

## **Social dynamics of suicide in South Africa: A theoretical perspective**

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### **Abstract**

Suicide rates in South Africa are on the increase, particularly amongst the youth. What are the complexities of modern life which are driving the increase? The suicidal act of self-destruction signals society's failure to provide good support systems and meaningful psycho-social well-being for its members. With its impressive Reconstruction and Development Programme (RDP), South Africa has not yet succeeded in extending the equivalent reconstruction of people's minds and thought processes. In some instances the art of negotiating one's existence on a daily basis is compromised by hostile socio-economic and political realities. The collective consciousness that once glued society has lost its bonding effect. Traditional systems of social support need to be revisited. The aim of this study is therefore to give a theoretical view of social dynamics of suicide in South Africa.

**Key words:** Suicide, suicide rates, HIV, AIDS, youth, society.

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### **Introduction**

Several studies (Madu & Matla, 2003; Schlebusch, 2004; Meehan, Peirson & Fridjhon 2007) have been conducted to try and unravel the triggers behind suicide in South Africa. Almost all studies indicate that suicide is on the increase. The complexities of modern life seem to be exerting immense pressure on individuals and not everybody survives the onslaught. However, Jones (2003) who is the chairperson of the Council for the International Institute of Traumatology in Johannesburg, points out that even though South Africa is a third world country with high unemployment and high HIV/AIDS prevalence, its suicide rate (15.4 suicides per 100 000) is not unusually high compared to countries such as Hungary (45.3 suicides per 100 000), Germany (43.1 suicides per 100 000) and Switzerland (23.8 suicides per 100 000). Schlebusch (2004) cautions that there is a dearth of reliable data due to the inconsistent and inadequate reporting of suicidal behaviour, but states that nevertheless the available data show that suicidal behaviour is a significant health concern in South Africa. In this article the author intends to give an interpretative narrative as it unfolds from reading about and trying to understand the relentless scourge of suicide.

## **Abridged Suicide Statistics in South Africa**

The point of departure is to share some shocking facts regarding suicide in South Africa. The purpose of doing so is to demonstrate the gravity of the problem and how the suicide rate impacts on our society.

While suicide is not a leading cause of death in South Africa, it is a serious public health concern with the incidence of suicide varying across different ethnic and socio-economic groups and geographic regions (Burrows & Laflamme, 2006). Clark (2004) maintains that “at least two fatal suicides occur in South Africa every hour and 20 attempted suicides occur every 60 minutes”. He stated that we have a severe problem with self-destructive behaviour in this country which needs to be addressed.

According to Schlebusch, Vawda and Bosch (2003), between 6 893 and 8 000 South Africans commit suicide every year, which translates into 667 deaths a month, 154 every week, and 22 every day.

Schlebusch et al. (2003) further note the following suicidal behaviour patterns in South Africa:-

- Up to 8 000 South Africans commit suicide annually.
- Nearly five times more males than females commit suicide.
- Suicides occur in the younger age group (15-34 years old).
- The youngest suicide fatality in 2001 was 10 years old, but more often suicides which are fatal occur in the age group of between 15 and 19 years.
- Firearms, hanging and poison ingestion were found to be the most common methods of suicide in South Africa.

## **Suicide and Gender**

Unpacking the above-mentioned suicidal behaviour patterns will be helpful in getting a more focused view on the scourge of suicide that continues to ravage society.

As stated earlier it has been established that nearly five times more males than females commit suicide. However, according to Edwards and Holden (2001) suicidal ideation and behaviour differ depending on gender. Women have higher levels of suicidal ideation and make more suicides attempts but men complete suicides more often than women. Suicide attempts are therefore more common among females, while completed suicides are more common among males.

Nolen-Hoeksema and Girgus (1994) conclude that the most likely source of gender difference in depression is the gender difference in methods used by

males and females in coping with stressful situations. Suicidal behaviour can be interpreted as a coping strategy and due to traditional gender socialization, women may be hindered from choosing active coping strategies and hence attempt suicide, as a way of telling those around them that they need help.

### **Influence of Patriarchy**

In most societies men remain the chief breadwinners in the family. Even in situations where the wife works, men continue to earn disproportionately higher salaries than women. The notion of being the main financial contributor puts men under extreme pressure to maintain the status of the breadwinner. In cases where men fail to live up to this expectation, their ego is seriously undermined. This low ego strength may be viewed by men as stripping them of their masculine role in the family. Such thoughts are often brought about by a sudden, unexpected, and unusual negative change in their life circumstances (Dryden-Edwards, 2011).

### **Mental Health and Suicide**

Society seems to expect men to be more independent and emotionally stronger than previously thought. It is only in recent past that men began to recognize that they also need to admit that they are equally vulnerable. Men are generally not expected to show emotions and to cry. Thus, experiencing emotions such as depression can be so stressful that they can lead to suicidal thoughts. Meehan et al. (2007) studied suicide ideation in adolescent South Africans and found that there was a significant difference between males and females regarding coping strategies, with females scoring higher than males in each strategy studied. They further found that the female sub-sample revealed significant correlations between functional coping and positive suicidal ideas scores, while the only significant correlation found within the male sub-sample was between dysfunctional coping strategy and negative suicidal ideation scores. Men who have a history of previous suicidal threats or attempts are at higher risk of attempting suicide in the future. Mpiana, Marincowitz, Ragavan and Malete (2004) found that social or contextual problems mentioned as factors contributing to suicide 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 expectations to die and rest in peace.

The South African Stress and Health Study (SASH) which investigated the prevalence and correlates of common mental disorders revealed that having a mental disorder is a risk factor for a lifetime suicide attempt. Respondents with at least one Diagnostic and Statistical Manual 5 (DSM-V) disorder were four times (95%) more likely to attempt suicide than those with no disorder

(Khasakhala et al., 2011). Some anxiety disorders, like Post Traumatic Stress Disorder (PTSD) and Obsessive Compulsive Disorder (OCD) also produce suicidal thoughts amongst men (Dryden-Edwards, 2011). To some men this brings a lot of shame and embarrassment. To those with uninhibited moral concerns the temptation to end their own life becomes strong. A study conducted by Mpiana et al. (2004) exploring factors contributing to suicide in the Waterberg District of Limpopo Province in South Africa found that participants expressed feelings of depression, loneliness, emptiness and hopelessness.

### **Different behavioural patterns amongst youth**

Moving to another suicidal behaviour pattern, we look at the high rate of suicide among the younger age groups. Meehan et al. (2007) refer to the National Injury Mortality Surveillance System (NIMSS) report that indicates that fatal suicides do occur in the age group of 10 to 14 years, indicating a growing trend towards younger South Africans taking their lives. According to Pillay and Wassenaar (2007) youth suicide, suicidal thoughts, threats, plans and attempts are common in South Africa. Youth of various ages are continually under pressure to live up to unrealistic expectations. A study by Mhlongo and Peltzer (1999) found that youth suicidal behaviours constituted about 10% of cases referred to the Clinical Psychology Section at Letaba Hospital in the Limpopo Province of South Africa. There are many youths who have relinquished the freedom and innocence of youth. Children are increasingly adopting the full responsibilities of fatherhood and motherhood. At a very young age children find themselves having to carry the burden of providing livelihood either for their siblings or their ailing parents/grandparents. Child-headed households are becoming a common phenomenon in South Africa. According to Meintjies, Hall, Hugh-Marera and Boule (2010), the proportion of children living in child-headed households was 67% in 2006. Children in child-headed households live in conditions that are on average worse than those in mixed-generation households.

Deaths caused by HIV/AIDS related illnesses leave older children as caretakers of their younger siblings. The high rate of divorce and marital discord has also contributed to young people having to take on greater responsibility in our society. Society no longer shows great commitment to adequately care for its youth. The interplay of extreme social, cultural, political, and economic factors impact upon the lives of South African adolescents and play a role in stress, depression, and feelings of hopelessness, helplessness, and possible suicidal ideation. Given the rapid political, social and cultural change in South Africa, adolescents are particularly vulnerable as they respond to these challenges in addition to the usual developmental crises. Being overwhelmed by these tensions can easily lead to a sense of despair that in turn often leads to suicide (Moller-Leimkuhler, 2003). According to the South African Depression and Anxiety Group (SADAG) (2011: 1-4) one of South Africa's largest mental health

initiatives, between 70% and 90% of adolescents who die by suicide have an underlying mental illness. “Our teens are depressed and often have no-one to turn to for support”, says SADAG founder, Zane Wilson. “Combined with a lack of resources, family problems, poverty, AIDS and loss, suicide all too often seems to be the only answer for these children”.

The collective consciousness of our society as embraced in the “Ubuntu” philosophy is getting weaker and weaker. South African Department of Social Development’s White Paper on Social Welfare (1997:12) defines ‘Ubuntu’ as ‘the principle of caring for each other’s well-being and a spirit of mutual support. Each individual’s humanity is ideally expressed through his or her relationship with others and theirs in turn through recognition of the individual’s humanity. Ubuntu means that people are people through other people. It also acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being. The basic tenet of Ubuntu which our society once thrived on is being eroded. The caring socio-cultural imperatives of a people are diminishing. This is happening as there is growing evidence that traditional culture in South Africa is undergoing a period of transition and is largely influenced by westernisation. According to Wood and Wassenaar (1989) this transition is being fostered by the influence of western values and systems on the youth.

### **Suicide and Psycho-social Variables**

Rutter and Behrendt (2004) identified negative self-concept as one of the four psychological factors that correlate with adolescent suicide risk, the others being hopelessness, hostility and isolation. With regard to social support, Moller-Leimkuhler, (2003) maintains that the movement of society from a collectivist to an individualistic culture has meant that there is less emphasis on social norms and more on personal freedom in making choices in all areas of life including construction of identity. Youth who are subjected to these conditions are seen to be more prone to suicide. Laubscher (2003) maintains that the transition into democracy has led to changes in social status, loss of traditional coping methods and changes in cultural narratives for these young men resulting in identity confusion and the associated sense of hopelessness which often leads to suicide.

The stress of teenage pregnancy can trigger suicidal behaviour (Moosa, Jeenah, Pillay, Vorster & Liebenberg, 2005). Other triggers include alcohol or substance abuse. Examples of illegal drugs that may produce suicidal thoughts include marijuana, cocaine, methamphetamine, phencyclidine (PCD), and Liquid Crystal Display (LCD). In rare instances, suicidal thoughts may be associated with medication side effects. The risk of developing suicidal thoughts in reaction to medications is thought to be higher in children and teenagers, although still uncommon, compared to adults (Dryden-Edwards, 2011).

Not everyone in South Africa has access to basic needs: running water, sanitation, electricity, and housing. There is also a lack of positive role models, increased demands due to more materialistic values, and a lack of emotional security because of social and cultural transition. It is the interplay of these social, cultural, political and economic factors that impact on the lives of adolescents living in South Africa and plays a role in development of stress, depression, feelings of hopelessness, helplessness and possible suicidal idealization (Meehan, Peirson & Fridjhon, 2007). Teenage rebellion is also a compounding factor in the high suicide rate. Teenagers who do not submit to parental control are more prone to seek alternative means of expressing themselves and suicide is one such option.

According to Newman (2004) suicide in South Africa rose by 48% over the ten years prior to 2004, and one-third of all non-fatal attempts were recorded among children. Newman (2004:1-4) quotes World Health Organization (WHO) statistics showing that in South Africa hanging accounted, for (36.2%) percent, followed closely by shooting (35%), gassing (6.5%) and burning (4.1%). Among victims, those aged 10-34 years mainly used hanging, 25-29 years old used poison, burning and jumping, 30-34 years old used firearms, and those ages between 40-44 years frequently chose gassing. Madu and Matla (2003:126-132) found the most frequent methods used for attempted suicide was self-poisoning (44%), followed by drug overdoses (25.3%), and hanging (22%). These findings were based on school adolescents in the Limpopo Province of South Africa. Meel (2003) found an increasing incidence of deaths due to hanging in the Transkei region of South Africa. Half of the deaths (51%) due to hanging comprised young adults, between 16 and 30 years of age, while 13% were adolescents younger than 15 years.

According to Garrib, Jaffar, Knight, Bradshaw and Bennish (2006) levels of child mortality in South Africa are increasing and much of this has been attributed to the impact of the HIV and AIDS epidemic. Mothers who lose their children are subjected to extreme pain and suffering. To some mothers the death of that child dashes their only hope of having a child. To some mothers that child could be the only child who was born after many years of hoping, praying and sacrifice. In many African cultures the birth of a child is always associated with God's or ancestral blessing. In some instances, mothers who are deprived the opportunity to fulfill this responsibility of womanhood respond by getting angry at themselves and may end up developing a deep sense of worthlessness. The perceived shame that these mothers have devastates them and makes them vulnerable to suicidal thoughts. Mothers who cannot access professional therapy and who might not have a good support network are likely to be suicide victims.

Whilst communities in the global village are hard at work to combat the scourge of HIV and AIDS and other life threatening diseases, the stigma associated with

their diseases is equally devastating. Throughout South African history, many diseases have carried considerable stigma, including leprosy, tuberculosis, cancer, mental abuse and many sexually transmitted diseases. HIV/AIDS is the only latest disease to be stigmatized. Brown, Macintyre and Trujillo (2003) reviewed 22 studies that test a variety of intervention to decrease the AIDS stigma in developed and developing countries. In this study they found that some stigma reduction interventions appear to work but many gaps remain especially in relation to scale and duration of impact and in terms of gendered impact of stigma intervention. It is believed that there is a deep social stigmatization of HIV/AIDS (Marzuk, 1994). The misconceptions and at times, deliberate distortions, compound the problems that these diseases are associated with. Citizens that are infected and affected by these diseases in most instances, see themselves as “dead” already. It is known that there is significant association with HIV/AIDS and depression and such symptoms as hopelessness and helplessness. Most individuals who were HIV positive and committed suicide were physically asymptomatic at the time of their death (Marzuk, Tardiff, Leon, Hirsch, Hartwell, Portera & Iqbal, 1997). The stigma attached to the diseases incapacitates sufferers to face life within their own predicament. Some sufferers begin to believe that they not only brought shame on themselves, but on their families as well. The imagined shame and embarrassment can easily catapult imaginations towards suicide.

## **Conclusion**

The suicidal act of self-destruction signals society’s growing failure to provide good support systems and meaningful psycho-social well being for its members. Suicide has proven to be a costly act not only to the remaining family members, relatives and friends but also to the national development. The collective consciousness that once glued society together is fast growing its bonding effect. Social cohesion has been dealt a severe blow. The challenges of managing a myriad of transitions have heralded a state of hopelessness and helplessness. The benefits of the new political dispensation have ushered in a new wave of episodes involving negotiating one’s existence. The state has dismally failed to create an environment wherein the reconstruction, development of identities and dispositions provide comfort and solace during moments of serious life changes. As stated in the intents of her constitution, South Africa has a responsibility of taking care of its less fortunate members. Government, Non-Governmental Organisations (NGO’s) and Faith Based Organizations (FBO’s) have moral obligations to create a climate where-in human life is celebrated and valued at all times. The traditional systems of social support need to be revisited. More psycho-social and health practitioners need to be trained to reactivate the norms and values that put the human being at the center. The tenets of Ubuntu should be preserved, nurtured, and entrenched in the South African society.

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