.2%), Friday 51 cases (69.9%) Saturday 49 cases (57.6%) and on Sunday 75 cases (55.2%).

In July 1984, 54 cases (87.1%) and in 1983, 545 cases (84.1%) came from Durban.

With regard to the geographical distribution of the parasuicide admissions (Table 9A) in the prospective study 41 cases (66.1%) and in the retrospective study 474 cases (73.2%) were from Chatsworth representing 250 cases per 100 000 population of Chatsworth of the 474 cases. 35 cases (85.4%) and 436 (92.0%) were from the Chatsworth Council housing schemes while the remaining 6 cases (14.6%) and 38 cases (8.0%) were from the ownership residential areas of Chatsworth, namely Mobeni Heights, Silverglen, Umhlatuzana and Kharwastan (Table 9B, 9C).

Of the cases originating from the other areas of Durban 5 cases (8.1%) were from Phoenix in the North, 5 cases (8.1%) from Merebank in the South and 3 cases (4.8%) of which one was from each of Mayville, Sea Cow Lake and Clairwood during July 1984, as compared to 20 cases (3.1%) from Phoenix, 41 cases (6.3%) from Merebank, and 10 cases (1.5%) from other areas of Durban respectively in 1983 such as Overport (1), Reservoir Hills (3), Effingham Heights (1), Red Hill (1), Clare Estate (1), Sea Cow Lake (1), Orient Park (1), Clairwood (1) (Table 9A).

From outside Durban 8 cases (12.9%) and 103 cases (15.9%) were admitted (Table 9A).

When comparing the ages of the cases admitted during July 1984 (Table 10) 19 cases (30.6%) were between 15 - 19 years followed by 15 cases (24.2%) between the age of 20 - 24 years and 8 cases (12.9%) from 25 - 29 years. Similarly in 1983, 233 cases (36.0%) were in the 15 - 19 year age group followed by 156 cases (24.0%) being from 20 - 24 years and 86 cases (13.3%) between 25 - 29 years.

In the prospective study 6 cases (9.7%) were between 30 - 34 years, 7 cases (11.3%) were between 35 - 39 years and 5 cases (8.1%) were between 40 - 44 years. While in the retrospective study 63 cases (9.7%) were in the 30 - 34 year age group, 28 cases (4.3%) in the 35 - 39 year age group, 18 cases (2.8%) in the 40 - 44 year age range, 12 cases in the 45 - 49 year range, 5 cases in the 50 - 54 year age group, 3 cases (0.5%) in the 55 - 60 year age group, 3 cases (0.5%) were over 60 years.

With regard to the religious origin of the patients (Tables 11A, 11B, 12A and 12B) in July 1984 and in 1983, 41 cases (66.1%) and 449 cases (69.3%) respectively were Hindu, 16 cases (25.8%) and 140 cases (21.6%) were Christian, 5 cases (8.1%) and 56 cases (8.6%) were Muslim respectively. In 1983 one case (0.2%) was a Buddhist.

In the prospective and retrospective studies 26 cases (63.4%) and 327 cases (72.8%) were of the Tamil language group whereas 9 cases (22.0%) and 108 cases (24.1%) were of the Hindi language group respectively.

Spouses in both studies in the Tamil language group numbered 26 spouses (42.0%) in July 1984 and 124 spouses (19.1%) in 1983. However the religion of 421 spouses (65.0%) of patients in 1983 was not known.

When comparing the marital state of cases in both studies (Table 13A) in July 1984 29 cases (46.8%) were married and 24 cases (38.8%) were single.

However in 1983 272 cases (42.0%) and 323 cases (49.8%) were married and single respectively. 31 spouses (50.0%) were resident in July 1984 and 248 (38.3%) in 1983. None were previously married in July 1984 and 4 cases (1.8%) were married once before in 1983 (Table 13B).

Of the 62 cases who were admitted in July 1984 and of the 648 cases in 1983, 4 cases (6.5%) and 13 cases (2.0%) did not have any education, 15 cases (24.2%) and 97 cases (15.0%) had done Standard 8, 4 cases (6.5%) and 67 cases (10.4%) had done Standard 10, 3 cases (4.8%) and 13 cases (2.0%) had done post-matric studies respectively (Table 14).

With regard to occupation and income, in July 1984 and in 1983 respectively, 2 cases (3.2%) and 7 cases (1.1%) were professionals, 4 cases (6.5%) and 47 cases (7.2%) were non-manual workers, 13 cases (20.4%) and 139 cases (21.5%) were manual-skilled or semi-skilled workers, 2 cases (3.2%) and 22 cases (3.4%) were unskilled, 16 cases (25.9%) and 154 cases (23.8%) were housewives, 10 cases (16.2%) and 117 cases (18.1%) were students, 9 cases (14.5%) and 114 cases (17.6%) were unemployed, 6 cases (9.6%) and 33 cases (5.1%) were grantees respectively (Table 15A).

59 cases (95.2%) of the 62 cases and 601 (92.7%) of the 648 cases earned less than R500. Of these 35 cases (56.5%) and 385 cases (59.4%) did not earn anything. 1 case (1.6%) in July 1984 earned between R1000 - R1999 and 3 cases (0.5%) were in the same salary bracket in 1983 (Table 15B, 15C, 15D).

The joint family income of 47 cases (75.8%) in July 1984 and of 504 cases (77.8%) in 1983 was less than R500 (Table 16) and 1 family (1.6%) and (0.2%) earned more than R2000, 4 families (6.5%) and 16 families (2.5%) earned between R1000 - R1999.

According to Table 17 in July 1984 51 cases (82.2%) and in 1983 513 cases (79.2%) lived with the family. In the prospective and retrospective studies respectively 35 admissions (56.4%) and 448 admissions (69.2%) lived in a nuclear family unit comprising of parents and their children. In July 1984 and in 1983, 18 cases (29.0%) and 152 cases (23.5%) lived with their spouses and children; 17 cases (27.4%) and 272 (42.0%) with parents and siblings, 19 cases (2.9%) lived with their children only, 1 case (0.2%) with a stepmother and 4 cases (0.6%) with a stepfather. In July 1984 and in 1983, 16 admissions (25.8%) and 65 admissions (10.0%) lived in the joint or extended family structure respectively. The joint or extended family included husband, wife and children living with either parents, siblings, aunt, uncles and or with grandparents. Of these 4 cases (0.6%) lived with grandparents only and 18 cases (2.8%) with an aunt and or uncle and or their families.

8 cases (13.0%) and 78 cases (12.0%) lived with in-laws, 2 cases (3.2%) and 17 cases (2.6%) with friends, 1 case (1.6%) and 23 cases (3.6%) lived alone in the prospective and retrospective components of the study respectively.

In addition 4 cases (0.6%) lived in the Aryan Benevolent Home in Chatsworth, and 6 cases (0.9%) were from prison, under police guard, from the nurses' residence, living with a cousin, niece or relatives.

The occupancy of the households of the parasuicide admissions were assessed according to Tables 18 and 19A. In the prospective component of the study the number of occupants ranged from 1 person to 14 people and in the retrospective component from 1 to 12 people. In July 1984 in 16 cases (25.8%) there were 5 occupants per household and in 1983 in 109 cases (16.8%) there were 3 occupants per household. In 41 cases (66.2%) the occupants were living in less than 3 bedrooms and in 19 cases (30.6%) in 3 or more bedrooms. In July 1984 1 case (1.6%) had no fixed abode and in 1 case (1.6%) the number of bedrooms was not known. Of the 648 cases 224 cases (34.6%) occupied less than 3 bedrooms, 90 cases (13.9%) occupied 3 or more bedrooms

and in 328 cases (50.6%) the number of bedrooms was not known. 6 cases (0.9%) lived in an institution.

The birth order was assessed in the prospective study only. From Table 20 10 cases (16.1%) were the youngest, 21 cases (33.9%) were the eldest, and 16 cases (25.8%) were in the middle of the family.

From Table 23 in July 1984, 4 cases (6.4%) lived with step-mother, 1 case (1.6%) lived with the step-father and 2 cases (3.2%) with both step-parents.

Of the 62 cases, 5 cases (8.1%) were members of a social organisation.

In July 1984 33 cases (53.3%) had lost their parents as follows : 4 cases (6.5%) had lost a mother, 14 cases (22.6%) had lost a father both through death, and 15 cases (24.2%) had lost both parents through death, divorce or abandonment. In 1983 155 cases (24%) had lost their parents. Of these, 24 cases (3.7%) had lost a mother, 98 cases (15.2%) a father and 32 cases (4.9%) had lost both parents either by death, divorce, abandonment or for unknown reasons (Table 22).

In the prospective study in Table 21, 19 cases (30.6%) did not have any close friends, 10 cases (16.1%) had 4 friends and 12 cases (22.6%) had more than 5 friends.

According to Table 24, 16 cases (25.8%) discussed problems with a family member, 12 cases (19.4%) with their spouse, 25 cases (40.3%) with a friend, 1 case (1.6%) with a psychiatrist and 6 cases (9.7%) did not discuss problems with anybody and in 2 cases (3.2%) it was not known who the patients discussed problems with.

A variety of means and agents which were non-violent and violent were used in the prospective (83 means) and retrospective (755 means) studies (Table 25).

Of the non-violent means, 70 medicines (113%) were ingested in July 1984 and 534 (57.8%) in 1983. Other agents in July 1984 were disinfectants 7 (11.3%), insecticides 3 (4.8%) miscellaneous 3 (4.8%). In 1983 43 (6.6%) disinfectants, 22 (3.4%) insecticides and 35 (5.4%) miscellaneous items were ingested.

No violent means was used in July 1984. However in 1983 10 cases (1.5%) attempted strangulation, 4 cases (0.6%) stabbed themselves, 1 case (0.2%) burnt herself with methylated spirits, 1 case (0.2%) fell from a high place, 2 cases (0.3%) attempted gassing themselves in a car, 2 cases (0.3%) swallowed foreign objects such as a blade, coins and glass pieces and 1 case (0.2%) jumped through a window and slashed his wrist.

The variety of medicines in Table 25 include analgesics, psychotropic drugs, wintergreen, asthma medicines, cardiac/hypertensive medicines, hypoglycaemic agents, antibiotics and other medicines such as Vitamin B Co, multivitamins, ferrous sulphate, oral contraceptives, bisolvon, stilboestrol, ear drops, slow k, slimming tablets, buscopan, antabuse, algist skin tablets, cough mixture, lozenges, warfarin, maxolon, eskornade spansules, isoniazid, snellerin and trisilicate.

Other agents include disinfectants, insecticides and other miscellaneous substances such as herbal medicines, hair lotion, eucalyptus oil, cleaning solvents, paraffin, bleach, gentian violet, cobra polish, brake fluid, poisonous seeds, clearasil, battery acid, deodorant.

Reasons for the parasuicides were categorised into family, in-law, marital friends and miscellaneous problems. In July 1984 there were 84 varieties and in 1983, 717 varieties (Table 26) of problems.

In July 1984 there were 24 cases (38.7%) with family problems, 7 cases (11.3%) with in-law problems, 28 cases (45.1%) with marital problems, 10 cases (16.2%) with problems with friends and their parents and 15 cases (24.2%) with miscellaneous problems. In 1983 226 cases (34.9%) had family problems, 41 cases (6.3%) had in-law problems, 211 cases (32.6%) had marital problems, 107 cases (16.5%) had problems with friends and their parents and 132 cases (20.4%) were involved in miscellaneous problems such as work, neighbourhood, financial, medical, psychiatric, school, emotional, pregnancy, legal, foster-mother and no known problems.

In the prospective study in 6 cases (9.7%) suicide had occurred in people close to the patients, either a spouse, family member or neighbour. Parasuicides occurred in 9 cases (14.5%) in similar instances. In the retrospective study suicides occurred in people close to the patient in 6 cases (0.9%) and parasuicide in 12 cases (1.9%) (Table 28).

Objective 3 : Of 62 cases, 15 cases (24.2%) had attempted suicide before as follows : 12 (19.4%) had attempted suicide once, 2 cases (3.2%) twice and one (1.6%) three times. Of the 648 cases in the retrospective study 74 cases (11.4%) had attempted suicide in the past, of these 49 cases (7.6%) attempted once, 20 cases (3.0%) twice, 5 cases (0.8%) three times (Table 27).

Objective 4: Aid was sought in the past by the cases admitted for parasuicide in July 1984 prior to their admission from welfare agencies in 32 cases (51.6%); from other sources in 7 cases (11.2%) and from psychiatrists in 10 cases (16.1%) (Table 29).

In 1983 aid was sought from welfare agencies in 86 cases (13.3%), from other sources in 37 cases (5.7%) and from a psychiatrist in 48 cases (7.4%). Other sources of aid were Sanca and or Alcoholics Anonymous, hospital admissions for overdose, religious priests, relatives, school counsellors and work supervisors (Table 29).

The welfare agencies whose help was sought were the Chatsworth, Durban, Phoenix and Pinetown child and family welfare societies, the Department of Indian Affairs, legal aid, the Aryan Benevolent Home, the RK Khan Hospital social worker and other welfare agencies in Verulam and Tongaat, Marriage Guidance and Blind societies.

Personalities of the cases were not identified as hospital records did not identify personalities in the retrospective study and in the prospective study it was difficult to assess personality so soon after parasuicide.

LIST OF SUPPORTIVE SERVICES AVAILABLE TO PEOPLE IN CHATSWORTH

1	Number of general practitioners	=	40
2	Number of schools	=	59
3	Number of psychiatric clinics	=	2
4	Community Health clinics	=	3
5	Community liaison - number of women's groups	=	9

	Number of Social Workers	
1	Department of Indian Affairs (DIA)	9
2	Chatsworth Child Welfare Society	12
3	RK Khan Hospital	2
4	University of Durban-Westville	1
5	Cripple Care Association	2
6	Legal Aid - Magistrate's Court	
7	Psychiatric Clinic (included in DIA)	
8	Aryan Benevolent Home and Dayanand Gardens	2
9	City Health Department clinics	—
	T o t a l	28

SUPPORTIVE SERVICES AVAILABLE IN DURBAN CENTRAL FOR PARASUICIDES OR WOULD BE PARASUICIDES INCLUDE :

- 1 Durban Mental Health Society
- 2 SANCA or Alcoholics Anonymous
- 3 Lifeline
- 4 Marriage Guidance
- 5 Other private family welfare societies

TABLE 1

SUICIDES ADMITTED AS PARASUICIDES DUE TO DRUG OVERDOSAGE TO
R K KHAN HOSPITAL ACCORDING TO MEANS USED IN 1983 :
NUMBER AND PERCENT (%)

<u>MEANS USED</u>	<u>ADMISSIONS</u>
Wintergreen	4 (50.0)
TCP	1 (12.5)
Codis	1 (12.5)
Unknown analgesic	1 (12.5)
Diabetic tablets	1 (12.5)
<u>TOTAL</u>	<u>8 (100.0)</u>

TABLE 2

ADMISSIONS TO R K KHAN HOSPITAL OF ACCIDENTAL
DRUG OVERDOSAGES AND PARASUICIDES IN 1983 :
NUMBER AND PERCENT (%)

<u>TYPE OF CASES</u>	<u>1983</u>	<u>MONTHLY AVERAGE</u>	<u>DAILY AVERAGE</u>
Parasuicides	648 (82.1)	54	1.8
Accidental drug overdoses	141 (17.9)	11.8	0.4
<u>TOTAL</u>	<u>789 (100.0)</u>	<u>65.8</u>	<u>2.2</u>

TABLE 3A
 ADMISSIONS TO R K KHAN HOSPITAL ACCORDING
 TO REASON FOR ADMISSION AND WARD TYPE IN 1983
 NUMBER AND PERCENT (%)

	W A R D T Y P E			<u>TOTAL</u>
	<u>MEDICAL</u>	<u>SURGICAL</u>	<u>OTHER</u>	
Parasuicide	627 (96.7) (10.3)	21 (3.3) (0.3)	0 (0) (0)	648 (100.0) (2.1)
Other admissions	5 492 (18.3) (89.7)	7 099 (23.7) (99.7)	17 339 (58.0) (100.0)	29 930 (100.0) (97.9)
TOTAL	6 119 (20.0) (100.0)	7 120 (23.3) (100.0)	17 339 (56.7) (100.0)	30 578 (100.0) (100.0)

TABLE 3B
 ADMISSIONS TO R K KHAN HOSPITAL ACCORDING TO
 REASON FOR ADMISSION AND WARD TYPE IN JULY 1984
 NUMBER AND PERCENT (%)

	W A R D T Y P E			<u>TOTAL</u>
	<u>MEDICAL</u>	<u>SURGICAL</u>	<u>OTHER</u>	
Parasuicide	62 (100.0) (10.6)	0 (0) (0)	0 (0) (0)	62 (100.0) (2.2)
Other admissions	525 (19.6) (89.4)	673 (25.2) (100.0)	1 478 (55.2) (100.0)	2 676 (100.0) (97.8)
TOTAL	587 (21.4) (100.0)	673 (24.6) (100.0)	1 478 (54.0) (100.0)	2 738 (100.0) (100.0)

TABLE 4
 PARASUICIDE ADMISSIONS TO KING EDWARD VIII
 AND R K KHAN HOSPITALS ACCORDING TO RACE AND SEX
 NUMBER AND PERCENT (%)

<u>RACE</u>	<u>SEX</u>	<u>KEH</u>	<u>RKK</u>
African	Male	14 (66.7)	0 (0)
	<u>Female</u>	<u>7 (33.3)</u>	<u>0 (0)</u>
	<u>Total</u>	<u>21 (100.0)</u>	<u>0 (0)</u>
Indian	Male	38 (48.1)	180 (27.9)
	<u>Female</u>	<u>41 (51.9)</u>	<u>466 (72.1)</u>
	<u>Total</u>	<u>79 (100.0)</u>	<u>646 (100.0)</u>
Coloured	Male	0 (0)	1 (50.0)
	<u>Female</u>	<u>0 (0)</u>	<u>1 (50.0)</u>
	<u>Total</u>	<u>0 (0)</u>	<u>2 (100.0)</u>
All Races	Male	52 (52.0)	181 (27.9)
	<u>Female</u>	<u>48 (48.0)</u>	<u>467 (72.1)</u>
	<u>Total</u>	<u>100 (100.0)</u>	<u>648 (100.0)</u>

TABLE 5
 PARASUICIDE ADMISSIONS TO R K KHAN HOSPITAL
 ACCORDING TO SEX : 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

	<u>JANUARY TO DECEMBER 1983</u>	<u>JULY 1984</u>
Male	181 (27.9)	15 (24.2)
Female	467 (72.1)	47 (75.8)
TOTAL	648 (100.0)	62 (100.0)

TABLE 6
 DISTRIBUTION OF PARASUICIDE ADMISSIONS TO
 R K KHAN HOSPITAL ACCORDING TO MONTH OF THE YEAR 1983
 NUMBER AND PERCENT (%)

<u>MONTH</u>	<u>ADMISSIONS</u>
January	57 (8.8)
February	58 (9.0)
March	68 (10.5)
April	52 (8.0)
May	60 (9.3)
June	44 (6.7)
July	37 (5.7)
August	59 (9.1)
September	66 (10.2)
October	46 (7.1)
November	47 (7.3)
December	54 (8.3)
TOTAL	648 (100.0)

TABLE 7
 PARASUICIDE ADMISSIONS ACCORDING TO DAY OF THE WEEK :
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>DAY OF THE WEEK</u>	<u>1983</u>	<u>JULY 1984</u>
Monday	103 (15.9)	6 (9.7)
Tuesday	83 (12.8)	8 (12.9)
Wednesday	86 (13.3)	7 (11.3)
Thursday	82 (12.6)	9 (14.5)
Friday	73 (11.3)	7 (11.3)
Saturday	85 (13.1)	10 (16.1)
Sunday	136 (21.0)	15 (24.2)
TOTAL	648 (100.0)	62 (100.0)

TABLE 8
 PARASUICIDE ADMISSIONS ACCORDING TO TIME OF THE DAY :
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>TIME OF DAY</u>	<u>1983</u>	<u>JULY 1984</u>
24h00 to 16h59	261 (40.3)	26 (41.9)
17h00 to 23h59	360 (55.5)	36 (58.1)
Unknown	27 (4.2)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 9A
GEOGRAPHICAL DISTRIBUTION OF PARASUICIDE ADMISSIONS
JANUARY TO DECEMBER 1983 AND JULY 1984
NUMBER AND PERCENT (%)

<u>AREA</u>	<u>1983</u>	<u>JULY 1984</u>
Chatsworth	474 (73.2)	41 (66.1)
Phoenix	20 (3.1)	5 (8.1)
Other Durban	51 (7.8)	8 (12.9)
Elsewhere	103 (15.9)	8 (12.9)
TOTAL	648 (100.0)	62 (100.0)

TABLE 9B
DISTRIBUTION OF PARASUICIDE ADMISSIONS FROM CHATSWORTH
TO R K KHAN HOSPITAL ACCORDING TO SOCIO-ECONOMIC AREA
JANUARY TO DECEMBER 1983 AND JULY 1984
NUMBER AND PERCENT (%)

<u>CHATSWORTH</u>	<u>1983</u>	<u>JULY 1984</u>
Council Housing Schemes	436 (92.0)	35 (85.4)
Other Residential Areas	38 (8.0)	6 (14.6)
TOTAL	474 (100.0)	41 (100.0)

TABLE 9C

DISTRIBUTION OF PARASUICIDE ADMISSIONS TO R K KHAN HOSPITAL
 FROM CHATSWORTH ACCORDING TO RESIDENTIAL AREA
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>CHATSWORTH COUNCIL HOUSING SCHEMES</u>		<u>1983</u>	<u>JULY 1984</u>
Unit			
1	Havenside	37 (7.8)	0 (0)
2	Bayview	52 (11.0)	3 (7.3)
3	Westcliff	81 (17.1)	5 (12.2)
5	Croftdene	59 (12.4)	2 (4.9)
6	Arena Park	25 (5.3)	2 (4.9)
7	Montford	82 (17.2)	10 (24.4)
9	Moorton	33 (7.0)	5 (12.2)
10	Woodhurst	33 (7.0)	6 (14.6)
11	Crossmoor	34 (7.2)	2 (4.9)
Subtotal		436 (92.0)	35 (85.4)
<hr/>			
<u>CHATSWORTH OTHER RESIDENTIAL AREAS</u>			
	Mobeni Heights	4 (0.8)	1 (2.4)
	Silverglen	16 (3.4)	4 (9.8)
	Umhlatuzana	7 (1.5)	1 (2.4)
	Kharwastan	11 (2.3)	0 (0)
Subtotal		38 (8.0)	6 (14.6)
<hr/>			
TOTAL		474 (100.0)	41 (100.0)
<hr/>			

TABLE 10
 PARASUICIDE ADMISSIONS ACCORDING TO AGE GROUP
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>AGE</u>	<u>1983</u>	<u>JULY 1984</u>
< 10	1 (0.2)	0 (0)
10 - 14	34 (5.2)	2 (3.2)
15 - 19	233 (36.0)	19 (30.6)
20 - 24	156 (24.0)	15 (24.2)
25 - 29	86 (13.3)	8 (12.9)
30 - 34	63 (9.7)	6 (9.7)
35 - 39	28 (4.3)	7 (11.3)
40 - 44	18 (2.8)	5 (8.1)
45 - 49	12 (1.8)	0 (0)
50 - 54	5 (0.8)	0 (0)
55 - 60	3 (0.5)	0 (0)
> 60	3 (0.5)	0 (0)
Unknown	6 (0.9)	0 (0)
<hr/> TOTAL	<hr/> 648 (100.0)	<hr/> 62 (100.0)

TABLE 11A
 RELIGION OF PARASUICIDE ADMISSIONS AND THEIR SPOUSES
 JULY 1984
 NUMBER AND PERCENT (%)

P A R A S U I C I D E A D M I S S I O N S								
<u>SPOUSE</u>	<u>CHRISTIAN</u>		<u>HINDU</u>		<u>MUSLIM</u>		<u>TOTAL</u>	
Christian	3	(50.0)	3	(50.0)	0	(0)	6	(100.0)
		(18.7)		(7.3)		(0)		(9.7)
Hindu	9	(21.0)	34	(79.0)	0	(0)	43	(100.0)
		(56.3)		(82.9)		(0)		(69.3)
Muslim	1	(14.3)	1	(14.3)	5	(71.4)	7	(100.0)
		(6.3)		(2.5)		(100.0)		(11.3)
No Spouse	3	(60.0)	2	(40.0)	0	(0)	5	(100.0)
		(18.7)		(4.8)		(0)		(8.1)
Unknown	0	(0)	1	(100.0)	0	(0)	1	(100.0)
		(0)		(2.5)		(0)		(1.6)
TOTAL	16	(25.8)	41	(66.1)	5	(8.1)	62	(100.0)
		(100.0)		(100.0)		(100.0)		(100.0)

TABLE 11B
 LANGUAGE GROUP OF HINDU PARASUICIDE ADMISSIONS AND SPOUSES
 JULY 1984
 NUMBER AND PERCENT (%)

<u>SPOUSE</u>	<u>P A R A S U I C I D E A D M I S S I O N S</u>			
	<u>HINDI</u>	<u>TAMIL</u>	<u>TELUGU</u>	<u>TOTAL</u>
Christian	0 (0) (0)	3 (100.0) (11.5)	0 (0) (0)	3 (100.0) (7.3)
Hindu :				
Hindi	5 (83.3) (55.6)	1 (16.7) (3.8)	0 (0) (0)	6 (100.0) (14.6)
Tamil	1 (5.5) (11.1)	16 (89.0) (61.6)	1 (5.5) (16.7)	18 (100.0) (43.9)
Telugu	1 (10.0) (11.1)	4 (40.0) (15.5)	5 (50.0) (83.3)	10 (100.0) (24.4)
Muslim	0 (0) (0)	1 (100.0) (3.8)	0 (0) (0)	1 (100.0) (2.5)
No spouse	1 (50.0) (11.1)	1 (50.0) (3.8)	0 (0) (0)	2 (100.0) (4.8)
Unknown	1 (100.0) (11.1)	0 (0) (0)	0 (0) (0)	1 (100.0) (2.5)
TOTAL	9 (22.0) (100.0)	26 (63.4) (100.0)	6 (14.6) (100.0)	41 (100.0) (100.0)

TABLE 12A
RELIGION OF PARASUICIDE ADMISSIONS
JANUARY TO DECEMBER 1983 AND JULY 1984
NUMBER AND PERCENT (%)

<u>RELIGION</u>	<u>1983</u>	<u>JULY 1984</u>
Christian	140 (21.6)	16 (25.8)
Hindu	449 (69.3)	41 (66.1)
Muslim	56 (8.6)	5 (8.1)
Buddhist	1 (0.2)	0 (0)
Unknown	2 (0.3)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 12B
LANGUAGE GROUP OF HINDU PARASUICIDE ADMISSIONS
JANUARY TO DECEMBER 1983 AND JULY 1984
NUMBER AND PERCENT (%)

<u>LANGUAGE GROUP</u>	<u>1983</u>	<u>JULY 1984</u>
Gujerati	1 (0.2)	0 (0)
Hindi	108 (24.1)	9 (22.0)
Tamil	327 (72.8)	26 (63.4)
Telugu	8 (1.8)	6 (14.6)
Unknown	5 (1.1)	0 (0)
TOTAL	449 (100.0)	41 (100.0)

TABLE 13A
 MARITAL STATE OF PARASUICIDE ADMISSIONS
 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>MARITAL STATE</u>	<u>1983</u>	<u>JULY 1984</u>
Single	323 (49.8)	24 (38.8)
Married	272 (42.0)	29 (46.8)
Widowed	11 (1.7)	2 (3.2)
Divorced	12 (1.8)	1 (1.6)
Cohabitation	25 (3.9)	6 (9.6)
Unknown	5 (0.8)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 13B
 RESIDENCY OF SPOUSES OF PARASUICIDE ADMISSIONS
 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>RESIDENCY</u>	<u>1983</u>	<u>JULY 1984</u>
Resident	248 (38.3)	31 (50.0)
Non-resident	225 (34.7)	27 (43.5)
No spouse	0 (0)	4 (6.5)
Unknown	175 (27.0)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 14
 EDUCATIONAL QUALIFICATIONS OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>EDUCATIONAL QUALIFICATIONS</u>	<u>1983</u>	<u>JULY 1984</u>
Less than Std 1	14 (2.2)	8 (12.9)
Std 1 to 5	109 (16.8)	11 (17.7)
Std 6 to 8	250 (38.6)	30 (48.5)
Std 9 to 10	132 (20.4)	10 (16.1)
Post Matric	13 (2.0)	3 (4.8)
Unknown	130 (20.0)	0 (0)
<hr/> TOTAL	<hr/> 648 (100.0)	<hr/> 62 (100.0)

TABLE 15A
 OCCUPATION OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>OCCUPATION</u>	<u>1983</u>	<u>JULY 1984</u>
Professional	7 (1.1)	2 (3.2)
Non-manual	47 (7.2)	4 (6.5)
Manual/semiskilled	139 (21.5)	13 (20.9)
Manual/unskilled	22 (3.4)	2 (3.2)
Housewife	154 (23.8)	16 (25.9)
Student	117 (18.1)	10 (16.2)
Unemployed	114 (17.6)	9 (4.5)
Pensioner or grantee	33 (5.1)	6 (9.6)
Unknown	15 (2.2)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 15B
 PERSONAL INCOME OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>PERSONAL INCOME</u>	<u>1983</u>	<u>JULY 1984</u>
< R100	407 (62.8)	35 (56.5)
R 100 - R 499	194 (29.9)	24 (38.7)
R 500 - R1 999	27 (4.2)	3 (4.8)
Unknown	20 (3.1)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 15C
 OCCUPATION AND PERSONAL INCOME OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983
 NUMBER AND PERCENT (%)

OCCUPATION	P E R S O N A L I N C O M E				TOTAL
	<R100	R100 - R499	R500-R1999	UNKNOWN	
Professional	0 (0) (0)	0 (0) (0)	7 (100.0) (25.9)	0 (0) (0)	7 (100.0) (1.1)
Non-manual	0 (0) (0)	33 (70.3) (17.0)	13 (27.6) (48.2)	1 (2.1) (5.0)	47 (100.0) (7.2)
Manual/ semi/skilled	0 (0) (0)	129 (92.8) (66.5)	7 (5.0) (25.9)	3 (2.2) (15.0)	139 (100.0) (21.5)
Manual/ unskilled	3 (13.7) (0.8)	18 (81.8) (9.3)	0 (0) (0)	1 (4.5) (5.0)	22 (100.0) (3.4)
Housewife	154 (100.0) (37.8)	0 (0) (0)	0 (0) (0)	0 (0) (0)	154 (100.0) (23.8)
Student	117 (100.0) (28.7)	0 (0) (0)	0 (0) (0)	0 (0) (0)	117 (100.0) (18.1)
Unemployed	114 (100.0) (28.0)	0 (0) (0)	0 (0) (0)	0 (0) (0)	114 (100.0) (17.6)
Pensioner/ grantee	19 (57.6) (4.7)	14 (42.4) (7.2)	0 (0) (0)	0 (0) (0)	33 (100.0) (5.1)
Unknown	0 (0) (0)	0 (0) (0)	0 (0) (0)	15 (100.0) (75.0)	15 (100.0) (2.2)
TOTAL	407 (62.8) (100.0)	194 (29.9) (100.0)	27 (4.2) (100.0)	20 (3.1) (100.0)	648 (100.0) (100.0)

TABLE 15D
OCCUPATION AND PERSONAL INCOME OF PARASUICIDE ADMISSIONS

JULY 1984

NUMBER AND PERCENT (%)

OCCUPATION	P E R S O N A L I N C O M E			TOTAL
	< R100	R100-R499	R500-R1999	
Professional	0 (0) (0)	0 (0) (0)	2 (100.0) (66.7)	2 (100.0) (3.2)
Non-manual	0 (0) (0)	3 (75.0) (12.5)	1 (25.0) (33.3)	4 (100.0) (6.5)
Manual/ semi-skilled	0 (0) (0)	13 (100.0) (54.2)	0 (0) (0)	13 (100.0) (20.9)
Manual/ unskilled	0 (0) (0)	2 (100.0) (8.3)	0 (0) (0)	2 (100.0) (3.2)
Housewife	16 (100.0) (45.7)	0 (0) (0)	0 (0) (0)	16 (100.0) (25.9)
Student	10 (100.0) (28.6)	0 (0) (0)	0 (0) (0)	10 (100.0) (16.2)
Unemployed	9 (100.0) (25.7)	0 (0) (0)	0 (0) (0)	9 (100.0) (4.5)
Pensioner/ grantee	0 (0) (0)	6 (100.0) (25.0)	0 (0) (0)	6 (100.0) (9.6)
TOTAL	35 (56.5) (100.0)	24 (38.7) (100.0)	3 (4.8) (100.0)	62 (100.0) (100.0)

TABLE 16
 FAMILY INCOME OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>FAMILY INCOME</u>	<u>1983</u>	<u>JULY 1984</u>
<R100	117 (18.1)	7 (11.4)
R100 - R499	387 (59.7)	40 (64.4)
R500 - R1999	76 (11.8)	14 (22.6)
>R2 000	1 (0.2)	1 (1.6)
Unknown	67 (10.2)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

TABLE 17
 DOMICILIARY CIRCUMSTANCES OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>DOMICILIARY CIRCUMSTANCES</u>	<u>1983</u>	<u>JULY 1984</u>
Nuclear family unit	448 (69.2)	35 (56.4)
Joint/extended family unit	65 (10.0)	16 (25.8)
In-laws	78 (12.0)	8 (13.0)
Other *	50 (7.7)	3 (4.8)
Unknown	7 (1.1)	0 (0)
TOTAL	648 (100.0)	62 (100.0)

* Other = in an institution, with friends, living alone

TABLE 18
 OCCUPANCY OF HOUSEHOLD : JULY 1984
 NUMBER AND PERCENT (%)

NUMBER OF OCCUPANTS IN HOUSEHOLD	NUMBER OF BEDROOMS				TOTAL
	< 3	3 AND > 3	NO FIXED ABODE	UNKNOWN	
1 to 5	22 (68.8) (53.6)	9 (28.1) (47.4)	1 (3.1) (100.0)	0 (0) (0)	32 (100.0) (51.5)
6 to 10	17 (68.0) (41.6)	8 (32.0) (42.0)	0 (0) (0)	0 (0) (0)	25 (100.0) (40.5)
> 10	2 (50.0) (4.8)	2 (50.0) (10.6)	0 (0) (0)	0 (0) (0)	4 (100.0) (6.4)
Unknown	0 (0) (0)	0 (0) (0)	0 (0) (0)	1 (100.0) (100.0)	1 (100.0) (1.6)
TOTAL	41 (66.2) (100.0)	19 (30.6) (100.0)	1 (1.6) (100.0)	1 (1.6) (100.0)	62 (100.0) (100.0)

TABLE 19A
 OCCUPANCY OF HOUSEHOLD : 1983
 NUMBER AND PERCENT (%)

<u>OCCUPANTS</u>	<u>N U M B E R O F B E D R O O M S</u>				<u>TOTAL</u>
	<u>< 3</u>	<u>3 AND > 3</u>	<u>INSTITUTION</u>	<u>UNKNOWN</u>	
1 to 5	149 (35.9) (63.3)	39 (9.4) (43.3)	0 (0) (0)	227 (54.7) (69.3)	415 (100.0) (64.0)
6 to 10	70 (42.7) (31.5)	44 (26.8) (48.9)	0 (0) (0)	50 (30.5) (15.2)	164 (100.0) (25.3)
> 10	0 (0) (0)	1 (50.0) (1.1)	0 (0) (0)	1 (50.0) (0.3)	2 (100.0) (0.4)
Unknown	5 (7.5) (2.2)	6 (9.0) (6.7)	6 (9.0) (100.0)	50 (74.5) (15.2)	67 (100.0) (.10.3)
TOTAL	224 (34.6) (100.0)	90 (13.9) (100.0)	6 (0.9) (100.0)	328 (50.6) (100.0)	648 (100.0) (100.0)

TABLE 19B
 POPULATION, NUMBER OF DWELLING UNITS AND OCCUPANCY FOR
 CHATSWORTH, PHOENIX AND MEREBANK

<u>AREA</u>	<u>POPULATION (1980 CENSUS)</u>	<u>NUMBER OF DWELLING UNITS (MAY 1984)</u>	<u>OCCUPANTS PER DWELLING (MEAN)</u>
Chatsworth	183 180	19 538	9.4
Phoenix	42 820	13 668	3.1
Merebank	31 320	6 874	4.6

TABLE 20
 BIRTH ORDER OF PARASUICIDE ADMISSIONS : JULY 1984
 NUMBER AND PERCENT (%)

<u>BIRTH ORDER</u>	<u>NUMBER</u>
Eldest	21 (33.9)
Youngest	10 (16.1)
Middle	31 (50.0)
<hr/>	
TOTAL	62 (100.0)
<hr/>	

TABLE 21
 NUMBER OF FRIENDS OF PARASUICIDE ADMISSIONS : JULY 1984
 NUMBER AND PERCENT (%)

<u>FRIENDS</u>	<u>ADMISSIONS</u>
0	19 (30.6)
1 - 4	29 (46.8)
> 5	12 (22.6)
Unknown	2 (3.2)
<hr/>	
TOTAL	62 (100.0)
<hr/>	

TABLE 22
 LOSS OF PARENTS OF PARASUICIDE ADMISSIONS
 THROUGH DEATH, DIVORCE OR FOR AN UNKNOWN REASON
 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>PARENT LOST</u>	<u>1983</u>	<u>JULY 1984</u>
Mother	24 (3.7)	4 (6.5)
Father	98 (15.2)	14 (22.6)
Both parents	32 (4.9)	15 (24.2)
Unknown	1 (0.2)	0 (0)
Nil lost	493 (76.0)	29 (46.7)
TOTAL	648 (100.0)	62 (100.0)

TABLE 23
 PARASUICIDE ADMISSIONS WITH STEP-PARENTS
 JULY 1984
 NUMBER AND PERCENT (%)

<u>STEP-PARENT</u>	<u>ADMISSIONS</u>
Stepmother	4 (6.4)
Stepfather	1 (1.6)
Both parents	2 (3.2)
No step-parents	55 (88.8)
TOTAL	62 (100.0)

TABLE 24
 CONTACTS WITH WHOM PARASUICIDE ADMISSIONS
 DISCUSSED THEIR PROBLEMS IN JULY 1984
 NUMBER AND PERCENT (%)

<u>CONTACT</u>	<u>ADMISSIONS</u>
Family member	16 (25.8)
Spouse	12 (19.4)
Friend	25 (40.3)
Other	1 (1.6)
Nobody	6 (9.7)
Unknown	2 (3.2)
<hr/>	
TOTAL	62 (100.0)
<hr/>	

TABLE 25
 MEANS ADOPTED BY PARASUICIDE ADMISSION
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>MEANS</u>	<u>1983</u>	<u>JULY 1984</u>
Medicinal preparations	634 (97.8)	70 (113.0)
Other agents	100 (15.4)	13 (20.9)
Violent means	21 (3.3)	0 (0)
<hr/>		
TOTAL	755	83
<hr/>		

TABLE 26
 REASONS FOR THE PARASUICIDE
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>REASONS</u>	<u>1983</u>	<u>JULY 1984</u>
Family problems	226 (34.9)	24 (38.7)
In-law problems	41 (6.3)	7 (11.3)
Marital problems	211 (32.6)	28 (45.1)
Problems with friends	107 (16.5)	10 (16.2)
Miscellaneous problems	132 (20.4)	15 (24.2)
TOTAL	717	84

TABLE 27
 PREVIOUS ATTEMPTS AT SUICIDE BY PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>PREVIOUS ATTEMPTS AT SUICIDE</u>	<u>1983</u>	<u>JULY 1984</u>
Nil	574 (88.6)	47 (75.8)
1	49 (7.6)	12 (19.4)
2	20 (3.0)	2 (3.2)
3	5 (0.8)	1 (1.6)
TOTAL	648 (100.0)	62 (100.0)

TABLE 28
 SUICIDE AND PARASUICIDE AMONG FAMILY AND
 CLOSE CONTACTS OF PARASUICIDE ADMISSIONS
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>EVENT</u>	<u>1983</u>	<u>JULY 1984</u>
Suicide	6 (0.9)	6 (9.7)
Parasuicide	12 (1.9)	9 (14.5)
Nil	630 (97.2)	47 (75.8)
TOTAL	648 (100.0)	62 (100.0)

TABLE 29
 AID SOUGHT BY PARASUICIDE ADMISSIONS PRIOR TO ADMISSION
 JANUARY TO DECEMBER 1983 AND JULY 1984
 NUMBER AND PERCENT (%)

<u>AID SOUGHT</u>	<u>1983</u>	<u>JULY 1984</u>
Welfare agencies	86 (13.3)	32 (51.6)
Elsewhere	37 (5.7)	7 (11.2)
Psychiatrist	48 (7.4)	10 (16.1)
TOTAL	171	49

DISCUSSION

The RK Khan Hospital in Chatsworth has 689 beds serving the needs of the Indian population of Durban and surrounding areas although people of other race groups presenting at the hospital do receive attention. This was demonstrated by the fact that 2 cases in the retrospective sample were Coloured.

It was alarming that 10.3% of the medical inpatients for 1983 were parasuicides (Table 3A) and that 17.9% of patients admitted following an overdose was due to an accidental overdosage (Table 2). The majority of patients admitted following parasuicide survived. However 8 cases died in 1983 while 648 cases survived (Table 1).

Parasuicide admissions accounted for half the work-load of the social work department at RK Khan Hospital (42). There were 2 social workers to whom all parasuicide consultations were sent (42). They managed the cases and referred them to outside agencies when indicated. Those cases, whom in their assessment required psychiatric management, were referred to the visiting psychiatrist at the RK Khan psychiatric outpatient clinic as were repeated parasuicides. This was the procedure adopted since there was no resident psychiatrist nor a psychiatric unit at the hospital.

The majority of cases admitted for parasuicide were female conforming to studies undertaken by Stengel (15), Minnaar (6), Pillay (7), Edwards et al (4) and Cheetbam et al (37) (Table 5). Women in other countries demonstrated an increase in parasuicide as shown in studies by Sainsbury et al in 1981 (7). Krietman reported an increase in the admission rates for women in Edinburgh between 1968 to 1974 (17).

Pillay (36) contended that the high rate of suicide among Indian females occurred because they had strong inhibitions against the open expression of hostility that arose from conflict situations because Indian girls were trained by their parents to accept restrictions and to view them as "proper". This contention was substantiated by Cheetham et al who stated that it was due to the subservient role of the Indian women and the restriction on their ability to either protest or to relieve tension and anxiety through verbal or physical expression of aggression (37).

Most cases were admitted in March 1983 followed by September and the least number of cases admitted was in July 1983 (Table 6).

Minnaar (6) noted a seasonal fluctuation with a peak during spring and the summer months of December to February and the highest number of parasuicides was in December in her study amongst the White population of Durban. This was not found in the present study. Meer (39) observed no relationship between the time of month and the incidence of suicide.

Many patients were admitted on a Sunday in both the prospective and retrospective components of the study (Table 7). In the prospective study Saturday was the next highest day of admissions while in the retrospective study Monday had the next highest number of admissions.

Families met over weekends and in the evenings highlighting inter-personal or family differences which resulted in conflict terminating in parasuicide behaviour.

Meer (39) observed a progressively increasing risk in suicides from Monday to Sunday for women of all races. Amongst the Coloured population she noted a Sunday peak followed by the next highest number being on a Monday. In assessing the rate of suicide per day of the week she contended that it was of limited value. However she observed high suicide rates over weekends and Mondays among Indians, Coloureds and Africans due possibly to poor recreational activities and facilities over weekends.

More admissions occurred in the evenings between 17h00 to 23h59 in the retrospective study (Table 8) when families were together. Meer (39) did not find any significant relationship between the occurrence of suicide and the time of day. She demonstrated no correlation between the nature and tempo of social activity characterising a particular time and the occurrence of suicide and to know when frustrations intensify but not when they will finally precipitate into parasuicidal behaviour.

RK Khan Hospital is situated in Chatsworth which has the largest Indian population in Durban (Table 19B) so not surprisingly most admissions were from Chatsworth (Table 9A). However Meer (14) found that the rates of suicides were greater in Chatsworth between 1962 - 70 than in Riverside, which was a shack area, between 1940 - 60 and which had the highest suicide rate at the time.

With regard to the age of the parasuicide cases, the peak in both prospective and retrospective components were in the 15 - 19 year and 20 - 24 year age group (Table 10) concurring with McCulloch and Phillip (27). In Pillay's (7) study on Indian scholars admitted to RK Khan Hospital with parasuicide there was a preponderance in the 16 to 18 year age group. Krietman (17) observed an increase in the admission rates in the 15 - 19 year age group. This was contrary to Stengel's (15) results as he found the peak age for attempted suicide to be in the older age groups between 24 to 44 years. Minnaar (22, 6) observed that among White parasuicides in Durban most occurred in the 20 - 29 year age group followed by the 10 - 19 year age group. However Edwards et al (4) found the highest incidence of parasuicides in the Durban Indian community to be in the 21 - 30 year age range followed by the 11 - 20 year age range.

According to Jacobs (21) and Engelbrecht (22) adolescents resort to suicide for many reasons such as problems from early childhood, failure to adapt and to cope with problems, and isolation from meaningful relationships. Engelbrecht (22) stated further that

parents did not respond appropriately to young peoples' feelings resulting in their withdrawal from the family. Newnes (25) stated that poor communication, conflict within the family, poor problem-solving ability, parental helplessness, inconsistent praise and excessive punishments from parents contributed to suicide attempts in young people.

In the retrospective study there was a case who was less than 10 years old which was a source of concern. Pfeffer (23) stated that parasuicides were found in children under 12 years and may be increasing.

In both prospective and retrospective studies members of the Hindu religion predominate (Table 12A). Within the Hindu religion the Tamil language group was in the majority (Table 11B and 12B). There were more Christian cases than Muslim as found by Pillay (7) among Indian scholars (Table 12A).

Edwards et al (4) reported a preponderance of Hindu parasuicides in their study among Durban Indians.

Meer (12) noted that about 75% of the Indians in Durban were Hindu, about 16% Muslim and about 7% Christian in 1969. Within the Hindu group, the Tamil language group were 38%, Telugu 12%, 25% of the Hindi language group and less than 2% were from the Gujelati language group. This explained the higher occurrence of parasuicides among the Hindu and especially among the Tamil-language group. However proportionately more Christian cases per Christian religion group were admitted with parasuicides in both prospective and retrospective studies than Hindu and Muslim cases per their own religious group. Pillay (7) observed that parasuicide among Christian scholars was highest when comparing the numbers in relation to their religious groups. Among the Hindu in the present study parasuicide in the Tamil-language group was proportionately higher per Tamil-language section of the community.

Pillay (7) stated that attitudes to suicide varied with different religions. Islam forbade suicide but Hinduism accepted suicide under certain conditions such as "sati" which was suicide performed by widows and when a person suffered from an incurable disease (7). Christianity condemned suicide for the same reason that Islam forbade suicide. They believed that life was given by God and to take life was an act against God but Christianity did not condemn suicide as severely as Islam where one became an outcast (7).

Stengel (15) was of the opinion that it was religious devoutness rather than a specific religious faith which was decisive, however, Pillay (7) found the highest rate of parasuicide to be among those who were devoutly religious.

In the prospective study most cases were married but in the retrospective study most cases were single (Table 13A).

Edwards et al (4) reported that parasuicide among married people was lower than among single individuals. Dublin (38) found that widowed, divorced or never married individuals had higher rates than married people but Meer (14) found a lower rate among widowed and divorced people as was found in this study. Minnaar (6) attributed a high parasuicide rate among single people to social isolation and the paucity of close ties and among married people to poor marital communication.

In both studies the majority of cases had done Standard 8 (Table 14). More cases who had a high school education attempted suicide than those who had a primary school education concurring with Pillay's (7) findings in her study on Indian scholars where most cases were between Standard 8 to 10 and the least between Class 1 to Standard 4.

Haim (28) observed that it was difficult to assess the suicidal process in relation to education because teachers in schools vary from one school to another.

In both the prospective and retrospective studies manual skilled or semiskilled workers dominated followed by housewives, students and unemployed people (Table 15A). There were more non-manual workers than grantees in the retrospective study than the prospective study.

Edwards et al (4) noted that the highest rate of parasuicides among Indians in South Africa was in the upper lower class group followed by the middle class. Pillay (7) found that more cases came from a family where the father had a middle and low status occupation and where the mothers were housewives.

McCulloch and Philip (27) observed the highest incidence among the lowest social class such as the unskilled worker. Bhana (8), Dublin (38) and Stengel (15) concluded that members of white-collar occupations had a lower rate for parasuicide than blue-collar workers.

Those cases earning less than R500 and where the joint family income was less than R500 predominated in both studies (Table 15B, 15C, 15D and 16). Very few cases who earned more than R1 000 were admitted to RK Khan Hospital for parasuicide. It must be noted that the higher income group has access to the private sector of medical care elsewhere. Pillay (7) also observed a preponderance of parasuicide in families earning less than R500. Meer found suicide rates to be higher in the poorer areas of Durban among Indians (39) and this may be attributed to the fact that most Indians belonged to the lower income group (12).

Sainsbury (27) found that more people committing suicide were in the middle and upper social classes in Edinburgh.

McCulloch and Philip (27) observed a correlation between suicidal behaviour and children taken into care. In this study 4 cases (0.6%) were from an institution of foster care (Table 17).

However the majority of parasuicide admissions were living with family in the nuclear pattern rather than in the joint or extended family system. Very few cases lived alone or with friends or with step parents. In the prospective and retrospective studies an equal percentage of the admissions lived with in-laws.

More families lived in the nuclear pattern than in 'the past (12) accounting for the greater proportion of nuclear families in both studies. Meer (12), in 1969 and Jithoo (43), in 1975 reported an increase in the nuclear family pattern of living compared to the joint or extended system. Pillay (7) in 1983 also found the nuclear family system predominant in her study and that a greater proportion of parents of Indian scholars who attempted suicide were married and the possibility of parental incompatibility and disruption of close inter-personal relationships leading to highly stressful situations preceding the parasuicide. According to Pfeffer (23) and Weiner (24) poor family communication promoted stress and conflicts with the mother especially often formed a background for a suicidal act (23).

In Chatsworth the mean occupancy per dwelling unit was 9.4, in Phoenix 3.1 and in Merebank 4.6 (Table 19b).

Occupancy of 5 people to a household was commoner in the prospective study while in the retrospective study occupancy of 3 people was in the majority and most lived in a household with one or two bedrooms (Tables 18 and 19A). Pillay (7) found that a greater proportion of cases were from families consisting of 3 to 5 people and fewer from families greater than 5 people. Stengel (15) and Meer (14) indicated that large families insulated individuals during stressful situations. However according to Jithoo (14) conflicts within a joint family system led to segmentation.

Meer (14) observed that improved housing units did not relieve suicide since in her study on suicides the rate of suicides was greater in Chatsworth (a council housing scheme) between 1962 - 70 than in Riverside (which was a shack area) between 1940 - 60 which had the highest suicide rate at the time.

With regard to the birth order, in the prospective study cases in the middle of the family predominated. Haim (28) attributed many authors to be of the belief that the elder children had a higher proportion of parasuicides but he himself saw no evidence of this in his studies. Pillay (7) found no consistent link between birth order and suicidal behaviour concurring with Haim's findings.

In the prospective study the case's social life was assessed and it was found that very few were members of a social club or group and despite the fact that the majority of patients did not have close friends most cases discussed their problems with a friend instead of a family member or spouse (Tables 21 and 24). There were some who did not discuss their problems with anybody (6).

In both studies many cases did not have a father who was lost either through death, divorce or abandonment (Table 22).

Dorpat et al (26) demonstrated that parental loss in childhood predisposed to depression and suicide later in life which were theories put forward by Bowlby and Zilboorg - and this occurred more frequently when the parental loss happened before the age of 12 years. However Jacobs (21) stated that it was loss of a love object which was part of a process and not only did its presence or absence predispose to depression and suicide later in life.

Non-violent means of parasuicide occurred most commonly in the retrospective study and was the only means occurring in the prospective study. The ingestion of medicinal preparations was the commonest means used in both studies (Table 25) as was found by Minnaar (22,6) and Pillay (7). Analgesics and psychotropic medicines predominated in both the prospective and retrospective components concurring with Minnaar's findings (6). Many cases ingested other substances such as disinfectants, insecticides and various other toxic agents as was found by Bhana (8) in his study on Indian female parasuicides and by Edwards et al (4) in their study on Indian parasuicides in Durban. Very few violent means of parasuicide were used in the retrospective study only.

Availability of substances (7, 12, 27) rather than choice of any particular substance influenced the method used by the parasuicide cases. It had been reported in 1980 by Farmer (16) that episodes of poisoning had increased in recent years and this was borne out in the present study.

The prime reasons for the parasuicide were mainly social in nature. Marital and family problems predominated in both studies (Table 26). Many problems occurred with parents, brothers and there were general family problems.

Since there was an increase in the number of nuclear families, problems were more concentrated within the nuclear family than in the extended family as reported by Meer (12). If members of the nuclear family could not cope with their problems and since there was nobody immediately at hand to help sort out their problems parasuicide was resorted to.

However Cheetham et al (37) found the major precipitating factor to be interpersonal disputes involving the extended family, spouse, relatives, lover or romantic attachments; parental disapproval of marriages, romantic relationships or friendship; and cultural

factors transgressing cultural norms in cross-caste marriages, romantic attachments or sex relationships and cultural deviance. They also described the Indian community as an acculturating and a deculturating community leading to a transitional state of values and norms causing psychological stresses within the community and thus creating major precipitating factors for parasuicide (37).

Pillay (7) found the major precipitating factors to be general familial discord, faulty parent-child communication and marital discord as was found in the present study. Minnaar (6) found marital relationships to be the commonest cause of parasuicide and then social problems followed by interpersonal problems.

In the older Indian traditions each child had its own designated position and this curbed sibling rivalries (12). However in urban families sibling rivalries arose (12) and this has been demonstrated in the present study (Table 26). Females were expected to be obedient to male and female authority while boys only to male authority in the past (12). However nowadays females rejected this idea and demonstrated this "passively" by their parasuicide acts (12).

Concerning marital problems alcoholism, assaults and extramarital affairs on the husbands' part dominated the picture. Husbands generally were authoritarian and regarded their wives as minors and as their possessions needing protection and correction. Now they observed that their wives were not submissive anymore due to a higher education and an occupation by their wives resulting in a demand for equality and freedom within the household which he resented and felt was an erosion of his power (12). Men were brought up to believe that they could "do as they wanted to" without question (12) while women were denied this privilege and it seemed in the present study that women (single and married) rebelled against this belief and demonstrated their frustration by parasuicide acts.

Merlov (20) contended that suicide was attempted in relation to other people and was directed towards somebody to elicit remorse, guilt, shock or embarrassment.

Hurlock (31) stated that poor marital relationships affected the whole family making the home environment very emotionally "charged" with the result that every member was at odds with every other member. Interpersonal troubles became progressively more deleterious as demonstrated by McMohan (18).

Choron (19) stated that suicidal individuals complained that their lives had lost meaning and were no longer worth living. When an individual believed that he or she was incapable of coping with circumstances and that nothing would improve in the future suicide was resorted to as an act of "desperation" in extreme circumstances was Lingen's opinion (19).

Many cases had problems with their romantic attachments. Conflict arose because either one or other of the partners wanted termination of the relationship sometimes after an intimate sexual relationship or the female was pregnant or there was opposition to the relationship by parents for many varied reasons such as religion, language, occupation and class differences (12,37).

Youngsters "falling in love" formed very possessive and exclusive attachments which led to increased isolation as they cut off other friendships and when the romance failed, they felt hopeless, lost and in despair they attempted suicide (19).

Financial, work and school problems, loneliness and psychiatric illnesses were not major features of the immediate reason (4) for the parasuicide act although they did occur or may have been implicated in events leading up to the parasuicide act which was precipitated by another factor. Many cases demonstrated impulsive behaviour (7,13) in the "heat" of emotion which were communication attempts to give a message or were manipulative to alter the behaviour of others as Morrice (13) demonstrated.

Some cases also felt that life was not worth living (19) and some had a painful illness but these were fewer in the present study.

In the prospective study there were more cases with close contacts either in the family, spouse's family, close friends or neighbours who had attempted suicide or parasuicide than in the retrospective study (Table 28). Edwards et al (4) reported a 14% incidence of a family history of suicide. Other researchers such as Bhana (8) found no history of suicide or parasuicide in families of individual cases (8).

Many cases in the prospective and retrospective studies had attempted suicide in the past (Table 27). According to McCulloch and Philip (27) people making repeated suicidal attempts were the most deviant in terms of psychiatric features, personality characteristics and level of social functioning. The reported number of parasuicides repeating the attempt varied greatly (8). Edwards et al (4) found 28% had a history of previous self-poisoning acts and 23% acts of self injury in their study on Indian parasuicides in Durban. Among White parasuicides in Durban, Schlebush (22) and Minnaar (6) found that more than a third had made previous suicidal attempts. Stengel (15) stated that the critical period was 4 years following the last suicide attempt.

More cases sought aid in the prospective study than in the retrospective study (Table 29). Aid from welfare agencies ranked highest and it is a cause for concern that despite being clients of welfare organisations, parasuicide occurred.

Cases who had been consulting a psychiatrist either at a psychiatric clinic, hospital or privately and after being admitted for parasuicide in the past attempted suicide (Table 29). Schlebush (22) and Minnaar (6) found that one third of White parasuicides had had previous psychiatric treatment.

Stengel (15) stated that a majority of the people committing suicide had not been receiving psychiatric treatment. Researchers such as Turner (29), Greer and Bayley (29), Chowdhung et al (29), Gibbons et al (30) disagreed on whether psychiatric intervention was beneficial in preventing repetitive suicide attempts.

Very few cases sought help from alcoholic organisations, religious bodies, relatives or school counsellors (Table 29). Pillay (7) found that scholars who had attempted suicide had little contact with school counsellors and were not aware of the counsellors' role. Many scholars indicated to her that contact with the social worker at the hospital was helpful (7). Rocher (32) recommended that school social workers should be allocated to large schools in areas where there was such a need to assist the scholar to gain maximum advantage from school experience in preparation for future roles in society as an adult. School personnel viewed the school first and foremost as an institution of learning and programmes to extend interaction may reduce or prevent suicidal attempts (7).

Not one case in either the prospective or retrospective study contacted Lifeline (22), an organisation available on the telephone for 24 hours a day to help people threatening suicide, to sort out the crisis situations and crisis teams went out to help the person personally if the problem was not resolved on the telephone. Jacobs (21) suggested using people who had attempted suicide to volunteer their service in setting up a suicide prevention centre.

Turner (29) and Krietman (17) cited non-help seekers as those whose episodes of distress were of an acute onset and whose lives were acutely disrupted, often due to interpersonal difficulties.

According to the World Health Organisation (33), prevention of suicide was an important public health responsibility (6). They suggested psychiatric consultations to be available within a few hours.

Price and Carney (34) stated that most parasuicides could be helped by medical or social agencies, since not all parasuicides required psychiatric treatment but might need assistance from social welfare agencies.

Pillay (7) suggested a multi-disciplinary team to explore and mobilise patients' physical, intellectual, social, emotional and vocational resources to bring about an integration. According to her the Indian family was in a process of acculturation resulting in conflict over norms and traditional values as demonstrated by Cheetham et al (37), therefore the introduction of adult socialisation as described by McBroom (35) may be useful by using the process of teaching and learning social roles, with competence as the goal.

RECOMMENDATIONS

It is recommended that :

- 1 All cases of parasuicide and accidental drug overdose be notified to the local authority for investigation.
- 2 From notification trends further action be decided by the health services.
- 3 Recordings of parasuicides be standardised.
- 4 Social workers do preventive social work in addition to "curative" social work.
- 5 The social work staff at RK Khan Hospital and at the Psychiatric units at the Psychiatric clinics in Chatsworth be increased.
- 6 Home visits of all parasuicide cases be done by health personnel such as community health nurses, social workers and psychiatric staff.
- 7 Counselling centres and advice centres rather than welfare agencies be established in each unit manned by advisors to resolve problems and to offer advice on various issues.
- 8 After normal working hours availability of advisors or health personnel either in person or through the telephone be established.
- 9 A centre for temporary admission of potential parasuicide people be established, to overcome the crisis period, at the hospital and at various sites in the community.
- 10 A Psychiatric Unit with psychiatric nurses, psychiatric social workers, psychologists and a resident psychiatrist be available 24 hours a day at RK Khan Hospital.
- 11 Social workers be employed at school.
- 12 Lectures on life style, problem solving, preparation for adolescence and adulthood, interpersonal communication, finance, be given to scholars and to the community to both men and women.

- 13 Practical assignments and tasks be given to scholars at school concerning recommendation 12 and constructive extracurricular activities be arranged by the schools.
- 14 Less medicines be prescribed by hospital and private medical practitioners. Three days supply be given and to be repeated when the patient returns with the empty medicine packet.
- 15 Outlets be established at the hospital and outside the hospital for repeat medications.
- 16 Health education on the dangers of medicines and overdosages be increased. Use of the mass media be made.
- 17 Employment opportunities be improved by employers enabling housewives and other people at home to perform work at home for remuneration. Employers should employ social workers or counsellors to advise workers and help workers solve problems.
- 18 Alcoholism centres, marriage guidance centres and lifeline centres be established in Chatsworth.
- 19 Crisis groups and problem solvers from the community be established in each street to aid and advise families especially "at risk" families.
- 20 Religious bodies take an active role in suicide prevention and in counselling of the communities they serve.

CONCLUSIONS

The very fact that parasuicide occurred was a sign that a problem existed in the community concerned and which needed to be resolved. For any individual to attempt to kill himself for whatever reason is very perturbing as the person threatening or attempting suicide was by his behaviour communicating to others that he was in difficulties and was using suicide as a gesture to express his inability to handle his stress, conflict and problems.

It is imperative that active steps be taken by the authorities and the communities concerned to prevent the occurrence of parasuicide through the recommendations suggested by the researcher.

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THE EPIDEMIOLOGY OF PARASUICIDE AT
RK KHAN HOSPITAL

RESEARCH PROTOCOL

for a Dissertation in partial fulfilment
of the requirement for the Part II M Med
(Community Health) of the University of
Natal

M Bhamjee

May 1984

THE EPIDEMIOLOGY OF PARASUICIDE AT RK KHAN HOSPITAL

1 DEFINITION OF THE PROBLEM

The epidemiology of parasuicide cases presenting at RK Khan Hospital.

2 DEFINITION OF THE OBJECTIVES

- i) To determine the extent of the occurrence of parasuicide admissions to RK Khan Hospital.
- ii) To investigate the multiple epidemiological factors associated with the occurrence of parasuicide in respect of the person affected, the means used, and the social and cultural characteristics of the affected person's background.
- iii) To ascertain previous attempts at suicide and previous psychiatric care received.
- iv) To identify supportive services available in the community concerned and to ascertain the contribution made by these in respect of identified cases.
- v) To determine multiple methods of interception of the various associated factors in respect of the reduction of the incidence of parasuicide.
- vi) To make recommendations in respect of (v) above.

3 COLLECTION OF DATA

a) DEFINITION OF CRITERIA

Suicide : self inflicted violence with the apparent or stated intention to terminate the life of the person concerned

Parasuicide : an unsuccessful attempt at suicide

b) SELECTION OF SAMPLE AND CONTROL GROUPS

The sample will consist of all those patients admitted to RK Khan Hospital with a diagnosis of parasuicide during :

- i) 1 January 1983 to 31 December 1983 (retrospective)
- ii) 1 July 1984 to 31 July 1984 (prospective)

A control study is not necessary for the purpose of this study.

c) DETERMINATION OF METHODS OF DATA COLLECTION

- (i) This study will include both prospective and retrospective components.
- (ii) For the purpose of the retrospective study the patients will be identified from the hospital records in the medical registry.
- (iii) Relevant information will be extracted from the hospital case notes onto a standard checklist (Annexure A).
- (iv) In respect of the prospective component arrangements will be made with the Medical Superintendent of RK Khan Hospital for the wards to notify the researcher of any cases of para-suicide admitted during the study period.
- (v) These patients will be interviewed by the researcher and relevant information will be recorded on the standardized questionnaire and checklist (Annexure B).

d) ELIMINATION OF VARIABLES

Variables will be reduced by means of :

- (i) adhering to defined criteria
- (ii) the administration of the standardized questionnaire and checklist by the researcher only

e) SETTING OF TIME BARRIERS

(i)	Completion of research protocol	30 4 84
(ii)	Checklist and Questionnaire finalised	21 5 84
(iii)	Commencement of data collection	1 7 84
(iv)	Completion of data collection	31 7 84
(v)	Collation and analysis of data	31 8 84
(vi)	Completion of dissertation	30 9 84

f) APPRAISAL OF THE LITERATURE AND OTHER AVAILABLE INFORMATION ON THE PROBLEM

This will be ongoing throughout the study by the researcher. Relevant published and unpublished material will be reviewed.

4 COLLATION OF COLLECTED DATA

Data will be collated and analysed manually by the researcher.

5 EVALUATION OF THE INTER-RELATIONSHIPS OF THE DATA

This will be carried out by the researcher.

6 ADVANCEMENT OF HYPOTHESES OF THE MULTIPLE FACTORS OF CAUSATION
AND METHODS OF INTERCEPTION

Hypotheses will be advanced upon completion of the research project. Recommendations will be made in respect of the reduction of the occurrence of parasuicide.

7 PUBLICATION OF FINDINGS

This dissertation will be presented in partial fulfilment of the requirements for the Part II M Med (Community Health) of the University of Natal in a format suitable for publication in the medical press.

THE EPIDEMIOLOGY OF PARASUICIDE AT RK KHAN HOSPITAL

IDENTITY

Patient (Name)

RK Khan Number /

Address

Chatsworth = 1 Phoenix = 2 Other Durban = 3 Elsewhere = 4

Age (completed years)

Sex (male = 1, female = 2)

ENVIRONMENT

Race (African = 1, Asian = 2, Coloured = 3, White = 4)

Religion (Christian = 1, Hindu = 2, Muslim = 3, Other = 4)
specify

Denomination (specify)

Home language (English = 1, Gujerati = 2, Hindi = 3, Tamil = 4,
Telugu = 5, Urdu = 6, Other = 7 specify)

Marital State (Single = 1, Married = 2, Widowed = 3, Divorced = 4
Living together = 5)

Spouse : Resident (Yes = 1, No = 0) Age (completed years)

Comments

Number of previous marriages

Occupation (Professional = 1, non-manual = 2, manual skilled/
semi-skilled = 3, manual unskilled = 4, housewife = 5,
child/student = 6, unemployed = 7, pensioner = 8)

Monthly Income (Nil = 0, <R100 = 1, R100 - R499 = 2, R500 - R999 = 3,
R1000 - R1999 = 4, R2000+ = 5 specify)

Living with family ? (Yes = 1, No = 0) specify)

Contribution to family expenses (Yes = 1, No = 0)
Specify how much

Home type (Detached house = 1, semi-detached = 2,
flat = 3, other = 4 specify)

Home Ownership (Owner = 1, tenant = 2, boarder = 3)

FAMILY

Number

Position in family

Number of siblings

Number of males (including patient)

Number of females (including patient)

Mother alive (Yes = 1, No = 0)

Father alive (Yes = 1, No = 0)

Step-parents (Yes = 1, No = 0)
specify

Attitude to mother (Like = 1, neutral = 2, dislike = 3)

Attitude to father (Like = 1, neutral = 2, dislike = 3)

Attitude to siblings (Like = 1, neutral = 2, dislike = 3)
specify

Loss of parent (Mother = 1, father = 2, both = 3)

Time of loss (years ago)

Reason for loss (Death = 1, divorce = 2, abandonment = 3,
other = 4, specify)

Age of respondent at time of loss

Family history : Suicide (Yes = 1, No = 0)

Parasuicide (Yes = 1, No = 0)

specify

SOCIAL

Member of any club (Yes = 1, No = 0)
specify

Friends - how many

With whom do you discuss intimate problems ?

(Family member = 1, spouse = 2, friend = 3,
other = 4 specify)

PSYCHIATRIC ASSESSMENT

Personality type

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Possible reason why attempt was made

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Treatment

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COMMENTS

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