NON-FATAL SUICIDAL BEHAVIOUR IN SOUTH AFRICA: A STUDY OF PATIENTS OF AFRICAN DESCENT

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Abstract

Little published research exists on non-fatal suicidal behaviour amongst persons of African descent. This investigation sampled 82 patients of African descent who presented with non-fatal suicidal behaviour at psychological clinics in general hospitals in Pietermaritzburg (South Africa). Over half of the sample engaged in suicidal behaviour over the weekend. Significantly more adolescents than adults ingested medicinal substances, and significantly more adults than adolescents used violent methods in their non-fatal suicidal behaviour. Interpersonal conflict was cited as a short term precipitant to non-fatal suicidal behaviour in most of the cases. Financial stressors and employment difficulties were predominantly cited as recent stressors to non-fatal suicidal behaviour amongst adults. The findings demonstrate similar demographic and psychosocial correlates of non-fatal suicidal behaviour amongst Africans as other cultural groups in South Africa. The hypothesised effects of Apartheid and acculturation are discussed.

Key words: Non-fatal suicidal behaviour; self-destructive behaviour; self-poisoning; South Africa

Résumé

Peu de recherches ont été entreprises sur le comportement suicidaire non mortel chez les personnes de descendance sud-africaine. Cette recherche étudie 82 patients de descendance sud-africaine présentant des symptômes de comportement suicidaire non-mortel et ayant été acceptés dans les sections de psychologie d'hôpitaux généraux à Pietermaritzburg (Afrique du Sud). Plus de la
moitié d'entre eux manifestèrent un comportement suicidaire durant le week-end de leur internement. Un plus grand nombre d'adolescents que d'adultes absorbèrent des substances médicinales, et un plus grand nombre d'adultes eurent recours à des méthodes violentes dans leur comportement suicidaire non mortel. Dans la plupart des cas, les patients mentionnèrent qu'un conflit avec une ou d'autres personnes avait précipité leur comportement. Les adultes mentionnèrent en majorité des difficultés financières ou d'emploi comme facteur prédominant de leur comportement suicidaire. Les résultats de cette étude montrent une similaire corrélation démographique et psychologique avec ce comportement suicidaire non mortel tant chez les Africains que chez les autres groupes culturels d'Afrique du Sud. Les possibles effets de l'Apartheid et de l'acculturation sont en cours d'étude.

Mots clés: Comportement suicidaire non mortel; comportement auto-destructeur, auto-empoisonnement; Afrique du Sud.

INTRODUCTION

The term 'non-fatal suicidal behaviour' (NFSB) in this paper refers to a non-fatal act of deliberate self-harm, making no inferences about the individual's intent. NFSB may occur by way of intentional self-injury, the intentional ingestion of medicines in excess of therapeutic doses, or the ingestion of substances not intended for human consumption (Pillay & Wassenaar, 1991). Although efforts have been made to clarify suicidological terminology (O'Carroll, Berman, Maris, Moscicki, Tanney & Silverman, 1996), there is still little consistency in the literature. Our definition as used above conforms with that used by Canetto (1997) which is based on outcomes in an effort to avoid terms such as 'suicide attempts' and 'parasuicide', both of which have intentional inferences which may be incorrect.

Although there is a substantial body of South African research into NFSB, investigations to date have sampled mainly White, Indian and 'coloured' population groups. Racial classification is used here only because this work focuses on a specific cultural group. The classification system employed in this paper is in accordance with that used by Statistics South Africa (2000). The paucity of research on NFSB patients of African descent largely mirrors the political and social inequities caused by the Apartheid system. Considering the apparent increase in the incidence of NFSB in the African population (Pillay, Wassenaar & Kramers, 2000) which constitutes 76.7% of the country's
people (Statistics South Africa, 2000) the need for suicidological research in this cultural group can no longer be ignored.

Forster and Keen (1988) reported a low incidence of NFSB and fatal suicide in Africans during the years prior to the dissolution of Apartheid in South Africa. Former Apartheid policies that resulted in unequal access to health care, inaccurate recording practices and, of course, that government's tendency to produce statistics favouring its political position may well confound these findings. More recent research suggests that while the incidence of NFSB is increasing among Africans (Schlebusch, 1995), it remains lower than for Indian or White South Africans (Naidoo & Pillay, 1993).

The relatively few epidemiological studies of NFSB on the African continent have shown somewhat disparate findings. An earlier review by Odejide, Oywunmi and Ohaeri (1989) noted very high rates in Zambia and Uganda, but very low rates in Nigeria and Senegal, concluding that suicidal behaviour is far less prevalent in Africans compared to Caucasians, with East Africa having higher rates than West Africa. More recent findings suggest that suicidal behaviour occurs more frequently in Africa than was previously found (Peltzer, Cherian & Cherian, 1998). Although no reliable data are available for South Africans prior to the 1960's it does appear that this was not a significant problem amongst indigenous Africans, and that it has escalated into a more serious problem over the last two decades or so.

The literature advances several explanations for this increase, including the hypothesized effect of acculturation and the adoption of Western lifestyles (Pillay, Naidoo & Tlou, 1992). Living in a country that is in political and cultural transition demands many shifts in lifestyle that may not be easily mastered or accommodated. The adverse psychosocial consequences of years of Apartheid oppression should also not be overlooked - years of oppression which did not equip black South Africans for the challenge of adjusting to a globalised neo-liberal ethos with its pressures, contradictions and hazards. Although cultural diversity is a national treasure, cultural interactions often result in a blurring of cultural norms and boundaries that exert stress at the individual, family, and cultural group level (Wassenaar, Pillay, Descoins, Goltman, & Naidoo 2000; Wassenaar, le Grange, Winship & Lachenicht, 2000; Wassenaar, van der Veen & Pillay, 1998). Such deculturative and acculturative phenomena have often been associated with suicidal behaviour, due to the stresses these bear on the family system, especially in more traditional families (Pillay & Wassenaar, 1997a). Family and intimate relationship conflicts are also being increasingly recognised as risk factors for
suicidal behaviour among young Africans (Mayekiso, 1995; Mhlongo & Peltzer, 1999).

The present investigation, which forms part of the Pietermaritzburg Suicidology Project, is a preliminary attempt to supplement the South African suicidology literature and, more specifically, to examine NFSB related variables in a sample of African NFSB patients in comparison with other cultures. The study was conducted at the Psychological Clinics at general hospitals in Pietermaritzburg, where all NFSB patients are seen following their suicidal behaviours, and after they have been medically stabilized (usually within 48 hours of admission to the hospital).

**METHOD**

A prospective design was employed in order to capture data on all patients of African descent, regardless of ethnicity, presenting with NFSB over a 6 month period. A short questionnaire was designed for completion by the attending clinical psychology intern following the initial consultation. The following details were recorded: age, gender, educational level, marital status, previous mental health treatment, day and time of NFSB, method employed, short-term precipitants (or trigger events) occurring just prior to the NFSB, and recent stressors experienced over the preceding 6 months. The last mentioned was recorded through a checklist of the following stressors: death, illness, divorce/separation, financial problems, significant failures, legal problems, familial conflict, employment problems, school difficulties, relationship conflict, other. More than one stressor could be checked. A distinction was made between trigger events and stressors over the six months preceding hospital admission, in view of the importance of distinguishing between patients' ongoing problems and other specific events which may have triggered the NFSB (Hawton, 1986). This checklist has been successfully used in previous research into NFSB (Pillay & Wassenaar, 1997b). The questionnaire was conducted in English although this was a second language for some patients. White and Indian patients were excluded from the study although they received identical clinical services at the clinics used for this study. Patients were assured of confidentiality equivalent to being clinical service recipients and were assured that only group trends would be published. No reliability or validity tests were conducted on the questionnaire although it was similar to that used in earlier studies of suicidal patients (Pillay & Pillay, 1987). For the purposes of this study the term 'adolescents' was applied to those between 13 and 21 years of age.
The data were analysed using the SPSS/PC programme (Norusis, 1990).

RESULTS

A total of 82 NFSB patients were seen during the period of investigation, 56 (68.3%) of whom were female. A female: male ratio of 2.2:1 was found. The age range of the sample was 15-48 years (Mean = 24.6 years, \(SD = 7.68\)). The majority of the sample (52 or 63.4%) were adults between the ages of 22 and 48 years, while 30 (36.6%) were adolescents under 21 years of age. The majority (69 or 84.1%) of the sample had secondary education, while 6 (7.3%) received tertiary education. Over three quarters of the patients (64 or 78.0%) were single. None of the adolescents were married. Of the total sample 11 (13.4%) had histories of previous mental health treatment.

Over half of the sample (47 or 57.3%) had engaged in NFSB over the weekend, i.e. between Friday afternoon and Sunday evening. In general most (78 or 95.1%) NFSB's occurred during the afternoons (\(n = 44\)) and evenings (\(n = 34\)). As shown in Table 1, ingestion of poisons constituted the predominant method of NFSB, being used by 36 (43.9%) patients.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingestion: poisons</td>
<td>10</td>
<td>26</td>
<td>36 (43.9%)</td>
</tr>
<tr>
<td>Overdose: Non-Prescribed Meds</td>
<td>3</td>
<td>20</td>
<td>23 (28.0%)</td>
</tr>
<tr>
<td>Cutting, hanging, burning</td>
<td>11</td>
<td>5</td>
<td>16 (19.5%)</td>
</tr>
<tr>
<td>Overdose: Prescribed Meds</td>
<td>2</td>
<td>5</td>
<td>7 (8.5%)</td>
</tr>
</tbody>
</table>

Non-prescribed medicinal substances ranked second and were ingested by 23 (28%) of the patients. Significantly more adolescents (18 or 60%) than adults (12 or 23.1%) ingested medicinal substances in their NFSB (Chi square = 11.18, d.f. = 1, \(p < 0.001\)). Also, significantly more adults (15 or 28.8%) than adolescents (1 or 3.3%) used violent methods such as hanging and cutting.
(Chi square = 7.88, d.f. = 1, p < 0.01). Ingestion of prescribed medicines was the least common method used by only 8.5% of patients.

TABLE 2: Recent stressors by Gender and Developmental Level

<table>
<thead>
<tr>
<th>STRESSOR</th>
<th>MALES</th>
<th>FEMALES</th>
<th>TOTAL*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adolescents</td>
<td>Adults</td>
<td>Adolescents</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Family Conflict</td>
<td>5</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Relationship</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Employment</td>
<td>10</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Financial</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>School</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorce/Sep</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Death</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Failure</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Illness</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Legal</td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*Totals do not add to 82 as some cases included multiple stressors.

Seventy B eight patients (95.1%) reported interpersonal conflict as short term precipitants or trigger events to their NFSB’s. Almost half the patients (40 or 48.8%) cited conflict in intimate relationships (i.e. with boyfriend, girlfriend or spouse) as trigger events, while 15 (50%) of the adolescents experienced conflict with their parents shortly before engaging in NFSB. Among the recent stressors (i.e. over the preceding 6 months), one quarter (13 or 25%) of the adult NFSB patients reported financial stressors, while close to half (22 or 42.3%) reported employment difficulties. As shown in Table 2, proportionately more adolescents (18 or 60%) than adults (20 or 38.5%) reported family
reported family conflict as a recent stressor, a finding that approached statistical significance (Chi square = 3.54, d.f. = 1, p = 0.06).

DISCUSSION

While the sample size of 82 in this investigation may appear relatively small, it translates into a rate of just over 3 NFSB patients hospitalised per week. Of course, this reflects only 'reported' cases in this area, i.e. those NFSB patients presenting for medical attention at state-funded general hospitals, and cannot be regarded as an incidence rate. However, the present figure suggests a much higher rate of hospitalised NFSB patients of African descent than those noted in a large academic hospital in Durban (almost 1 per week) during the latter days of Apartheid when access to health facilities was still fairly restricted (Naidoo & Pillay, 1993). Considering also that Pietermaritzburg, the site of the present study, has a markedly smaller population than Durban one can infer that either Pietermaritzburg has a substantially higher rate of NFSB than Durban or the rate of NFSB among Africans is actually increasing. The authors have no reason to believe the former is the case.

The female: male ratio of 2.2:1 in the present study is similar to that noted in a recent study at the Chris Hani Baragwanath Hospital (2.4:1) in Johannesburg (Deonarain & Pillay, 2000) but is higher than the female to male ratio of 1.7:1 reported by Mhlongo and Peltzer (1999). An earlier study of Indian and 'Coloured' NFSB patients revealed a ratio of 2.8:1 (Pillay & Pillay, 1987), while an investigation of White NFSB cases showed a rate of 2.6:1 (Pretorius & Roos, 1995). Bearing in mind that all of these studies are relatively small and geographically located in specific cities, and are not national studies, the gender ratio in the present study is nevertheless fairly similar to those noted in other cultural groups. As in most parts of the world, this trend of higher rates of female than male NFSB may be attributed to gender-specific cultural scripts concerning suicidal behaviour (Canetto, 1997), or to the functional and interactional purpose that suicidal behaviour serves to the individual. It has been argued that NFSB represents a form of communication for distressed individuals who feel unable to resolve their conflicts through conventional means (Wassenaar, 1987). Considering that females express their emotions and feelings, and disclose their distress more easily than males (Bee, 1987; Pillay & Sargent, 2000) it is not surprising to find a preponderance of females among NFSB patients. Recent research has also confirmed that women and those living below the poverty threshold are the more vulnerable groups for depressive illness (Patel, Araya, Lima, Ludermir & Todd, 1999).
The finding that 36.6% of the sample was under 18 years of age seems consistent with the mean sample age of 20.2 years reported by Mhlongo and Peltzer (1999) but is at variance with that of Deonarain and Pillay (2000) where adolescents (under 20 years) constituted only 20.5% of their African sample, and Pretorius and Bodemer (1992) who noted that just 21.8% of their White sample was under the age of 20 years. Of course, the latter 2 samples were considerably larger than the present one, and may be providing a broader picture of the age distribution for NFSB. On the other hand, there is an increasing body of evidence showing that adolescents dominate NFSB populations worldwide. The well known Oxford studies have revealed peak rates for female NFSB in the 15-19 year age group, with that for males slightly higher (Williams, 1997). Earlier South African research with other cultural groups also noted similar age distributions (Pillay & Pillay, 1987). Focusing specifically on secondary school pupils of African descent, Peltzer et al. (1998) found that just over 10% of the sample had histories of NFSB. Researching suicidal behaviour specifically among African adolescents in the eastern Cape region, Mayekiso and Mkize (1995) argued that the psychosocial changes that characterize adolescence may result in parent-child conflicts which precipitate suicidal intentions. This is consistent with theories advanced to explain adolescent NFSB in other cultural groups in South Africa and elsewhere in the world (Pillay & Wassenaar, 1997a; Kienhorst, De Wilde & Diekstra, 1995).

Another interesting finding is the complete absence of NFSB patients over the age of 48 years, which differs from findings reported from research with other cultural groups (Kok, Du Preez & Bosch, 1992; Pretorius & Bodemer, 1992). The present finding lends support to the cross-cultural research findings of Schlebusch (1995) showing a maximum age of 45 years among African NFSB patients compared to 51 years among 'Coloured', 58 years among White and 62 years among Indian NFSB patients. This may be related to the very strong adherence to cultural beliefs and practices in older Africans. In particular Africans over the age of 45 years have been found to adopt a more serious approach to life, showing a preference for traditional rather than 'westernized' or acculturated lifestyles (Thwala, Pillay & Sargent, in press). Furthermore, it has been documented within the realm of traditional African belief, that ancestral spirits tend to look rather unfavourably upon senior family members, especially the patriarch, who fail to assume their responsibilities (Mkhize, 1999). Therefore, it is very likely that lifestyle preferences and spiritual influences may be protective factors against suicidal behaviour.
The majority of the sample had received secondary education, with only 7.3% having had tertiary education, which is similar to the 6% reported by Mhlongo and Peltzer (1999). Although only indirectly comparable, these findings differ from Schlebusch's (1995) White sample where almost 30% of the patients were in 'professional' occupations (i.e. occupations requiring tertiary education), but relatively similar to his African sample where only 1.6% were in 'professional' occupations. Of course, this difference in educational levels across cultures must be viewed as an effect of the disadvantages of Apartheid on Africans, rather than specifically as a relationship between education and NFSB.

The high percentage of single patients in the present sample is consistent with the findings of other studies (Mhlongo & Peltzer, 1999; Naidoo & Pillay, 1993), especially considering that all of these samples had mean ages lower than 24.6 years, reflecting relatively young samples. Similar findings were noted by Schlebusch (1995) for his African and 'Coloured' samples, although his White and Indian samples had higher mean ages, and understandably, more married patients. The present finding is also supportive of British research demonstrating higher NFSB risk among single and divorced people (Williams, 1997). As previously documented, individuals living in situations without much support are particularly vulnerable in times of stress and emotional trauma since they perceive no source of help or comfort (Pillay & Pillay, 1987). This is also true in the case of young single people living with their families of origin, but who experience ongoing conflict with their parents. Research has demonstrated that young NFSB patients report less perceived support and understanding from their families than depressed individuals (Kienhorst, de Wilde & Diekstra, 1995).

The finding that 13.4% of the sample had previously sought and/or received mental health treatment is similar to Schlebusch's finding (9.4%) among African NFSB patients in Durban, but much lower than that noted in his White (29.4%) and Indian (37.1%) samples. Access to health care facilities must certainly be a confounding variable in view of the disparate services during the Apartheid era. Also, help seeking behaviour, which is very likely influenced by education and socioeconomics, may account for Indian and White NFSB samples showing higher rates of previous mental health contacts. This is consistent with a study by Lupuwana, Simbayi and Elkonin (1999) which found low access to and poor utilisation of psychological services amongst a sample of South African Blacks. Of course it is also possible that the present sample has a lower rate of mental illness than those in other studies.
Interestingly, almost all patients engaged in NFSB during the afternoons and evenings with the majority over the weekends. Considering interpersonal conflict was the trigger event in almost all of the patients (discussed below) this finding is not surprising. Interpersonal conflict usually occurs during late afternoons, evenings and weekends when individuals are at home or in contact with significant others. A study in Johannesburg confirmed these findings revealing that NFSB rates peaked between 18h00 and midnight (O'Neill-Kerr, 1995), while Schlebusch's (1995) study in Durban noted that almost three-quarters of his African sample engaged in NFSB over the weekends. During afternoon or evening conflicts, individuals are likely to feel alone and unsupported since friends or other supportive relatives are not immediately accessible. This escalates the feeling of hopelessness, which is a key ingredient in the development of suicidal ideation (Pillay & Wassenaar, 1995). The feeling of 'aloneness' following conflict with significant others is a significant risk factor for suicidal behaviour which would be aggravated during the late evening when others in the house have gone to bed. In addition, the weekends which are usually times of recreation and enjoyment can be perceived as particularly distressing periods for individuals who are emotionally troubled or depressed, especially if those in the vicinity are in a joyful mood. Of course, an additional variable which has not been investigated in this study is alcohol use which is generally higher during weekends and evenings, and which has previously been linked to NFSB as a risk factor (Williams, 1997).

The finding that the ingestion of poisons was the predominant method of NFSB (43.9%) is consistent with that noted by Schlebusch (1995) in his African sample (59.4%) but is considerably lower than the 84% reported by Mhlongo and Peltzer (1999). Our data also differs markedly from Schlebusch's (1995) data on other South African cultural groups where poisons were rarely used and overdoses of medicinal substances predominated. Similarly, research in developed countries show that poisons are infrequently used (Williams, 1997). The present finding must certainly be due to the issue of access and availability. Africans in this country have, until a few years ago, been denied adequate health services with the result that medicinal preparations have not been readily available in most homes. Instead, toxic substances such as paraffin, for example, may be found in more African homes than homes of other cultural groups due to its use as a domestic fuel in the absence of electricity, which is also an effect of Apartheid. In line with this argument, it is not surprising to find that significantly more adolescents than adults ingested medicinal substances (over the counter and prescribed) than older
individuals who have historically not had much access to, or familiarity with them. Similarly, the significantly higher rate of violent methods used may be related to the issue of access and familiarity. It is, however, possible that the more violent methods of adults may reflect more serious suicidal intent. It has been documented that suicidal intent does influence the method used in the self-destructive behaviour (Pillay, 1988; Rubinstein, 1992). The predominance of more violent methods of self-destructive behaviour in this South African adult sample is contrary to findings in Tanzania where most NFSB involved the ingestion of medicinal substances and self-poisoning (Ndosi & Waziri, 1997). This difference in method may be explained by the variable effects of acculturation in different African countries, as well as factors such as suicidal intent and accessibility to other methods of NFSB. Also, not to be ignored is the high level of violence that appears to have become endemic to South Africa, both in the Apartheid and post-Apartheid years. In their South African study, Peltzer et al. (1998) also found a preference for violent methods such as firearms, even among adolescents.

The high rate of interpersonal conflict reported as trigger events is consistent with earlier findings with African patients (Deonarain & Pillay, 2000; Mhlongo & Peltzer, 1999) as well as other cultural groups (Bosch, McGill & Noor-Mohammed, 1995; Pretorius & Roos, 1995). Conflict in intimate relationships was the predominant type of conflict, similar to the findings of Wassenaar (1987) and Pillay and van der Veen (1995) with other cultural groups. This is clearly a significant trigger event considering the destabilisation that can occur in a relationship and the resultant distress in the individual following conflict with a spouse or boy/girlfriend. The sense of hopelessness that can be generated in such situations is a known risk factor for suicidal behaviour. The finding that half of the adolescents experienced conflict with their parents shortly before their NFSB is consistent with South African and overseas research (Pillay & Wassenaar, 1997a; Kienhorst et al., 1995). Clearly African adolescents with NFSB, like adolescents of other cultures, experience conflicts with their parents to the extent that these conflicts appear to trigger self-destructive behaviours in some cases. While the present study did not ascertain the nature of the conflicts, the authors' clinical experiences have shown that issues relating to adolescent individuation and autonomy are common and very similar to that noted in adolescent NFSB research internationally.

Very significant numbers of patients reported financial (25%) and employment (42.3%) difficulties (mainly unemployment) as recent stressors over the preceding 6 months. This is consistent with overseas research.
showing unemployment to be a major correlate of NFSB (Williams, 1997). Of course, the currently high rate of unemployment in South Africa of 33.9% (Statistics South Africa, 2000) has an alarming relevance to NFSB risk. This is probably most relevant to the African community who under Apartheid were denied adequate educational opportunities, resulting in massively disadvantaged employability in the currently difficult economic period.

More adolescents than adults reported family conflict as a recent stressor over the previous 6 months. This must be seen in the context of the trigger events, showing a large proportion of adolescents experiencing conflict with their parents. The present finding then serves to emphasize that these adolescents have been experiencing ongoing difficulties which they have not been able to resolve and have resorted to NFSB as a means of communication (Wassenaar, 1987) since previous conventional communication methods have failed. In addition, adults appear to have experienced relatively less family conflict over the proceeding 6 months possibly because their recent stressors included financial and employment problems as well. Considering the developmental levels it is expected that problems of a financial and employment nature will affect adults more than adolescents, hence the greater weighting of these stressors for adults, and family (mainly parent-child) problems for adolescents. Again the finding of family conflict as a predominant recent stressor among young African NFSB patients is similar to that noted in an earlier study of young Indian South African NFSB patients (Pillay & Wassenaar, 1997b).

Our study did not seek nor find evidence of suicidal behaviour preceded by what Mhlongo and Peltzer (1999) have called 'AIDS phobia' (p. 73). They found that NFSB was associated with AIDS phobia in 17% of their sample. It is clear, however, that future studies of NFSB should include careful questions around HIV/AIDS in view of the dramatic escalation of HIV/AIDS in the same demographic cohort (African females, single, unemployed, mean age below 24 (Williams, Gouws, & Abdool Karim, (2000)) characterising most African NFSB samples.

CONCLUSION

The most significant finding to emerge from the present investigation is that African NFSB patients show a similar demographic and psychosocial profile to NFSB patients of other cultural groups. This is similar to recent South African findings suggesting that rates for fatal suicide amongst Africans in recent years are roughly equivalent to those of Whites and Indians in the
Pietermaritzburg magisterial district in Kwa-Zulu Natal (Wassenaar et al., 2000). These studies make it clear that prevailing assumptions that suicidal behaviour amongst Africans is uncommon need to be urgently revised, particularly by health policy makers and service providers.

The findings also point to the need to develop more vigorous preventative strategies, particularly with regard to increasing awareness of and accessibility to mental health services.

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REFERENCES


