



NON-FATAL SUICIDAL BEHAVIOUR IN WOMEN — THE ROLE OF SPOUSAL SUBSTANCE ABUSE AND MARITAL VIOLENCE

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Objective. To investigate the precipitants of non-fatal suicidal behaviour in women using a gender-based comparison.

Design. A retrospective analysis of case records. Data were analysed using chi-square tests of significance.

Subjects. One hundred men and 100 women admitted for non-fatal suicidal behaviour at a general hospital.

Outcome measures. Subjects' biographical details and self reports of precipitating factors such as marital conflict, spousal extramarital affairs, alcohol abuse and marital violence.

Results. Significantly more married women than men cited spousal extramarital affairs, spousal alcohol abuse and marital violence as precipitants of their self-destructive behaviours.

Conclusion. The findings emphasise the role of spousal behaviour and resultant stress in precipitating non-fatal suicidal behaviour in women. Preventive efforts must focus on the psychological, social and economic empowerment of women.

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Self-destructive behaviours affect men and women differently, in terms of both epidemiology and psychosocial variables. Much higher rates of non-fatal suicidal behaviours (NFSB) are reported among women, whereas men are known to have considerably higher rates of suicide than women.¹

The World Health Organisation (WHO)² has reported that women are less likely to kill themselves than men in almost all countries that reported suicide mortality data to this body. China and Papua New Guinea are exceptions in that considerably more women than men kill themselves in those countries. In the rest of the world, however, male/female ratios of between 2:1 and 5:1 have been reported and have persisted

over the centuries.³ Unfortunately, not all countries report suicide data to the WHO. For historical reasons South Africa has been one such country. Nevertheless, local research has shown the suicide mortality rate in South Africa to be approximately four times higher among men than women, with slight variations in this ratio across cultural groups.⁴

International data on NFSB have generally shown higher rates among women, with gender ratios of around 2:1 in many countries, although a few centres, for example Italy and Finland, have reported higher rates in men.⁵ Research in South Africa, on the other hand, has consistently noted female/male ratios of 2:1 and higher.⁶

Similarly, psychological studies around the world have noted different variables influencing vulnerability or precipitating suicidal behaviour in men and women. Unemployment and work and financial problems have been found to be significant factors in male suicidal behaviour.³ In addition it has been noted that substance abuse is considerably more prevalent among suicidal men than women. Canetto and Lester⁶ reported that factors such as marriage, support, and social and family status are important in influencing women's vulnerability. Being in an abusive relationship is also cited as an important risk factor for self-destructive behaviour. Suicidal behaviour is often seen to reflect the powerlessness evident in the economic and social positions of affected women.⁷ Very often anger is the predominant feeling, but for various reasons the individual feels unable or not allowed to express this emotion in an interpersonal context. As a result there may be: (i) a need to escape from this intolerable situation that does not allow for individual expression; and/or (ii) a need to communicate, in non-verbal terms, the level of distress that is being experienced in the situation.

Internationally, investigators have also confirmed higher rates of female suicidal behaviour in societies where the status of women is low, and where married women are not recognised as being equal to their husbands.⁶ Women in patriarchal families may find themselves oppressed and reduced to the status of children, with little or no say in managing their personal or family lives. Their situations are usually chronic, leaving them pessimistic about the future, with thoughts of self destruction becoming increasingly prevalent over time.⁵

In contrast to the wealth of international research, there are very few South African data on the demographic, clinical and psychosocial variables relating to adult suicidal behaviour, especially with reference to gender. A few studies have focused specifically on women and suicidal behaviour.^{5,8,9} For this reason the present study was initiated to secure data that could provide a relevant gender-based comparison on specific variables.

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SUBJECTS AND METHOD

The investigation was conducted at the clinical psychology department of a large general hospital in Pietermaritzburg. The hospital caters mainly for patients of low socio-economic status and those who are unable to afford private health care. The clinical psychology department has been in existence for approximately 15 years at this institution, and among its numerous referral and consultation-liaison functions, it has rendered a continuous specialised service for NFSB patients. All patients admitted to the hospital following suicidal behaviours are routinely referred to the psychology department for assessment of suicide risk and psychotherapy. A combination of individual and family therapy is usually employed in the treatment programme. Data on a controlled effectiveness study have been reported in detail elsewhere.¹⁰

The research design involved a retrospective analysis of case records and clinical data of NFSB patients. For the purpose of this study the term NFSB refers to all deliberate self-harm behaviours (e.g. poisoning, wrist-cutting, etc.) not resulting in death.

The sample comprised consecutive admissions of 100 male and 100 female parasuicide patients between the ages of 25 and 50 years. No other exclusion criteria were applied. From the standard clinical file data the following variables were recorded: age, gender, marital status, number of children, employment status, method of parasuicide, number of previous attempts and short-term precipitants of the NFSB. The latter focused on factors such as marital conflict, extra-marital affairs, alcohol abuse and violence in the marriage. For the purpose of this investigation, alcohol abuse referred to alcohol consumption resulting in abusive or neglectful behaviours, or occupational impairment, as perceived by significant others. No strict diagnostic nomenclature was used in this regard since: (i) the substance-abusing spouse was not always available to be interviewed; and (ii) it was considered more relevant to focus on the subjective experiences of family members and significant others.

RESULTS

One hundred women were admitted for NFSB over the preceding 6 years, whereas the same number of men were seen over a 12-year period. The female sample had a mean age of 32.6 years, while that of the male sample was 32.9 years. Sixty-one women and 63 men were married. No significant gender differences were noted in terms of marital status, number of children or number of previous NFSB episodes. While 49% of the men were unemployed, significantly more men (51) than women (32) were employed outside the home ($\chi^2 7.43$, $df = 1$, $P < 0.01$).

Ingestion of medicines or poisons was used as a method of NFSB in significantly more women (94) than men (80) ($\chi^2 8.66$,

$df = 1$, $P < 0.01$). Marital conflict was cited as a precipitant of NFSB by 61 women and 61 men. Suicidal behaviour as a response to extramarital affairs by spouses was significantly more prevalent among married women (22) than married men (8) ($\chi^2 9.23$, $df = 1$, $P < 0.01$). Similarly, significantly more married women (18) than men (2) reported marital violence perpetrated by a spouse as a precipitant to their suicidal behaviour ($\chi^2 14.00$, $df = 1$, $P < 0.001$). Alcohol abuse by a spouse was reported by significantly more women (11) than men (2) as a precipitant to suicidal behaviour ($\chi^2 5.79$, $df = 1$, $P < 0.05$). A combination of both alcohol abuse and violence by a spouse was reported by significantly more women (16) than men (0) as a precipitant to their self-destructive acts ($\chi^2 16.71$, $df = 1$, $P < 0.001$). Only 1 of the men (and none of the women) citing these precipitants (spousal extramarital affairs, violence or alcohol abuse) used methods other than toxin ingestion, confirming that the above findings were, in fact, influenced by gender rather than method of NFSB.

DISCUSSION

The finding that 100 women presented with suicidal behaviour over half the time period as the same number of men is consistent with international rates of NFSB, which show this behaviour to be at least twice as common in women than in men.³⁵ The high rate of unemployment in this study is supportive of research showing a strong correlation between this financial stressor and suicidal behaviour.¹¹ The rates of 49% among men and up to 68% among women (since some of the women chose not to be employed) are higher than the provincial (39.1%) and national (33.9%) rates of unemployment among the economically active population (Durban Metropolitan Council Urban Strategy Department – personal communication). While not conclusive, this certainly seems suggestive of a greater vulnerability to NFSB among unemployed people. However, it is important to note that unemployment is often associated with other social problems which may be as much (or more) related to self-destructive behaviour than unemployment *per se*.

The differential pattern of employment between men and women in the present sample, however, may be more reflective of the trend in the general population than of specific gender differences among suicidal individuals. While increasingly more women have entered the labour market over the years it is still a fact that more men than women are employed outside the home. Also, the lower socio-economic population from which the present sample has been drawn generally produces fewer career women than is the case in higher socio-economic communities. Because of lower educational qualifications, women from a low socio-economic background find very limited employment opportunities.

The significantly higher rate of toxin ingestion as a method of NFSB among women than men is consistent with



international trends.³ The finding also supports the view that in keeping with gender-based personality differences, women tend to choose less violent means of self-harm. Of course, the lethality of the method employed may also be related to the level of suicide intent.¹² In other words, individuals more seriously intent on harming or killing themselves (i.e. having a death wish) are more likely to use more lethal means.¹

The finding that significantly more married women than men resort to suicidal behaviour in the context of spousal extramarital affairs is a matter of concern. Of course, this does not necessarily mean that more husbands than wives engage in adulterous relationships. Rather it is an indication that more women than men respond to spousal infidelity in a self-destructive manner. It is evident that the marital situation imposes severe levels of stress on these women who feel not only rejected and unloved, but hopeless and pessimistic about their situation. The theory that suicidal behaviour may be a desperate expression of communication in a contextually powerless individual has been proposed previously.¹³ Also, the feeling of pessimism or hopelessness that prevails is known to be a powerful psychological precipitant to self-destructive acts.¹⁰

Marital violence was found to be a precipitant to suicidal behaviour affecting significantly more women than men. The finding that almost 30% of the married women (18 of 61) in this sample reported this type of abuse is of concern, especially considering the widespread problem of marital violence in this country and elsewhere. Unfortunately, as a result of inadequate reporting of this problem, it is difficult to know whether the rate among NFSB subjects in the present sample is similar to, or greater than, that in the general population. Nevertheless, the present finding is suggestive of the degree of power and domination exerted by men in these marriages. Similar results have been reported by Bergman and Brismer,¹⁴ who noted an extremely high rate of self-destructive behaviours among women who had been physically abused by their husbands. In the face of marital stress there is a tendency towards 'tunnel vision' thinking, as described by Shneidman,¹⁵ where cognitive focus is constricted and the individual is unable to see any other (constructive) way of dealing with the situation.

Spousal alcohol abuse was also found to be a more significant problem precipitating suicidal behaviour among the women than the men. This finding is consistent with British reports of suicidal women, who blamed their self-destructive acts on their husbands' drinking behaviour.¹⁶ Women in these situations are usually distressed at the social and behavioural problems that result from their husbands' drinking behaviour, rather than at the alcohol consumption *per se*. Even in the absence of physical violence there is often verbal abuse and a neglect of familial responsibilities. Wives of such alcohol abusers have an elevated risk of suicidal behaviour, perceiving

this as a method of escaping or changing their intolerable life situations. Earlier research has indicated that in most of these cases the spousal alcohol abuse has been a problem for many years and that the woman's suicidal behaviour points to the threshold in her coping continuum, revealing her inability to deal with the problem any longer.⁵ In terms of the familial effects of alcohol abuse, this finding is similar to that of a recent South African study implicating parental alcohol abuse in the development of mental health problems in children.¹⁷

Even more significantly affected are the women who have been subjected to a combination of alcohol abuse and violence by their husbands. These women usually find that their safety and that of their children is at the mercy of the husband's alcohol consumption, which they believe to be an influential factor precipitating his violent outbursts. Reports of being chased out of the house with the children at night during such drunken rages are common. It is evident that the lives of these families are plagued by continual feelings of threat, anxiety and emotional trauma. Clearly there is little respite for the women in these marriages, and as their levels of distress and hopelessness increase, self-destruction becomes a more appealing alternative.

Among the limitations of this study are its retrospective design, reliance on self-reports and the use of an interview format, rather than standardised instruments. Retrospective investigations are, of course, restricted by the amount and quality of information noted in the case records. While the psychologists staffing the clinic are trained to interview NFSB patients using a fairly structured format, the use of standardised instruments could ensure more uniformity in the data collection and also allow for the examination of additional variables. It must also be remembered that the present sample comprised NFSB subjects of low socio-economic status and therefore caution is advised in attempting to generalise these findings to higher socio-economic strata. Nevertheless, problems such as spousal substance abuse and marital violence exist in all socio-economic groups, and these have been found to be precipitants of women's suicidal behaviour even in developed countries.^{3,7}

CONCLUSION

The present findings show significant gender differences, especially with regard to precipitants of suicidal behaviour. They also point to the need for: (i) gender-sensitive therapeutic approaches in managing suicidal patients; and (ii) concerted prevention efforts, including school-based programmes and long-range goals focusing on the differential socialisation processes to which boys and girls are subjected during their developing years. In the long term, the psychological, social and economic empowerment of women would appear to be vital elements in improving the quality of life for women in



South Africa. This is important for all women, but perhaps more so for women of low socio-economic status who may have little else by way of affirmation should their family life break down.

References

1. Canetto SS, Sakinofsky I. The gender paradox in suicide. *Suicide Life Threat Behav* 1998; 28: 1-33.
2. World Health Organisation. *Statistics Annual*. Geneva: WHO, 1991.
3. Williams M. *Cry of Pain: Understanding Suicide and Self-harm*. London: Penguin, 1997.
4. Wassenaar DR, Naidoo P. Suicide rates amongst Indians and Whites in Pietermaritzburg: a comparison with South African suicide data. In: Schlebusch L, ed. *Suicidal Behaviour* 3. Durban: University of Natal, 1995; 172-186.
5. Pillay AL, Van der Veen MBW. Factors precipitating suicidal behaviour in women. In: Schlebusch L, ed. *Suicidal Behaviour* 3. Durban: University of Natal, 1995; 120-129.
6. Canetto SS, Lester D. Gender and primary prevention of suicide mortality. *Suicide Life Threat Behav* 1995; 25: 58-69.
7. Jack R. *Women and Attempted Suicide*. Hove, UK: Lawrence Erlbaum, 1992.
8. Pillay AL, Vawda NBM. Alcohol-related parasuicide among married people. *S Afr Med J* 1989; 75: 120-121.
9. Wassenaar DR, Van der Veen MBW, Pillay AL. Women in cultural transition: suicidal behaviour in South African Indian women. *Suicide Life Threat Behav* 1998; 28: 82-93.
10. Pillay AL, Wassenaar DR. Psychological intervention, spontaneous remission, hopelessness and psychiatric disturbance in adolescent parasuicides. *Suicide Life Threat Behav* 1995; 25: 386-392.
11. Platt S, Kreitman, N. Trends in parasuicide and unemployment among men in Edinburgh, 1968 - 1982. *BMJ* 1984; 289: 1029-1032.
12. Pillay AL. Methods of self-destructive behaviour in adolescents and young adults. *Psychol Rep* 1988; 63: 552-554.
13. Wassenaar DR. Brief strategic family therapy in the management of adolescent Indian parasuicide patients in the general hospital setting. *S Afr J Psychol* 1987; 17: 93-99.
14. Bergman B, Brismar B. Suicide attempts by battered wives. *Acta Psychiatr Scand* 1991; 83: 380-384.
15. Shneidman E. *Suicide Thoughts and Reflections*. New York: Human Sciences, 1981.
16. Gath DH. The alcoholic patient. In: Weatherall DJ, Ledingham JGG, Warrel A, eds. *Oxford Textbook of Medicine*. Oxford: Oxford University Press, 1983; 24: 38-40.
17. Pillay AL, Van der Veen MBW. Prevalence of parental substance abuse among child psychiatric inpatients. *Percept Mot Skills* 1997; 84: 947-953.



SHORT REPORT

SIDE-EFFECTS OF ORAL MISOPROSTOL IN THE THIRD STAGE OF LABOUR — A RANDOMISED PLACEBO-CONTROLLED TRIAL

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Background. Misoprostol, an inexpensive, stable, orally active prostaglandin analogue, has been suggested for use in the prevention of postpartum haemorrhage. Potential side-effects, however, need to be quantified.

Objective. To compare the rate of postpartum shivering and pyrexia following oral misoprostol 600 µg and placebo.

Design. A double-blind placebo-controlled trial. Women in labour were randomly allocated to receive either misoprostol 600 µg orally or placebo after delivery. Conventional oxytocics were given immediately if blood loss was thought to be more than usual. Side-effects were recorded. Postpartum blood loss in the first hour was measured by collection in a special flat plastic bedpan.

Setting. The labour ward of an academic hospital in Johannesburg, with 7 000 deliveries per annum.

Main outcome measures. Shivering and pyrexia.

Results. The groups were well matched. Misoprostol use was associated with more shivering (44% versus 11%, relative risk (RR) 4.03, 95% confidence interval (CI) 2.85 - 5.70), pyrexia $\geq 37.8^{\circ}\text{C}$ (38% v. 6%, RR 6.23, CI 3.89 - 9.97), 1-hour systolic blood pressure ≥ 140 mmHg (33% v. 25%, RR 1.32, CI 1.03 - 1.70), and diastolic blood pressure ≥ 90 mmHg (10.5% v. 3.0%, RR 3.44, CI 1.67 - 7.11). There were no other significant differences. The study was not designed to be large enough to assess a difference in blood loss $\geq 1 000$ ml (9% v. 9.7%, RR 0.93, CI 0.56 - 1.53). Possible effects on blood loss may have been obscured by the lesser use of additional oxytocics in the misoprostol group (14% v. 18%, RR 0.78, CI 0.54 - 1.13).

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