"Why I tried to kill myself"- an exploration of the factors contributing to suicide in the Waterberg District

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Abstract

Background: One of the authors (PM) did a study of parasuicide patients at Voortrekker Hospital in the Waterberg District of Limpopo Province, South Africa. The aim of the study was to develop a deeper understanding of the parasuicide patients' perceptions regarding their reasons for attempting suicide.

Method: A qualitative descriptive study was conducted using free attitude interviews in English with eight purposefully selected participants. Participants were recruited from patients admitted to Voortrekker Hospital during the study period after attempting suicide. The interviews were audio-recorded and transcribed verbatim. Themes were identified through the McMillan method. A combined list of themes was compiled. The results were interpreted, conclusions were drawn and recommendations were made.

Results: Reasons identified were multi-factorial and can effectively be summarised by the term *bio-psychosocial*, which gives an indication of the range of problems. Included were predisposing economic and health-related factors, substance abuse and disturbed interpersonal relationships. Other contributory factors were emotional reactions, unpleasant feelings and thoughts of self-killing with the expectation to die and rest in peace. These factors were interrelated and connected to each other in various ways. The process of parasuicide consisted of a combination of these factors, but was different for each participant.

Conclusions and recommendations: A range of psychosocial risk factors contributes to parasuicide. Patients said that they had attempted suicide predominantly because there were faced by too many overwhelming physical or social problems, they felt isolated and that their lives were meaningless and purposeless. In addition to the findings obtained from the research, the process of qualitative free attitude interviewing were helpful in that the process of learning the interview techniques improved the researcher's skills and therefore the quality of care given to patients (participants in the study and others). The participants also felt that ventilating and sharing their problems were beneficial to them.

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Introduction

Suicide is the conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the act is perceived as the best solution.[1] Parasuicide, unlike suicide, is an act that is not completed and not fatal. It may be an expression of an individual's inability to cope with daily stress in a healthy way.[2] It is almost never the result of a sudden impulse, but is generally rather caused by longstanding mental or physical distress. What may appear to be the cause may often just be one of the many contributing factors. Many of those who commit suicide are ambivalent about their wish to die, and the attempt may result from a strong wish to live and a need to communicate a plea for help.[3] For them, life had become unbearable. The experience is traumatic for everyone. Deliberate self-harm is a major public and mental health problem and a

costly burden on the health care system,[4] and is showing an increase in many developed countries.[5] It is currently recognised as one of the leading causes of death in adolescents and young adults worldwide, and is mainly due to social, psychological and cultural factors rather than a recognised mental disorder.[6]

One of the authors worked in a district hospital in the Waterberg district of the Limpopo Province. A desire to understand the reasons for parasuicide, which causes a great deal of pain amongst patients, families and health workers, urged the researcher to do this study. A qualitative descriptive study was undertaken to develop a deeper understanding of the patients' perceptions regarding their reasons for attempting suicide.[7] Permission to do the study was obtained from the Research, Ethics and Publications Committee of Medunsa and the Limpopo Provincial Health Department.

Background information on the Waterberg district

The population of the Waterberg district was estimated at 112,156 in 2000.[8]. The population distribution according to age shows 58.05% below 20 years. The rest of the population, ranging in age from 20 to 64, constitutes 41.95% of the total population. Females outnumber males in both categories, possibly as a result of migrant labour practices that affect mainly men. Thirteen percent of the population resides in town, whereas 87% reside in the rural areas.

The population includes three different racial groups, namely Africans (Blacks), Afrikaners (Whites) and Asians (Indians). They speak Northern Sesotho, Afrikaans and English respectively. Africans constitute the majority of the population and reside mostly in rural areas.

The majority of the population is illiterate. Approximately 10% of the population has no education at all, and a further 47.3% have only a limited education of less than the standard 10 school-leaving certificate. Only 12.9% have tertiary qualifications. Forty-two percent of the de facto labour force of the Greater Mokopane (the sub-district where the research was conducted) is economically active. The unemployment rate is estimated at 58%.

Methods

The study was conducted at Voortrekker Hospital in Mokopane and all the participants were in-patients. Participants were recruited over a four-month period, from April to July 2000. Prior to the commencement of the main study, a pilot study was undertaken at the hospital. The results of the pilot study are not included in the main study. The pilot study was intended to test the researcher's capacity to conduct interviews and to evaluate the interview process, which used an open-ended questioning approach. In the main study, eight parasuicide patients were purposefully selected. The inclusion criteria were the participants' willingness to participate in the survey, their fluency in English, and their age (only participants older than 16 were included). The choice of English was convenient for the researcher. Informed consent was obtained from the participants. A reasonable level of saturation was reached, as the themes were similar in several interviews and little new data emerged from the last interviews.

The exploratory question was: **"You have been admitted to this hospital because you attempted to commit suicide. I will appreciate if we can talk about it. Please tell me why you attempted suicide"**. Prior to the interviews, all patients were clinically assessed and appropriate treatment was instituted. This included multiple interventions: supportive psychotherapy, counselling, symptom reduction, patient education, social worker referral, psychologist referral and pharmacological therapy, where indicated. Patients with psychiatric disorders were either referred directly to the psychiatrist for further assessment (including mental status examination) and care, or managed locally on the basis of the psychiatrist's instructions. All interviews were conducted by appointment and at a time agreed upon with the participants. Interviews took place two to five days after admission, depending on the general condition of each patient. The average length of the interviews was 25 to 30 minutes. All the interviews were audio-recorded, after which they were transcribed verbatim. Themes were identified throughout the individual interviews using the McMillan method. This method requires the researcher to familiarise him/herself with the data, indexing the concepts, identifying, charting and mapping the themes and, lastly, interpreting the themes identified. A combined list of themes representing the participants' reasons for attempting suicide was compiled. These themes represent the most important findings of this study and are presented in the next section.

Results

The participants perceived the reasons for their attempted suicide to be multi-factorial, and the factors were interrelated. The spectrum of reasons given by participants for attempting suicide can be summarised in one word: bio-psychosocial. The biological or physical factors that were cited were chronic medical problems, such as schizophrenia, epilepsy and infertility. The other physical problems mentioned were substance abuse, physical abuse and sexual abuse. These factors also have psychosocial dimensions. Social or contextual problems mentioned were unemployment, financial problems, problems at work and relationship problems in and outside the family. The psychological or personal factors included adverse emotional reactions, such as anger and

frustration, unpleasant feelings, such as unhappiness, depression, hopelessness and worthlessness, disturbed reasoning and suicidal thoughts, with the expectation to die and rest in peace.

The themes that emerged from the interviews were as follows:

Biological (physical or clinical) reasons:

One participant suffered from **schizophrenia,** which was of great concern to him. He explained his reason for attempting suicide as follows: *"Doctor, I have been hearing voices telling me I must commit suicide. Why am I hearing these voices?".* In addition, he was unable to provide for himself financially due to his illness.

Another participant had **epilepsy**. *"I can't get a permanent work because I am getting fits".* He was unable to lead a normal life and to perform normal work due to the frequency of the seizures. Life was unbearable for him.

Another participant cited **childlessness** as the reason for trying to commit suicide. To this participant, childlessness was actually more than just a health problem, as it touched her entire existence. As she put it: *"I can't get children. I struggled so much for that".* She felt she no longer had any purpose in life.

Two participants mentioned **substance abuse** as a reason by for their suicide attempt. One participant had a history of several previous unsuccessful suicide attempts and repeated hospital admissions due to mental illness. He sought refuge in alcohol and drugs, hoping this would help him forget his problems. He started with alcohol and later needed something stronger, leading to him using dagga, mandrax and cocaine. He felt nothing else could help him.

Another participant described the impact of **sexual abuse** on his life. A friend who had helped him financially had forced him into a homosexual relationship. He consequently felt dirty and dead inside. This relationship had continued for seven years and he felt that he had lost his own identity and that he was emotionally blunted as a result of the trauma. The participant stated: *"This guy took all my emotions and feelings away. I am feeling dirty inside, and abused, and this is troubling me".*

Social (or contextual) reasons:

Unemployment was a major problem and was significantly associated with parasuicide in several of the participants. One participant stated that he had *"no job, no money, no place to stay"*. This participant was unable to provide in his personal basic needs. He also had limited school training to qualify for a decently paid job.

Financial difficulties were also a problem for some of participants. As one man put it: *"I do an important job, but my salary is far smaller than what I am giving".* This participant was concerned about his meagre salary; he felt that he was doing an important job and that he did not receive recognition for the work. He also felt that he was not being appropriately remunerated, and that his salary was small in comparison to other workers. The small salary he earned was not sufficient to fulfil his needs.

Work-related problems also constituted a serious problem for one of the participants. He said: *"I work but they don't tell me when they are going to register me. I just work".* This participant was dissatisfied with his employer. He wondered why he was not registered like the other workers. He attempted to get himself registered to qualify for better treatment, like the other employees, but was unsuccessful and therefore attempted suicide. He felt his employer treated him unfairly and did not recognise his contribution.

Disturbed interpersonal relationships contributed to suicide attempts in all the participants. Conflicts were mentioned between spouses, siblings and friends, as well as between parents and children.

Psychological reasons:

Emotional reactions, such as anger and frustration, were significant in some participants. As one participant described her reaction towards her father after a confrontation: *"I feel I hate him".* This particular participant considered suicide because she was totally disappointed by her father's unexpected behaviour and had lost her temper. Another said: *"I have a drink because I was frustrated. I am frustrated in my inside".*

Unpleasant feelings were mostly longstanding and mainly due to unresolved psychosocial problems. Participants expressed feelings of depression, loneliness, emptiness and hopelessness. The inability to handle the numerous stressful life events subjected these patients to unhappiness and disappointment. They felt rejected and worthless and thus that life was not worth living anymore. These feelings reflect the degree of emotional pain they suffered. One participant stated: *"Life is not worth living. I don't wanna go like this anymore".*

Most of the participants had **longstanding thoughts of suicide**. As one participant put it: *"I always think I must kill myself".* This participant felt that suicidal thoughts were difficult to fight against. He also felt that he could not think clearly any longer. When the participants contemplated killing themselves they expected to die and rest in peace. One participant said: "*I committed suicide. I just wanted to end my life".* This participant attempted to harm herself by taking sleeping tablets with the intention of dying, as she had no desire to see the next day. She regretted that it had not worked.

Most participants said that they felt better after the interview. They attempted to provide sound reasons for their

behaviour during the interviews.

Discussion

The eight participants included four Africans, three Afrikaners and one Asian, and five of them were female and three were male. Participants were mostly aged between 22 and 38 years, with one participant aged 50. Half of the participants came from the urban area of Mokopane, a quarter from the semi-urban area and a quarter from the far rural area. Four participants were single parents, three were married and one was divorced. Other significant features included limited school training and unemployment. The education level was low (standard 7 to standard 10) in the majority of participants, and only one participant had a post-secondary school qualification (teachers' diploma).

The participants cited a wide variety of bio-psychosocial reasons for attempting suicide. Economic problems coupled with troubled interpersonal relationships constituted the main reasons for attempting suicide, while work-related problems constituted a serious problem for one participant. The overall results are consistent with other studies conducted in Limpopo Province by Mhlongo and Peltzer[9] and Peltzer *et al*.[10]

In the past, psychosocial problems have frequently been cited as an important reason for suicide.[5,6] Several participants said that they committed suicide as a result of extreme isolation and that their lives were meaningless. The fact that disturbed interpersonal relationships bring about extreme social destabilisation has been outlined by Breetzke[11] and Wassenaar et al.[12] These relationships reflect broken and dysfunctional families, and is predominant in younger patients and more often in females than in males.[9,13,14] In this study, family dysfunction was mentioned by two of the participants. Marital problems were sited by some participants and constitute an imminent risk factor for those who were married. Kornstein reported that women in general have a lower socioeconomic status and therefore are more prone to stressful life events, victimisation and maladaptive coping styles, all of which may contribute to their higher risk for major depression and suicide.[15]

Chronic conditions (e.g. schizophrenia, epilepsy, infertility) were associated with suicide attempts in this study. Having a chronic illness therefore increases the risk of suicide. In their study, Stenager and Stenager found that physical illness is significantly associated with parasuicide.[16] Another chronic condition, HIV/AIDS, is also associated with suicide, as has been reported by Mhlongo and Peltzer[9] and Berard and Boermeester[14], although it was not found in this study. This is an important factor in the light of the overwhelming effect of the disease in South Africa today.

Unpleasant feelings, such as depression, resulted from unresolved psychosocial problems. These results are consistent with the study conducted by Rinhmer.[5] He found that most people suffer from depression if there is an ongoing problem for which there is no solution.

Two participants unsuccessfully attempted to commit suicide several times. They felt they could not be helped. Dirks suggests that the repetition of parasuicidal behaviour is a considerable risk factor in all of those who have attempted suicide before.[17] Suominen et al. found that the more these people fail in their attempts, the more hopeless they become and the more likely they are to take refuge in addictive substances.[18] All the participants in this study described some form of disturbed reasoning and thinking. They felt they lacked a positive attitude towards life in general. This has also been reported by Mac-Leod et al., who described how depressed participants exhibit a lack of positive anticipation of future experiences as a result of continuous frustrations caused by longstanding and unresolved problems.[19]

For the researchers, being involved in this study also contributed to developing compassion and understanding for patients who attempt suicide.

The limitations of this study include the following:

- The participants were from only one hospital.
- The use of the English language excluded potential participants from the study due to the language barrier, namely those who could not speak English.
- The age restriction imposed on the sample (16 and above). Subjects below 16 years were not interviewed because of ethical implications.
- The role of the investigator as both researcher and caretaker became confused at times.

Factors that had the potential to introduce bias into the study included the following:[20] English was not the first language of most of the participants. Some patients who attempted suicide were excluded from the study due to their inability to speak English. The researcher attempted to reduce the interviewer bias by avoiding leading questions and self-disclosure and by remaining neutral, open-minded and open-hearted during the interviews. An attempt was made to reduce bias further by having the research work analysed by two other experienced researchers.

Conclusions and Recommendations

In this study, a wide variety of problems were cited as reasons for parasuicide. According to the patients, the reasons for attempting suicide were multi-factorial and the factors were interrelated. The participants said that they attempted suicide because they were too isolated and

felt their lives were meaningless and purposeless. Thus, having too many unresolved problems, isolation from others and living a meaningless and purposeless life, particularly in a rural context, are factors highly contributory to suicide. The rural areas, unlike urban areas, have a remarkable shortage of health professionals, such as physicians, nurses, social workers, psychologists and psychiatrists. This makes caring difficult in such an environment. Understanding the reasons why parasuicide patients attempt suicide may help to identify possible risk factors in order to plan early interventions. When patients therefore talk about suicide, especially if they have formulated plans, it becomes obvious that they are at risk of committing suicide. It is consequently very important to be vigilant and ready to intervene promptly.

It is important to note that the free attitude interviewing technique used in this research helped patients to ventilate and share their problems, which means that the qualitative research methodology is very relevant in family practice.[21] The authors felt that the interviewing technique was not only a research instrument, but also an intervention tool.

The main findings of this study make it reasonable to recommend that physicians should take special care to offer early interventions. When patients who are chronically ill have contextual problems or start experiencing unpleasant feelings, disturbed reasoning, inappropriate thinking and suicidal thoughts, timely and appropriate interventions should be planned. Doctors should be sensitive to patients' problems, assist them in dealing with frustrations and encourage them to speak out. Professionals need to adopt a non-judgemental attitude towards suicide victims. A comprehensive patient-centred approach combined with the principles of family medicine could be used to improve the care given to patients who contemplate suicide. It is necessary to undertake further research on the process of parasuicide to determine when to intervene and what type of intervention is suitable and effective.

Competing interests

None declared.

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