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**AN INVESTIGATION INTO THE RELATIONSHIP BETWEEN
ADOLESCENT PARASUICIDE, DEPRESSIVE ILLNESS AND
ASSOCIATED RISK FACTORS**

HALF THESIS

**SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
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BY

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ABSTRACT

This study aimed at investigating the relationship between adolescent parasuicide, depressive illness and associated risk factors. Reports worldwide indicate that suicidal behaviour in this age group has risen 150% over the past 20 years, whilst the rate for suicide in adults and the elderly has remained the same (Deykin et al, 1985; Neiger & Hopkins, 1988; Sudak, Ford & Rushforth, 1984a). In South Africa statistics confirm similar trends with regard to attempted and completed suicide. Statistics reveal that a high local incidence of adolescent suicide attempters are seen at psychiatric units. One pilot study recorded 187 adolescent suicide attempters during a three month period. This study was based on the hypothesis that the incidence of depressive illness in adolescent suicide attempters is higher than is generally accepted and that this condition often goes unrecognised and is misdiagnosed because it manifests differently with acting out behaviour and "masked" symptomatology. A random sample of suicide attempters between the ages of 13 - 25 who presented at C23 (psychiatric emergencies) Groote Schuur Hospital following a suicide attempt were assessed. 100 subjects were seen over a period of three months. The research procedure comprised a comprehensive assessment incorporating a semi-structured interview, self-report and objective rating scales for depression as well as instruments designed to assess the general health of each subject and their level of suicide intent. The depressive inventories used have been validated for use in this age group and were designed to elicit the associated features of adolescent depression. If warranted a clinical diagnoses was given, based on DSM IV criteria. This diagnosis was substantiated by information from the research instruments which formed part of the assessment process. A high incidence of clinical disorders was diagnosed in the sample (86%). Depressive illness was found to be a significant risk factor for suicidal behaviour with 68% of the subjects suffering from an affective disorder and 21% reporting depressive symptoms. This study shows that the correlation between parasuicide and depressive illness is high enough to suggest that all suicidal behaviour in this age group should be taken seriously as parasuicide in itself is often a reliable indicator of an underlying depressive condition. Additional risk factors for adolescent parasuicide identified in this study correlated well with the findings of similar research studies. Psychiatric co-morbidity, especially substance use (42%) and cluster B personality factors (54%), were high and served to increase an individual's vulnerability to suicide risk. Psychosocial factors such as sexual abuse (28%) and physical abuse (37%) were also identified as high risk factors for adolescent suicidal behaviour. Individuals at risk for depression and suicidal behaviour typically came from broken homes which were disrupted and unsupportive. Family members were frequently abusing alcohol and 67% of the subjects reported the presence of psychiatric illness in the family. The preferred method of suicide attempt was an overdose (90%). These attempts were generally unplanned and impulsive with no disclosure prior to the event. Intent was usually high at the time of the act. It is only through identifying the risk factors specific to the developmental concerns of this age group and acknowledging the role of depressive illness in adolescent suicidal behaviour that effective preventative measures can be devised.

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INTRODUCTION

AIMS OF THE STUDY

The main aim of this study is to investigate the relationship between suicidal behaviour and depressive illness in adolescents. This study is based on the hypothesis that the role of depressive illness in adolescent suicidal behaviour is more pervasive than is generally accepted. Depressive illness in this age group is widely acknowledged as an important risk factor for suicidal behaviour, however, depression in adolescents is frequently misdiagnosed and as a consequence suicidal behaviour misinterpreted. These misinterpretations arise out of the fact that suicide "gestures" are construed stereotypically as part of an oppositional or rebellious style of behaviour characteristic of adolescents. Such behaviour is often seen as attention seeking rather than as a serious indicator of clinical depression. Adolescent depression is difficult to diagnose as it typically manifests with extensive masking of symptoms and the externalisation of internal conflict in the form of oppositional or acting out behaviour.

The relationship between suicidal behaviour and depressive illness was investigated by assessing a randomly selected sample of 100 adolescent suicide attempters seen at Groote Schuur Hospital ward C23 (Psychiatric Emergencies) between the months of May and September 1995. The assessment procedure involved a comprehensive psychological interview and diagnosis for each subject focusing on both depressive and non-depressive symptomatology. The design incorporated the use of a comprehensive assessment form together with specific instruments for the purpose of assessing depression, general health and suicide intent. The assessment form was designed to provide a broad psychological profile of each subject. The depression inventories were used to assist in elucidating the presence of "masked" depressive symptomatology in adolescents which may be missed in a less rigorous interview. On the basis of this interview data a clinical diagnosis was given using the established DSM IV criteria. The depression inventory scales and a general health questionnaire were used to inform a clinical diagnosis of affective illness, if such a diagnosis was warranted. The suicide intent scale was used to assess the seriousness of each subject's suicide attempt.

A secondary aim of this study was to establish the presence of other risk factors - apart from depressive illness - which contribute to suicidal behaviour in this age group. The comprehensive assessment form was especially useful for this aim. Through the structured design of this form it was possible to identify non-depressive symptomatology and collect information pertaining to each subject's history.

This study is looking at various risk factors involved in "suicidal behaviour". Suicidal behaviour includes completed suicide, suicide attempts and suicide ideation (Beck, Resnik & Lettieri, 1974, p.36). The research focus of this study is confined to one aspect of suicidal behaviour, that is suicide attempts. Beck states that since completed suicides can only be studied retrospectively, it is more practical to obtain information from suicide attempts¹ for our source of data. Although parasuicide and suicide are distinct entities, it is useful to consider these behaviours on a continuum of suicidal behaviour; despite being separate there is some overlap. Many individuals seen for suicide attempts present with strong intent to die and a number of these individuals will go on to complete suicide: one outstanding prognostic feature for all completed suicides is a prior history of attempted suicide (*ibid.*): studies have shown that 10% to 14% of people involved in a parasuicide eventually succeed in completing suicide (Diekstra, 1993). Conversely, many individuals who do not intend to die do in fact complete suicide unintentionally through the use of methods more lethal than expected. For these reasons it is difficult to differentiate the risk factors that apply specifically to parasuicide and those that apply to completed suicide. Research has shown that the differences between completed suicides and parasuicides relate mostly to demographic features - sex, age, method - rather than to risk factors predisposing the individual to suicidal behaviour (Sudak, Ford & Rushforth, 1984). It may justifiably be claimed that there is a substantial overlap in risk factors applying to types of suicidal behaviour and that information collected from a sample population of suicide attempters can be extrapolated to all suicidal behaviour. To further extend the applicability of the conclusions reached in this study, literature discussing risk factors for all the aspects of suicidal behaviour was consulted.

This study is empirically based and is oriented towards developing a profile of the influence of affective illness and other risk factors on suicidal behaviour in adolescence. It is not a theoretical analysis of the etiological factors which predispose a person to be at risk.

CONTEXT OF RESEARCH

Suicide accounts for an increasingly high proportion of adolescent deaths. In South Africa 10.7% of all deaths in the 15-19 year age group during the period 1984-1986 were attributed to suicide (Flischer, Joubert & Yach, 1992). Suicidal behaviour is currently recognised as the second leading cause of death among adolescents and young adults worldwide (Stivers, 1988). Over the last 20 years there has been a marked increase, worldwide, in occurrences of adolescent suicide: the rate of suicide in this age group has risen 150%. The rate of suicide in adults and the elderly has, however, remained the same (Deykin *et al*, 1985; Neiger & Hopkins, 1988; Sudak *et al*, 1984a), which indicates that suicidal behaviour is becoming an increasing phenomenon of adolescence and that this age group is particularly vulnerable.

¹In this study the term "Parasuicide" will be used in place of suicide attempt. For a full definition of these terms see section 2.1 p.9.

This incremental global trend is supported by local data (Schlebusch, 1985). A study of parasuicides in young patients seen in the Department of Psychiatry, Addington Hospital, Durban in 1978 revealed that 25% of all patients referred for parasuicides were 19 years old or younger. A further study completed 5 years later (1983) in the same Hospital showed that 29% (almost one third) of all parasuicides were in this age group. These studies indicate a notable increase in adolescent self-destructive behaviour during a five year period (Schlebusch, 1985).

In July 1993 a study was completed establishing the prevalence of risk-taking behaviour among High School students in the Cape peninsula. The study examined a sample of 7,340 pupils from 16 schools in three major education departments (Flischer *et al*). Results revealed that 19% of these pupils had seriously thought of harming themselves in a way that might result in their death, 12.4% had told someone that they intended to put an end to their life and 7.8% had in fact attempted suicide. Most research studies on suicide indicate that a history of previous suicidal behaviour in the form of one or more nonfatal suicide attempts or parasuicides has emerged as the most powerful predictor of completed suicide (Egmond & Diekstra, 1990).

In the USA records show that over a half a million young people between the ages of 15 and 24 are attempting suicide each year. Of these attempters, 5000 are successful (Hepworth *et al*, 1986). Parasuicide behaviour is increasing in prevalence, with approximately 9% of High School students reporting that they have made a suicide attempt (Smith & Crawford, 1986). During the last two decades the health of all Americans has improved except for the age group 15 to 24. Researchers at Creighton University school of medicine found that there were 220 self-poisonings to every fatality among adolescent cases at poison control centres. Using this ratio the reported statistic of half a million adolescent parasuicides in the USA each year may in fact be 1 million. For this age group suicide is second only to accidents as the leading cause of death (Neiger & Hopkins, 1988).

The increasing occurrences of suicide and suicide behaviour in adolescents has generated much concern amongst health experts and educationalists, especially in the U.S.A. (U.S. Public Health Service, 1980). A pilot study in a local psychiatric ward revealed that during the period June 1994 to August 1994 187 patients (142 females and 45 males) between the ages of 13 and 24 were admitted to psychiatric casualty with suicide attempts. An analysis of central statistics on deaths in South Africa for the age group 15 to 19 years reports the following suicide statistics for specific populations between 1974-1983: Asians 8.7 suicides per 100 000 persons; Coloureds 4.1; Blacks 1.3 and Whites 7.8 suicides per 100 000 persons, between the ages of 15 to 19 (Ackerman, 1988). In fact poor reporting mechanisms makes these figures unrealistically low for the Coloured and Black populations: the prevalence of adolescent suicide in these communities is even higher than that in the Asian

community. The figures relating to over-all adolescent suicidal behaviour are significantly high and point strongly towards the urgent need for formalised research and intervention.

An association between depression and suicide was established by Beck and Albert (1975), and depression is now widely recognised as an important risk factor for parasuicide and suicide in adolescents (Myers *et al*, 1991). Data collated at the William Slater Centre for Adolescents show that of 695 adolescent patients assessed and/or admitted to the unit over the past 3 to 4 years, approximately 215 (31%) have at least one parasuicide attempt. Of those individuals who attempted suicide 47% suffered from a Major Depressive Episode (MDE) with Dysthymia, 10% had a Dysthymic disorder, and 1% had an MDE. That is, 58% of the patients seen at the unit with a previous suicide attempt had also an affective disorder of one or another type (Berard, Read & Ahmed, unpublished).

In 1975 childhood and adolescent depression was officially recognised by the NIMH (National Mental Health) in the USA. Although the essential features of a Major Depressive Episode are understood to be similar in children, adolescents and adults, it is also recognised that there are some important differences specific to each developmental phase (Bhatara, 1992). Adolescent depression has subsequently been linked to increasing rates of morbidity and mortality. It is estimated that as many as 15% of High School pupils suffer from clinically depressive syndromes (Forrest, 1983).

Whilst research has shown that depressive illness plays a significant role with regard to suicidal behaviour the range of other variables associated with parasuicide in an adolescent population is complex. Novick (In Sudak, Ford & Rushforth, 1984) describes suicidal behaviour as "the result of a complex interaction of many factors taking place over a long span of time and leading, by a sequence of steps, to this pathological solution" (p.135). That is, a suicide attempt is the end-point of a regressive sequence. By understanding the nature of this regressive process it becomes possible to identify those individuals at risk and intervene before this process reaches a critical stage.

SECTION ONE: ADOLESCENT DEPRESSION

1.1. ADOLESCENCE

Adolescence is generally construed as a period of transition in which a series of developmental tasks have to be negotiated. These include adjustment to physical change, disengagement from the family, and personal identity development. Theories of identity development state that the individual experiences uncertainty as the self definition and emotional support previously provided by the parental attachment is relinquished. Peer involvement compensates for these losses by providing an emotionally supportive context in which to explore interests, experiment with identities and develop social competencies. The

function of the peer group is therefore to offer a set of interpersonal bonds which provide the opportunity for the individual to achieve some psychological independence from the family, yet still have personal needs for emotional support met (Blos, 1967; Erickson, 1968; Eisenstadt, 1956. In Hopkins, 1994). Festinger (1954) stated that emotional uncertainty surrounding biological change leads adolescents to become dependent on similar others. Schachter (1959) argued that the anxiety generated by the uncertainty increases the need for peer affiliation. Adolescence can therefore be understood as a period of heightened susceptibility to influence. Individuals with self-esteem and identity uncertainty seek security through being similar to "the rest of the crowd". A heightened susceptibility to influence is then the price that the individual pays for the support and security offered by a peer group at this important developmental stage.(In Hopkins, 1994).

1.2. ADOLESCENCE AND DEPRESSION

Harrington (1992) states that although adolescence is considered to be a time of great inner turmoil and emotionality, most teenagers are generally happy individuals. Serious depression in this age group is relatively infrequent. In the last 20 years, however, there has been an increasing concern about depressive disorders amongst young people. Adolescents who develop serious depressive conditions are at high risk of having another episode in adulthood and have an increased risk of both attempted and completed suicide.

The public health issue of depressive disorder in adolescence is further underlined by the finding that, in both the UK and the USA, rates of suicide among [adolescents in general] and young men in particular have increased steadily. Many young suicides have suffered from depressive disorders (Harrington, 1992, p6).

Depression in adolescence is therefore associated with high mortality. It is estimated that over 90% of young people who commit suicide have an associated psychiatric disorder, most commonly an affective disorder, such as bipolar illness. These individuals may also have a conduct disorder, substance abuse and psychoses. These conditions often co-exist with an affective disorder, which increases lethality (Bhatara, 1992).

In the past it was not readily accepted that children and adolescents could experience depressive syndromes. The argument for this was drawn from both psychoanalytic and developmental theory. Psychoanalytic theory maintained that children had not attained the level of psychological development necessary to experience many of the feelings that are generally observed in the clinical syndrome of adult depression. Similarly developmental theory stated that many of the symptoms used to diagnose clinical depression in adults occur naturally, as transitory phenomena, in children and adolescents. Rabinovich (In Singer, Singer & Anglin, 1993) emphasises that this may be true for individual symptoms but is not the case when the cluster of symptoms that make up depressive disorders is observed as a set.

Table 1 (from Bhatara, 1992) outlines adolescent age-specific features of depression that often co-exist with the standard signs and symptoms of major depression as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

Table 1: Age-specific associated features of depression in Adolescents

- 1 Negativistic or antisocial behaviour
- 2 Oppositional and defiant behaviour
- 3 Feeling of wanting to leave home
- 4 Feeling of not being understood
- 5 Restlessness and moodiness
- 6 Aggression
- 7 Sulking, reluctance to co-operate
- 8 Withdrawal
- 9 School difficulties
- 10 Neglect of personal appearance
- 11 Rejection sensitivity
- 12 Increased emotionality
- 13 Substance abuse - especially alcohol abuse

The most serious depressive disorder in children and adolescents is major depressive disorder. This is the most difficult to treat and it confers a substantially increased risk for suicide in both male and female adolescents, particularly when accompanied by conduct disorder or substance abuse (Rabinovich in Singer *et al*, 1993).

The symptoms listed by Rabinovich are frequently misinterpreted by health care professionals: adolescent depression is often misdiagnosed as a behaviour style typical of this phase of development. Bhatara (1992) outlines the most common reasons for health care professionals to under diagnose adolescent depression:

- 1) A misconception about adolescent development and depression (and its etiological factors).
- 2) A high frequency of comorbid psychiatric disorders such as borderline syndrome, Attention deficit hyperactivity disorder, anxiety disorder, conduct disorder and substance abuse.

The diagnosis of adolescent depression is often missed because of unwarranted generalisations about adolescent development such as:

- 1) "All adolescents have mood swings". The assumption is that "mood swings" are not only considered normal in this age group but necessary for adolescent development.
- 2) A "hands off" approach is best because this is a stage they are going through".

Misconceptions also exist about the presentation of depression and mania. Irritability in adolescence is often dismissed as a normal reaction to stress when in fact adolescence is now believed to be a common age of onset for bipolar depression (Burke *et al*, 1990). Although the presentation of this disorder in the form of irritable and/or mixed mood states can be confusing, it reinforces the need for early diagnosis and treatment. The continuity of depression from prepuberty to adolescence and early adulthood has been well documented (Weller & Weller In Lewis, 1991). Health care professionals need to be aware of the discrepancy between the above mentioned misconceptions and the demonstrable facts regarding adolescent depression. It is part of the identity of an adolescent to convey a coping front to peers, also they are very sensitive to being perceived as different, the fear of being labelled in any way is great, yet the fear of being labelled "mentally ill" is profound.

Neiger provides the following description of adolescents who are at high risk for suicide:

Suicidal adolescents are usually dependent, accident prone, restless or bored, obnoxious (to receive attention), easily fatigued, experience notable changes in sleeping habits, are pessimistic, angry, guilty, have difficulty concentrating, have poor relationships, experience frequent mood swings, and feel rejected, lonely, isolated, or restricted (1988, p.474).

It is clear from this description that the features of adolescent depressive illness as outlined in Table 1 above is remarkably similar to Neiger's profile of a high-risk suicidal adolescent.

1.3. ASSESSMENT AND DIAGNOSIS OF ADOLESCENT DEPRESSION

Depressive disorders in adolescents are diagnosed using the same criteria as in adults. However there are some developmental variations in the manifestation of the disorder. For instance irritability, social withdrawal, hypersomnia and hyperphagia are particularly common in depressed adolescents when compared with their adult counterparts. There is also a strong association between depression and non-depressive symptoms. Vostanis and Harrington (1994) state that about 20% of young people with depressive disorders also have a conduct disorder, and nearly 50% have anxiety. These co-morbid non-depressive symptoms may contribute to concealing depression, however, a comprehensive and rigorous clinical examination will usually reveal the true nature of the underlying disorder. Assessment of depression in adolescence should therefore start with a thorough evaluation of both depressive and non-depressive symptomatology (Harrington, 1992). This normally involves interviewing the adolescent alone. It is generally accepted that the reliability of the parental report decreases as children become adolescents. It is also not suitable to rely on an account provided by an adolescent when the parent is present. Efforts to improve the reliability and validity of diagnosing depression in young people have focused on the use of standardised assessment instruments such as depression inventories. Depressed adolescents often have multiple problems such as educational failure, impaired social functioning, peer group difficulties and conflictual relationships which are important to identify when making a diagnosis.

SECTION 2: ADOLESCENCE AND SUICIDE/PARASUICIDE

2.1. DEFINITION OF TERMS: A CLASSIFICATORY SYSTEM

There is much semantic confusion, lack of clarity and vagueness of definition in the terminology used to describe suicidal behaviour. In response to this a classificatory system for suicidal behaviour was proposed at the conference on "Suicide prevention in the Seventies" held at Phoenix, Arizona, from January 30 - February 1, 1970. Professor Aaron T Beck was the chairperson of the committee on nomenclature and classification which met as part of this conference. The delineation of terms as proposed by this committee has provided a international basis for the discussion and study of factors involved in suicidal behaviour.

Three broad categories of suicidal behaviour were decided upon by the Nomenclature Committee and are now internationally accepted: these are *completed suicides*, *suicide attempts* and *suicidal ideas*.

- 1) *Completed suicide* includes all deaths in which a willful, self-inflicted, life-threatening act has resulted in death.
- 2) *Suicide attempt* includes those situations in which a person has performed an actual or seeming life-threatening behaviour with the intent of jeopardizing his/her life or to give the appearance of such an intent, but which has not resulted in death. This category includes all non-lethal actions previously classified as incomplete suicides, unsuccessful suicides, suicidal gestures, histrionic suicidal attempts, abortive suicides and ambivalent attempts.
- 3) *Suicidal ideas* include behaviours that may be directly observed or inferred, and that are concerned with or move in the direction of a possible threat to the individual's life, but in which the potentially lethal act has not actually been performed. Taking barbiturates out of a bottle and then returning them all to the bottle would be classified as suicide ideation or suicidal ideas. Swallowing several pills with the intent of committing suicide would be classified as a suicide attempt. (Taken from Beck *et al*, 1974, p.36)

Beck's committee further decided to rate each subject who had been placed into one of these three major categories on five other dimensions: *lethality*, *intent*, *mitigating circumstances*, *method* and lastly the degree of *certainty* on the part of the rater in judging whether the behaviour was suicidal

- 1) Certainty refers to the requirement that the rater should indicate his degree of certainty, in percentages, that a particular behaviour is or was suicidal.
- 2) Lethality refers to danger to life in a medical biological sense. The rating should be based on the objective medically accepted danger and not on the individual's subjective assessment (for instance, a fatal or near fatal dose of a drug that the subject may have expected to be relatively harmless is rated as *high* lethality). High lethality represents a lack of reversibility and a lack of possible medical rescue due to the method that is chosen or contemplated for suicide.

3) Mitigating circumstances would include those aspects of age, intelligence, toxicity, and organic or functional illness that might alter the awareness of the patient to the consequences of his/her action or could temporarily aggravate his/her propensity towards willful self-destructive behaviour. A common example is that of an acute alcoholic state, which may result in an emotional outburst or impulsive self-destructive action. The presence of transient mitigating factors at the time of an attempt might mean that recurrence would be less likely in their absence.

4) Intent means the seriousness or degree of sincerity of the subject in his/her actual or contemplated action in terms of ending his/her life. Intent may be judged from self reports (though the reliability of this data must be considered). Intent can be inferred from circumstantial evidence surrounding the event as well as background factors such as chronic feelings of dissatisfaction, unhappiness or a life-long pattern of dealing with problems through avoidance. Intent may also be measured by the individual's intensity of determination to end his life. These factors relating to the assessment of an individual's intent to die are incorporated into the Beck suicide intent scale.

5) Method of injury should also be documented for coding purposes as certain methods may be found to correlate with different degrees of lethality, intent, or mitigating circumstances. For example the frequent sedative overdoses encountered in clinical practice are generally not associated with psychotic illness as compared with suicides by fire where a severe psychotic illness is usually present (Beck *et al*, 1974).

The complete classification and rating scheme for a suicidal event devised by Beck *et al* (1974) is therefore as follows:

Main Class (Completed suicide, Suicide attempt, Suicide ideas)

Lethality: (Medical danger to life) Zero, low, medium, high

Intent: (To die) Zero, low, medium, high

Method: (for example Carbon monoxide poisoning) Not an ordinal scale

Mitigating circumstances: (Confusion, intoxication etc.) Zero, low, medium, high:

Certainty of classification: (1 - 100%)

Many researchers have had difficulties with the term "suicide attempt" on the basis that the semantic implications of "attempt" do not hold true for a number of suicide events. The researcher L. Kreitman suggested that the term was unsatisfactory "for the excellent reason that the great majority [*sic*] of patients so designated are not in fact attempting *suicide*" (Farmer & Hirsch, 1980, p.19). He proposed the term "parasuicide" to describe non-fatal suicide events, covering both suicide attempts with intent and suicide gestures with no or ambivalent intent. This study uses the term "parasuicide" as synonymous with Beck's "suicide attempt".

2.2 MODELS OF SUICIDE CAUSATION

"Suicidal" and depressive behaviour in adolescents is often misconstrued in the popular mind as typical of this stage of development: a normal stage through which most adolescents pass in the process of maturing. This notion is not, however, supported by psychological studies. Pfeffer (In Sudak *et al*, 1984) argues specifically against the notion that suicidal behaviour arises out of "normal developmental turmoil" in a young person (p.171). She argues instead that suicidal behaviour seems to be an "adaptive response to disturbed environmental situations" (p.175). With large numbers of adolescents attempting and completing suicide the question of why such behaviour exists and continues to rise has become increasingly important with regard to the development of effective preventative strategies. Three paradigms of understanding have been used to explain this abnormal pattern of behaviour: 1) Suicide as a result of the individual's internal or subconscious conflicts (the psychological model); 2) Suicide as a logical behaviour which follows from a particular individual's position in society and life situation (the sociological model), and 3) Suicide as the consequence of an individual's psychiatric illness (the disease model). The following paragraphs give a brief overview of specific theories relating to these paradigms.

Psychodynamic theory - emphasises the influence of past events on present behaviour. Suicidal behaviour is understood in the context of a loss of love resulting from circumstances such as deprivation, abandonment or rejection from significant others. Anger and resentment results with concomitant feelings of guilt, which manifest in self-destructive behaviour. This self destructiveness is understood as hostility turned inward: the suicidal individual is so enraged by some significant other that s/he wishes to kill the other. Rather than turning the rage and the murderous intent on the object of the anger, the suicidal individual is forced (by virtue of socialisation) to kill him/herself. Similarly the traditional psychoanalytic view of depression is that it also results from hostility turned inwards (Freeman *et al*, 1990).

Developmental theory - recognises the stress of the adolescent phase of development as a time of change, crisis pressure, and a tendency to impulsive over-reaction. The precipitating event is the culmination of a long-standing sense of entrapment and rage and is usually associated with moving, change of schools, romantic break up, death of a loved one or divorce of parents.

Cognitive theory - takes into account the meaning of death for the adolescent. Adolescents are understood to view their own lives as immortal. Death is therefore seen as reversible, not final. The adolescent perspective is seen as limited as a result of incomplete intellectual development as well as cultural attitudes and the media that supports the remoteness of death. Recent developments in cognitive theory maintain that the major precipitant for suicide is hopelessness rather than depressive illness *per se*. These theories state that the apparent relationship between depression and suicide is due primarily to the high incidence of hopelessness among depressed individuals. Cognitive theorists state that suicidal individuals hold the belief that there is no hope of things improving and therefore no longer any reason for continuing life. As an interventative strategy the individual is encouraged to challenge the

assumptions and misconceptions that are organised around such feelings of hopelessness (Freeman *et al*, 1990).

Sociological theory - emphasises anomie, alienation, withdrawal, isolation and loss of social contact. Anomie is characterised by a sense of weakening or disappearance of social guidelines - a lack of norms or structure in one's life. Suicide is seen as a response when considering the individual in this context. The social context of South Africa is particularly important when considering suicide from a sociological perspective. Erik Erickson's psychosexual stages of development describe adolescence as a phase of negotiation between identity versus role confusion. The fragmentation of the family unit together with severe socio-economic conditions in most South African communities has undoubtedly had an important effect on adolescents and young adults attempting to establish an identity in this context.

Biological theory - focuses on the biochemical correlates of suicidal behaviour and underscores the relationship of suicide to affective disorders. Recent studies suggest a deficiency in serotonin, a neurotransmitter, in people who attempt suicide. Additional studies have found other biological abnormalities associated with suicidal behaviour, which may prove to be helpful in the prediction and prevention of adolescent suicide (U.S. DHHS, 1984).

Psychiatric theory - this theory pre-supposes that suicide occurs as a consequence of the distortion of perception and judgement characteristic of a disturbance of mental state such as is brought about by psychiatric illnesses like depression or intoxication (alcohol or drug use). Suicide is not in itself a disease, but rather a symptom or sign of an underlying condition.

It is clear that each of these theories merely offers a different perspective on a complex phenomenon. Individually these theories do not offer an adequate explanation and are therefore best considered in conjunction with one another. Furthermore when attempting to understand the etiological factors involved in adolescent suicidal behaviour in South Africa, it is necessary to take into account the historical apartheid context. Historical factors of a socio-economic and political nature during the past two decades, such as living conditions, educational and employment status, and the disintegration of the family unit, have had a marked impact on individuals who are currently between the ages of 13 to 24.

2.3. PRECIPITATING CIRCUMSTANCES AND OTHER PREDICTORS

Cognitive therapists Beck, Steer, Kovacs and Garrison (1985) outline the concept of hopelessness as a major precipitant of suicidal behaviour. They state that it is often assumed that suicidal behaviour is directly linked to depression because the vast majority of persons who attempt or commit suicide show signs of depression. These theorists prefer to emphasise the relationship between hopelessness and suicide and state that the popular association of depression to suicide is due primarily to the high incidence of hopelessness amongst depressed individuals (Freeman *et al*, 1990). Some theorists believe that the accurate prediction of suicide in the long term is an almost impossible challenge, they focus

therefore on identifying short term etiological variables and immediate precipitants. Examination of short range precipitants is seen to be of more immediate practical value for treatment than long range prediction. Whilst causation is multifactorial and complex, the common denominators in the hours preceding a suicidal act are often very similar in most adolescents (Schlebusch, 1986).

Adolescent suicide and parasuicide is almost always precipitated by an identifiable event. A common precipitating circumstance is that of a disciplinary crisis. In some cases the individual is simply anticipating the discipline consequent upon some form of antisocial behaviour or truancy. Suicidal behaviour is also precipitated by perceived loss or rejection from a person important to the individual. Rejection may involve a family crisis or argument, poor performance in school activities, an argument with peers of the same sex or a dispute with a close friend of the opposite sex. Loss - either real or imagined - places an adolescent at higher risk for suicidal behaviour. This may include the loss of a loved one, the termination of a friendship, the loss of vitality or health, or the loss of security (Neiger *et al*, 1988). Suicidal behaviour is often related to the loss of friends and social status that occurs when a family moves from one area to another, or the loss of a boyfriend or girlfriend.

There are many other predictors of teenage suicide. Truancy, absenteeism and progressive failure in school often occur in response to parents applying too much pressure on their children to succeed academically. When these individuals fail in the school context they are likely to generalise this failure to all aspects of their lives. Above average intelligence and above average physical development, perfectionism and competitiveness are other characteristics that have been noted as predictors of suicidal behaviour in this age group. Another relatively unusual factor that deserves mention is that of the cluster effect. In some communities it has been noted that when a suicide has been attempted or committed by a popular peer it may be followed by a succession of associated attempts by members of the original peer group (Robbins, 1983).

Anger is another factor that can lead to suicidality, especially in those individuals who are unskilled in handling their anger. In such cases suicidal behaviour is understood as a form of "acting out". Individuals may use this type of behaviour as a way of punishing the external source of their anger.

Another type of motivation for suicide may be termed "histrionic" suicide: a suicide attempt that is motivated primarily by a desire for stimulation, excitement or attention. Some individuals will place themselves in dangerous and life-threatening situations when feeling "bored" or "anxious". Such deliberate "thrill seeking behaviour" is often interpreted as quasi-suicidal because of the risk of physical injury or loss of life. Although histrionic attempts may appear flamboyant or manipulative - and the individual may have little intention of dying - the

possibility of lethality surrounding an attempt for histrionic display exists and therefore such behaviour needs to be taken seriously.

A smaller group of individuals attempt suicide in compliance with an auditory hallucination.

2.4. ADOLESCENCE AND PARASUICIDE

Studies focusing on the prevalence of attempted suicide in adolescent and young adult populations have concluded that the incidence of suicide attempts is high, estimates on the prevalence of such attempts typically are in the range of 3% - 10% of the population (Fergusson & Lynskey, 1995). Adolescents - especially young girls - form a sizable proportion of the patients admitted to hospital after self-poisoning or other self-injury. The problems facing such individuals are different to the problems that face adults. However, the most common precipitant across all age groups appears to be recent conflict in the context of a significant relationship. Hawton *et al* (1982b) stated that of a sample of 50 young individuals (including 45 girls) between the ages of 13 and 18 who had taken overdoses, the most common precipitant resulted from their relationship to their parents. Three quarters of the sample group had difficulties with either or both parents. These adolescents complained particularly about their inability to discuss problems with their parents, especially their fathers. Some of the attempts were directly precipitated by an argument with a parent. This study also showed that the extent of disturbance in the family background was particularly pronounced. 36% were living with only one parent and 12% with neither parent. In addition 12% had been "in care" with social services at some time. These figures are far higher than those for adolescents in general, and are consistent with other studies in the United Kingdom (White, 1974; Walker, 1980) and from elsewhere in Europe (Bergstrand and Otto 1962; Choquet *et al*. 1980), the USA (Jacobs, 1971; Rohn *et al*, 1977) and Canada (Garfinkel and Golombek 1983) all of which have demonstrated a higher frequency of broken homes among adolescent suicide attempters.

Over half the subjects in Hawton's study had difficulties at school, both with school work and in their relationship to their teachers. Employment difficulties, including unemployment, were common amongst those who had left school. Half the subjects were experiencing problems in their relationship to either a boyfriend or a girlfriend. A recent argument in such a relationship was the most common precipitant of an overdose. Several subjects had poor relationships with peers, resulting in social isolation and a lack of friends.

As is the case in adults, poor physical health was a common precipitating factor. Not only were recent admissions to general hospitals common but almost a third of the adolescents in this study reported having a physical disorder at the time of their overdoses. Although these disorders were generally not disabling they were sometimes chronic (e.g. asthma, dysmennorrhoea) and appeared in some cases to have contributed to parasuicide in the sense of undermining these individuals' ability to cope with other stresses. Psychiatric disorder was

rare though approximately a quarter of the subjects had consulted a psychiatrist at some time. A small group within the sample showed the beginnings of considerable personality difficulties and some had moderately severe depressive symptoms (although these appeared transient) (Hawton *et al.* 1982b).

A similar study was conducted at Addington Hospital in Durban between 1st January and 31 December 1983 with 548 parasuicide patients, of which 39.6% were Coloured and 60.4% were white. Of this number 159 (29%) were between the ages of 10 and 19 years. Psychiatric disorders were diagnosed in slightly more than half - 87 - of the patient sample (54.7%). The most prevalent associated diagnosis, affecting 47 of the 87, was adjustment disorders of adolescence (54.0%). Most of these subjects manifested an anxious or depressed mood characterised by feelings of hopelessness, disturbances of conduct, or academic problems following a previously adequate academic performance. Next in prevalence in the sample of 87 were specific affective disorders (21.8%), largely manifesting as dysthymic disorder. None of these 19 patients met the criteria for a bipolar affective disorder or a major depressive episode. The third most common diagnosis associated with parasuicide was conduct disorder: 14 patients (16.1%). Most of these individuals with conduct disorder were socialised and non aggressive subjects manifesting persistent patterns of age-appropriate norm violations, at school and at home, and precocious sexual activity. Substance-use disorders were diagnosed in a minority (8.1%) of late adolescent patients (i.e. 16 years and older) and took the form of episodic alcohol and/or drug abuse rather than dependence. The remaining 45.3% of the patient sample were not diagnosed with a definite psychiatric disorder, although they did experience symptoms such as hopelessness. (Schlebusch, 1985)

Parent-child problems were the most common precipitants of parasuicide (29.2%). These mostly consisted of difficulties in relationships with either or both parents, caused by disciplinary measures, staying out late or dating someone against parental wishes. Academic problems, including scholastic under achievement in patients with adequate intellectual ability, and relationship problems with teachers, were the next most frequent (22.2%). Other specified family circumstances (19.4%) were largely associated with social and financial pressures, the latter often being related to occupational problems such as unemployment of the breadwinner or of the index patient who had left school. A number of these patients were in the care of social or child welfare agencies.

Other interpersonal problems centered principally around difficulties with romantic partners. Such problems included a recent termination of a relationship, fear of pregnancy, recent dissension between partners or parental disapproval of a partner (12.5%). A few patients were socially isolated from peers or had difficulty in establishing friendships. Parental marital problems constituted the fourth most common problem area (8.3%). Most stressors were related to psychological problems in the index patients' families, which frequently involved abuse of alcohol by one or both parents, estrangement between parents, or dissension which

affected the patient. Only three patients were married (4.2% of the sample); all were girls in late adolescence and all were experiencing marital conflict. An analysis of the medical files revealed that generally most of the patients had been in good physical health just before the parasuicide.

A study was conducted at William Slater Centre For Adolescents in Rondebosch, Cape Town (Berard, Read & Ahmed, 1995) where data on the total number of patients assessed at the unit over the past 3/4 years (695) was compared with those individuals presenting for assessment who had also had a parasuicide attempt prior to assessment. It was revealed that of the 695 individuals seen at the unit approximately one third (215) had at least one parasuicide attempt (39% of this sample had more than one attempt). The entire sample comprised a psychiatric population of individuals who were perceived as suitable for the therapeutic programme at this unit. Individuals presenting with persistent depressive symptoms were considered highly suitable for the therapeutic programme; individuals suffering from conduct disorders, although seen for assessment, were usually not admitted.

The parasuicide sample of 215 subjects was compared with the overall population of 695 subjects admitted to the unit over the past 3/4 years. The average age of the parasuicide sample was 18 years with individual ages ranging from 13 - 26 years. Most of the subjects were of school going age and most were at secondary school. The ratio of males to females was 1:6 (33 males and 182 females). This ratio was compared to the overall population of patients admitted to the unit (1:2), suggesting that there are considerably more females attempting suicide than males. This finding was consistent with other research findings that indicate three times as many females generally attempt suicide than males.

The range of clinical disorders emerging from the parasuicide sample was broad. Affective disorders were the most prevalent (58%) followed by substance use disorders and eating disorders. 10% were diagnosed with Dysthymia, 1% with Major Depressive Disorder and 47% with Major Depressive Disorder with Dysthymia. When compared with the overall population of 695 individuals it was found that affective disorders were generally high, approximately 60%. One interesting feature, however, was that the incidence of MDE with Dysthymia rose substantially from 30% - 47% in the parasuicide sample, indicating that the severity of the affective illness is much greater in those who attempt suicide.

The percentages of both alcohol and cannabis abuse was shown to increase in the parasuicide group. However, given that most of the parasuicide sample was suffering from a more severe affective illness than the general population, this proportionate increase in substance abuse could be understood as being reflective of the severity of affective illness rather than existing independently as a specific risk factor for parasuicide. It was found that although a high percentage of the sample were abusing substances very few individuals were in fact intoxicated at the time of the suicidal event. This finding was different to adult populations

where a high proportion of suicide behaviours are generally enacted within the context of intoxication. 18% of the parasuicide sample were diagnosed with an eating disorder against 9% of the total population. This percentage increase indicates that a significant proportion of those individuals who present at William Slater Centre with a previous suicide attempt also have an eating disorder. The range of personality disorders emerging from the parasuicide sample was broad.

The most prominent features on Axis 2 were Histrionic, Borderline and Avoidant traits. Histrionic and Borderline personality disorders were indicated as significant long-term risk factors for parasuicide in this sample. The psychosocial risk factors for parasuicide identified in this sample were extensive. The most persistent social difficulties experienced by individuals in the sample were categorised into three superordinates: Academic failure; Family Conflict and Relationship difficulties. These findings were in keeping with most studies which indicate that family dynamics play a significant role with regard to suicide probability in adolescence. Other psychosocial risk factors identified in the sample were sexual abuse (52%) and physical abuse (22%). The percentages for abuse in the parasuicide sample are substantially higher than in the general population and are significant enough to indicate that abuse is a significant risk factor for parasuicide. A history of abuse in this age group is repeatedly shown to be related to the later expression of suicidal behaviour.

75% of the individuals in the parasuicide sample had some form of previous psychiatric contact and 24% had received some form of psychiatric medication. 40% of the parasuicide sample came from families with a history of psychiatric illness and over half the sample came from broken homes where parents were either divorced, separated or widowed. 39% of the sample were had more than one parasuicide attempt (83 of the 215 subjects) and 28 individuals - 13% - had a third attempt. When considering the methods used across three episodes it was noted that overdose activity decreased and was replaced rather by more lethal methods such as slitting wrists, hanging and shooting. When considering the type of overdose commonly used in parasuicides it was noted that analgesics (especially Panado) were most common, followed by hypnotics, antidepressants and benzodiazepines. A general trend emerging from this study showed an intensification of clinical syndromes and psychosocial difficulties in those individuals seen at the William Slater Centre who have had a suicide attempt, compared to those who have not.

Table 2: Summary of comparison between the overall population of patients seen at WSH (1991 - 1995) with that portion of the population who presented with a previous attempted suicide.

Demographic Data	Parapop (n = 215)	Genpop (n = 695)
Female	182 (85%)	65%
Male	33 (15%)	35%
Race		
White	60%	71%
Coloured	35%	25%
Black	3%	2%
Asian	2%	2%
Employment & Education		
Primary	2%	2%
Secondary	61%	60%
Matric	24%	26%
Tertiary	13%	12%
Employed	24%	10%
Unemployed	18%	18%
Clinical Disorders		
Dysthymia	10%	23%
MDE	1%	7%
MDE with Dysthymia	47%	30%
Total Affective Disorders	58%	60%
Substance Use Disorders		
Alcohol	30%	23%
Cannabis	37%	29%
Eating disorders	18%	9%
Personality disorders		
Narcissistic Personality disorder	2%	2.5%
Narcissistic Traits	2%	5.6%
Histrionic Personality disorder	6.5%	1.5%
Histrionic Traits	9%	3%
Borderline Personality disorder	6.5%	3.5%
Borderline Traits	6.5%	0.2%
Avoidant Personality disorder	1.5%	3%
Dependent Personality disorder	1.5%	0.5%
Dependent personality traits	1.5%	9%
Conduct disorder	3%	3%

Total % of Personality disorders/ traits		
Psychosocial factors		
Sexual abuse	52%	27%
Physical abuse	22%	13%
Previous psychiatric contact	75%	49%
Previous psychotropic medication	24%	14%
Family history of psychiatric illness	40%	34%
Parental status		
Divorced	40%	40%
Single	2%	1%
Parasuicide attempts		
Attempt 2	39%	N/A
Attempt 3	13%	N/A

SECTION 3: RISK FACTORS FOR SUICIDE AND PARASUICIDE

The literature on suicidal behaviour in young people has identified a series of psychosocial factors that appear to be associated with increased vulnerability to this style of behaviour. These factors have been broadly classified into the following groups: Psychiatric disorders, disadvantaged or dysfunctional childhoods and problems of personal adjustment. This suggests that one of the more common pathways that leads to suicidal behaviours in young people may involve early dysfunctional or disadvantaged family circumstances which in turn increase vulnerability for psychiatric disorders and problems of personal adjustment (Fergusson & Lynskey, 1995). The role of psychiatric disorders in the development of suicidal behaviour in young people has been well illustrated in the findings of a study by Andrews & Lewinsohn (1992) who examined the prevalence and psychiatric co-morbidity of suicide attempts in a community sample of adolescents. Their results indicated that 57.9% of those individuals who reported having attempted suicide had a diagnosis of previous major depression, 15.7% had a diagnosis of alcohol abuse/dependence, 17.4% met criteria for disruptive behaviour disorder: in total, 80.2% met criteria for at least one psychiatric disorder.

A second recurrent finding in the literature is that individuals who engage in suicidal behaviour frequently come from home backgrounds characterised by various forms of dysfunction or disadvantage such as poor parent-child relationships, poor mental health of parents and parental offending.

In addition to having higher rates of psychiatric disorder and disadvantaged or dysfunctional childhoods, individuals who attempt suicide are also frequently characterised by other problems of personal adjustment including low self-esteem, increased risks of aggressive or antisocial behaviours, and substance use (Fergusson & Lynskey, 1995).

3.1. DEMOGRAPHIC FACTORS

Risk for suicide generally increases with age. Although children under the age of 13 do commit suicide the rates are much higher in the 15 - 24 age group. Women attempt suicide three times more often than men, though twice as many men actually succeed in completing suicide. This is especially true for adolescents where adolescent boys tend to use methods that are more lethal and therefore result in higher completion rates. Demographic statistics on race in the USA report that Black individuals complete suicide more often than do members of any other race. With regard to adolescents and young adults the rate of completed suicide is about the same across all racial groups. The rate among white adolescents increases sharply with age. Of all racial groups in the USA American Indians have the highest rate of completed suicide (Hafen & Frandsen, 1986).

In an attempt to determine the geographic patterns of adolescent suicide in the USA a national analysis of adolescent suicide was conducted between the years 1964-1978. Statistical analysis showed a strong inverse relationship between teenage suicide and population density. Previous research in this field related high population density (overcrowding) to social and behavioural pathology. This study indicated, however, that low population density (undercrowding) can also have adverse affects: social isolation and limited social services may also contribute to the accelerating adolescent suicide rate (Neiger & Hopkins, 1988).

3.2. PREVIOUS PARASUICIDE

It is well established that higher rates of completed suicide have been found among those who have made previous attempts (Shaunesey, Plummer, Cohen & Berman, 1993). Acute suicidal behaviour is an important indicator of suicide ideation. Evans (1982) states that in any sample of adolescent attempters one fourth have a previous parasuicide attempt. Frequent discussions of death, making plans for death, purchasing or carrying deadly weapons and risk taking or criminal behaviour are also indicators of suicide ideation. It is a common misconception that adolescents who talk about suicide are simply trying to get attention. Statistics indicate that more than 80% of those individuals who commit suicide talk about it first (Hafen & Petersen, 1983).

3.3. SUBSTANCE ABUSE

Substance abuse has been identified as a risk factor for suicidal behaviour in adolescence and has figured prominently in the diagnosis of between one third and one half of adolescent and young adult suicide completers, with as many as 70% of youthful attempters reporting the

use of psychoactive substances. Longitudinal studies have drawn attention to the importance of substance abuse also as a predictor for completed suicide in both younger and older adults. Suicide ideation and suicide attempts (both in the context of depressive illness and alone) have been documented as being associated with substance abuse (Bukstein, Brent, Perper, Moritz, Baugher, Schweers, Roth & Balach, 1993).

Sommer (1984) states that there appears to be a direct relationship between the use of drugs and/or alcohol and suicide attempts by adolescents. Alcohol is the most common drug used, followed by marijuana and stimulants. Neiger & Hopkins (1988) state that the risk for suicide in adolescence is substantially increased by alcohol or drug abuse for several reasons. Teenagers abusing substances generally exhibit low self-control and are more easily frustrated and affected by situational distress. In addition they are more apt to act impulsively when under the influence of such substances. In some cases the substance itself may serve as a mechanism by which the individual may choose to end his/her life. Bukstein *et al* (1993) discuss several possible mechanisms by which the abuse of substances may predispose a person to suicide. Substance abuse may influence multiple disruptions in key relationships, which in turn may increase the risk for suicide. The intoxicating effects of substance abuse may also impair judgement and make suicide (especially by firearms) more likely to occur. Substance abuse may have an acute and chronic mood altering effect which may exacerbate depressive symptoms, suicidal ideation, intent and behaviour.

The high frequency of substance use and abuse in the general adolescent population, however, suggests that substance abuse on its own is not a strong enough indicator for potential suicide behaviour. This raises the question of what other factors are involved that predispose substance abusing adolescents towards suicidal behaviour. Previous studies show that a high proportion of suicide attempters with substance abuse also have co-morbid affective illnesses. An examination undertaken on outpatient adolescent substance abusers found that a history of suicide attempts was associated with both current and past depressive symptoms (Berman & Scwhartz, 1990). Similarly another study of completed adolescent suicide found that the combination of alcohol abuse and major depression was more common in suicide victims than in controls (Shafii, Steltz-Lenarsky, Derrick, Beckner & Wittinghall, 1988). Bukstein *et al* (1993) state that suicide completers with a long-standing history of substance abuse will be more likely to exhibit one or more of the following risk factors: co-morbid major depression; current active substance abuse; co-morbid conduct disorder; previous suicidal ideation; family history of depression and substance abuse, and interpersonal discord or loss.

Bukstein *et al*, in their case control study of risk factors for completed suicide among adolescents with a lifetime history of substance abuse, found that current active substance abuse by adolescents shows an increased risk for suicide above and beyond a lifetime history of substance abuse (1993). This finding was consistent with other studies that have found an

association between suicidal behaviour and severity of substance abuse. One of the most significant risk factors for completed suicide in this sample was co-morbid major depression. Murphy, Wetzel, Robins, McEnvoy (1992) support this finding and note that depressive symptoms are more common in substance abusers with suicidal behaviour than those without such a history. Bukstein *et al* also found that whereas in most studies depression is seen as secondary to alcoholism, in a more youthful sample many of the substance users with co-morbid substance abuse developed depression first. They conclude that because depression in a substance abusing youthful population may be difficult to identify, a family history of affective illness may assist in proper diagnosis. The recognition and treatment of affective illness in substance abusing adolescents is critical to the prevention of suicide in this population.

Previous studies have indicated an association between antisocial disorder, substance abuse and an increased risk for suicidal behaviour in young adolescent males. Bekstein *et al* found that suicide completers did have a 3.2-fold increased rate of conduct disorder compared with controls. The completers also had much higher rates of legal interventions indicating a greater severity of conduct disorder. Runeson (1990) in comparing substance abusing and non-substance abusing suicide completers found higher rates of court appearances among substance-abusing suicide attempters.

3.4. SEXUAL ABUSE & PHYSICAL ABUSE

A pilot study by Deykin, Alpert and MacNamarra on the correlation between sexual abuse and suicidal behaviour in adolescence found that of an adolescent sample population attending an Emergency Unit, there were "frequent notations of child abuse, removal to foster care, and global family violence in the records of those who had attempted suicide. Rarely were such notations found in the records of the [non-suicide] subjects" (1985, p.1299). Deykin *et al* further point out that the well documented rise in the adolescent suicide rate is matched by a rise in the prevalence of sexual and physical abuse (1985, p.1300). In a further study by Shaunesey *et al* (1993) it was found that of a sample of 117 hospitalised adolescents those who had experienced some form of physical or sexual abuse made significantly more suicide attempts than did adolescents who had not experienced abuse. Shaunesey's study also showed that the higher the frequency of physical abuse, the more severe the self-reported suicidal thinking and the greater the number of previous suicide attempts. With regard to sexual abuse, however, it was found that the duration and frequency of abuse did not reveal more severe effects as the severity of the abuse increased.

Livingston, Lawson and Jones, in a study of self-reported psychopathologies amongst abused children, found that there are a number of pathologies with a high correlation to sexual abuse: these include suicidal behaviour, depression, anxiety, conduct disorder and somatisation (1993, p.948). Major depression, alone or co-morbidly with dysthymia, was very frequent in their subject group. They further conclude that abuse arouses specific

aggressive impulses in the victim: "it is common for abused individuals to show both the outward aggression associated with conduct disorder and the inwardly directed aggression associated with [depression and] suicidality" (p.952).

Livingston's findings are supported by other studies, all of which conclude that abuse commonly results in a pathological response: depression, substance abuse, conduct disorder and personality dysfunctions such as Borderline Personality Disorder are some of the more common adolescent responses (*vide* Hernandez, 1992; Otaga, Silk, Goodrich, Lohr, Westen & Hill, 1990). A number of these responses are implicated in suicidal behaviour. This provides additional evidence for the fact that a history of abuse is significantly related to later expression of suicidal behaviour or ideation.

The high correlation between suicidal behaviour and sexual abuse has been verified in local research. In a study at the William Slater Centre for adolescents it was found that within a large sample of 272 sexually abused adolescents 131 (48%) had had at least one suicide attempt. 57% of the 131 reported one attempt and 43% presented with a history of multiple episodes (Berard & Ahmed, 1995).

3.5. PERSONALITY FACTORS

During the 12 month period 1 January - 31 December 1978, 723 suspected suicide patients were seen in the casualty department of Addington Hospital, Durban. 326 of these individuals were referred to the attached psychiatric unit within 72 hours. Of these, 16 refused hospital treatment leaving 310 for psychiatric evaluation. This study revealed that parasuicide is closely related to a large variety of psychiatric disorders. The most frequently associated diagnosis was transient situational disturbance (56%), followed by depressive neurosis (13%) and conduct disorders (10%).

This study also revealed that of this sample the second highest parasuicide rate (25%) was in the 10 to 19 year old age group. Of the 78 adolescents seen 31 (39%) were diagnosed as having a conduct disorder. Follow up examination and treatment of these patients also revealed that most also had difficulties associated with ego identity and alienation from the dominant value demands in their specific societies (Schlebusch & Minnaar, 1980).

In psychological autopsy studies of adolescent suicide, Axis 1 psychiatric disorders have been found to be present in at least 90% of suicide victims (Brent, Johnson, Perper, Connolly, Bridge, Bartle & Rather, 1994). This figure must be considered in the context of the fact that the rate of psychiatric disorder in the total adolescent population is approximately 20% (Costello, 1989) : that is, only a small proportion of psychiatrically ill adolescents will commit suicide. Concomitant risk factors in addition to Axis 1 psychiatric disorders therefore need to be identified in order to understand the etiology of suicidal behaviour more comprehensively. Several studies of adolescent suicidal behaviour report a

close association between completed suicide and a tendency to unstable or labile affect corresponding to borderline or histrionic personality disorder (Brent *et al* 1990). Borderline personality disorder is most commonly associated with suicidal behaviour when co-morbid with affective or substance use disorders (Crumley, 1979). Avoidant disorders have also been found to be associated with attempted suicide (Brent *et al*, 1993a). Brent also suggests novelty-seeking is implicated in suicidal behaviour: the relationship is not direct, but novelty-seeking is linked to borderline personality disorder which in turn has been associated with suicidality (Brent *et al*, 1990).

In a study of completed suicide in a sample of individuals younger than 30 years of age, by Rich, Young & Fowler (1986), the reported rate of personality disorders was 10%. In a re-analysis of this data a much higher rate of borderline personality disorder - 41% - was reported (Rich & Runenson, 1992). Shafi *et al* (1988) in a controlled study reported a 29% prevalence of personality disorder against 10% in a comparison group. Although the literature strongly suggests an association between personality disorder and completed suicide in adolescents most of these findings derive from studies that have not been controlled. Brent *et al* (1994) conducted a study designed to assess the association between personality disorders, personality traits, impulsive violence and suicide. Personality disorders and traits in 43 adolescent suicide victims and 43 community controls were assessed from their parents using semistructured interviews and self report forms. It was found that personality disorders, particularly Cluster B type disorders (borderline, narcissistic, histrionic & antisocial), were more common in suicide victims than in controls. Dimensional measures of personality showed higher degrees of lifetime history of aggression and of an increased tendency to impulsive violence and "harm avoidance".

3.6. MOOD DISORDERS

It is estimated that as many as half of all adolescents suffer from regular periods of depression of various intensity. According to the American College of Emergency Physicians, the diagnosis of depression represents a major risk factor in the completion of teenage suicide (Rund & Harvey, undated). Fergusson & Lynskey's 1995 study of a cohort of New Zealand adolescent parasuicides found that 69.0% of the parasuicide group had a depressive disorder, compared to only 11.7% of the control group. The parasuicide group also showed a much higher proportion of anxiety disorders (p.616).

A strong indicator of depression in adolescence is low self-esteem, associated with self-blame, self-criticism and self-dislike. The individual becomes convinced of his/her worthlessness and ineptitude. S/He feels publicly scrutinised and show a prominent and persistent loss of pleasure in usual activities and pursuits. It is postulated repeatedly that the number of adolescent suicides can be dramatically decreased if signs of depression are recognised and aggressive action can be taken to help those who suffer from it (Neiger *et al*, 1988).

3.7. SOCIAL FACTORS

Livingston *et al* point out that environmental stressors have been shown to be risk-factors for both emotional and behavioural disorders (1993, p.952). These stressors include societal factors such as the high divorce rate and family fragmentation, violence, abuse, neglect or poor interpersonal dynamics within the family, limited financial resources and high unemployment rates amongst the young, and poor (frequently overcrowded) living conditions (Deykin *et al*, 1985; Neiger *et al*, 1988). Most of these stressors are located in the context of the family: most adolescents are still highly reliant on the family for psychological as well as financial support. Epidemiological studies suggest that the increasing rates of adolescent suicidal behaviour is temporally correlated with and might be contributed to by the rising rate of changes and instability in the basic family unit. Psychological studies have showed a strong connection between disordered family relationships and concomitant regressive responses to the adolescent task of individuation from the family (Sudak *et al*, 1984). In a review of research studies by Fergusson & Lynskey (1995) it was noted repeatedly that a very common characteristic amongst parasuicide adolescents is a home background characterised by various forms of dysfunction such as family breakdown, poor parent-child relationships, poor mental health of parents, or parental offending (p.613).

It is widely recognised that poor family relationships play a very significant role with regard to suicide probability in adolescence. Factors such as family violence, intense marital discord or loss of a parent through death or divorce can significantly increase the individual's sense of helplessness and vulnerability. Family dynamics, especially during early childhood, are also implicated in the individual's reaction to other stressors. Yama, Tovey and Fogas, in their study of the effect of the childhood family environment and sexual abuse on later depressive disorders, concluded that "high family conflict, low control (less emphasis on rules and procedures), and high cohesiveness, all in combination with a history of sexual abuse, placed victims at greater risk for subsequent depressive symptoms" (1993, p.140). Family dynamics therefore influence the individual both directly and indirectly in terms of vulnerability to suicidal behaviour.

Parent-child conflict is probably the most important external factor in the emotional disturbances of adolescent suicide attempters (Lukianowicz, 1968 In Sudak *et al*, 1984). In a study by Stern (1984) parents of adolescent parasuicides were found to be more hostile and indifferent to their children. Parents of parasuicide adolescents frequently appear to be rigid, over-controlling and exhibiting extremes of expectation. Other studies have noted indifference, withdrawal and lack of responsivity to adolescent crises as factors contributing to suicidal behaviour (Yusin, Sivay & Nihira, 1972 In Sudak *et al*, 1984). However, Rutter and Hersov state that parent-child conflict cannot always be attributed to the parent, as it is equally possible that personality and temperamental factors within the adolescent contribute to this conflict (1977 In Sudak *et al*, 1984).

Suicide is also more common in adolescents whose parents have either attempted or committed suicide (Neiger *et al*, 1988). In Shaffer's study on child suicides (Sudak *et al*, 1984), 4 out of 30 suicide victims had a family member committing suicide prior to their own: in 3 more cases a family member committed suicide after the death of the child. Not only suicidal behaviour but other psychiatric disturbances in the family also place the adolescent at greater risk. Hawton (In Roy, 1986) discusses Shaffer's findings that 55% of the suicide sample had a first-degree relative who had a history of psychiatric disorder, including suicidal behaviour. He suggests that such adolescents are influenced to perceive suicide as a "coping mechanism" (p.140). Common psychiatric disorders such as alcohol or other drug abuse often result in dysfunctions within the family unit, particularly if the family member is violent or otherwise abusive. Fergusson & Lynskey found that 31% of their adolescent parasuicide cohort had a parent who abused substances - very nearly double that of the control group (p.618).

The broader living environment also appears to have an impact on adolescent suicidal behaviour. Sudak *et al* found, in a comparison of the suicidal behaviour rate of adolescent city dwellers and "suburban" adolescents, that the group living in the high density city environment were at an increased risk of parasuicide or suicide. They attributed this to a greater alienation of the young due to social disorganisation within urban communities; increased criminal victimisation, and larger rates of youth unemployment (1984, p.65), amongst other factors. These findings must be seen in conjunction with those of Neiger and Hopkins (1988), which indicated that young people living in very isolated areas, with little or no social support, were also at risk to suicidal behaviour.

3.8. PHYSICAL ILLNESS FACTORS

A study done on adolescent suicide attempters in France found that 40% of the sample group suffered from "poor health", as opposed to only 12% of the general adolescent population; 29% had been seriously ill, and 36% had been hospitalised. The figure for the general population was 15% in both cases (Farmer & Hirsch, 1980). This suggests that ill health is a contributing factor in adolescent suicidal behaviour. These results are corroborated by a similar study on completed suicides in which over half of the sample were shown to have had a physical illness (Whitlock, In Roy, 1986, p.151).

It is generally acknowledged, however, that physical illness is a potential but not a high risk indicator of parasuicide in an adolescent population. Hawton (In Roy, 1986) states that physical illnesses are only rarely a major contributory factor in adolescent and child suicides; but adds that "a physical illness, even though minor, might constitute a predisposing factor rendering the individual more vulnerable than usual to distress caused by social factors" (p.142). Chronic ill-health often lowers resistance to other stressors. Perrone points out that a "combination of normative stress plus illness stress can result in feelings of helplessness and hopelessness" (1993, p.23).

While most studies agree that ill health is not a direct cause of suicidal behaviour, it is accepted that it is a risk factor in that it often influences the individual's state of mind: depression is a common consequence of prolonged ill health, or serious physical disorders. While children and adults are at risk for various health problems, adolescents are generally physically healthy. Ill health in adolescents tends to isolate an individual from his or her peer group, thereby undermining interpersonal relationships. This in turn affects self-esteem and increases the individual's vulnerability to depressive symptomatology and suicidal behaviour.

SECTION FOUR: METHODOLOGY

4.1. METHODOLOGICAL STRATEGY

Aims of the Research

The main aim of this study was to investigate the relationship between suicidal behaviour and depressive illness in adolescents. A secondary goal in this study involves investigating the context in which the parasuicide attempt occurs. This comprises examining risk factors and other co-morbid influences.

4.1.1. PROCEDURE

The research data was collected through the use of a clinical interview, conducted in Groote Schuur Hospital Ward C23. This interview took place on the day following each subject's suicide attempt, or as soon thereafter as possible. The data gathered through this interview was substantiated through the use of self-reports and objective clinical instruments, devised to extrapolate both the psychological profile of the subjects and their social contextual history.

The instruments used included a comprehensive assessment form for the elucidation of demographic data and the patient's history and psychosocial stressors; a self-report depression inventory (Beck Depression Inventory) and two objective rating scales for depression (the Hamilton and the Montgomery-Asberg), the Beck Suicide Intent Scale, and the 28-factor General Health Questionnaire.

The interviews took place in a private setting in the C23 Psychiatric Emergency Unit, with only the interviewer and the patient present. Some data was elicited from a parent or other guardian after the interview.

Sample This study focused on subjects between the ages of 13 and 25 who had made a suicide attempt serious enough to bring them into contact with a formal health care centre. Due to time constraints it was not possible for the researcher to see all parasuicide patients that passed through the ward (the psychiatric emergency ward C23 operates on a 24 hour

basis); patients were therefore selected for interview on the basis of their availability during the time the researcher was present. This ensured that the selection of patients was on a random basis and there was no selection bias. There was no pre-determined bias for sex or racial classification. The anticipated sample size was 100 patients, and the researcher continued to interview patients until this figure had been reached, spanning a period of three months. During this time approximately 280 patients who suited the parametres of this study passed through the unit. Some did not give consent, others were uncontactable and did not return for pre-arranged follow-up appointments.

Setting The study was based at Groote Schuur Hospital Ward C23 Psychiatric Emergencies and was conducted over a period of three months. This hospital is a tertiary level institution which has a wide catchment area covering the entire Cape peninsula. Subjects comprised those individuals who were referred to the unit from various sources within and without the hospital. All patients passing through the unit are entered into a register. Those who suited the required parameters were approached after they had been through the standard procedure of being clinically assessed by a psychiatric registrar or clinical social worker. The researcher outlined the nature of the study to the subjects and secured their consent before proceeding with the interview.

Implementation of the Research A pilot study conducted in C23 (psychiatric emergencies) during the period June 1994 to August 1994 showed that 187 patients (142 females and 45 males) between the ages of 13 and 24 were admitted to psychiatric casualty with failed suicide attempts. It was on the basis of these figures that a more formalised study was proposed. A proposal was submitted to the consultant-in-charge of C23, for discussion. On the basis of this discussion elements of the research design were modified to fit in with the day-to-day functioning of the unit. This proposal was then presented to the nursing staff and registrars during a ward round. It was agreed that a trial period was required to determine whether certain aspects of the procedure could be practically integrated into the day-to-day functioning of the unit without interfering with established clinical procedures, and to attend to unforeseen issues that might arise. After a trial period of one week it was decided that the proposed procedure would be effective with some minor adjustments.

Patients seen at Groote Schuur Hospital are transferred from General Hospitals and Day Hospitals. A portion are referred by general practitioners, clinical psychologists, schools and other agencies, depending on the perceived seriousness of the attempt. The majority of suicide attempters seen at C23 are referred via Casualty, the Emergency and Trauma Units, or the hospital medical wards. All individuals admitted to Groote Schuur Hospital who have medical complications relating to suicidal behaviour are stabilised medically in the casualty ward overnight and subsequently transferred to C23 the following day, where they are seen by a registrar or social worker. Those patients who are in a serious condition are referred to

the medical wards for treatment and subsequently referred to C23 for psychiatric evaluation prior to discharge.

One adjustment to the research design that was required related to the fact that it was not always possible to interview patients on the same day that they were seen in C23. This was because patients on arriving in the ward were often still suffering the effects of their suicide attempt and were feeling tired or nauseous. In such cases it was not appropriate to conduct an interview. Other patients had to be returned to the medical wards for ongoing treatment. In some cases patients were still suicidal and needed to be admitted to ward C23 for containment. Others were immediately referred to Valkenberg Hospital or other units. All subjects were seen as soon after the event as possible. At times this required following patients up at other units. In most cases an appointment was made with the patient to return for an interview the following day. This was because some patients did not want to wait for the interview. If their transport had arrived and they were being discharged they preferred to make an appointment for the following day. In many cases these patients did not return and had to be contacted if they had a telephone. Those who had no telephone were not contacted and therefore excluded from this study.

Consent Most patients consented to participate in the research³. Depending on the age of the patient consent was also required from a parent or legal guardian. In some cases the parents would not give consent.

4.1.2. DATA COLLECTION METHODS

The data collection methods in this study involved administering a comprehensive assessment form⁴ (developed at the William Slater Centre), the Beck Depression Inventory (BDI), the Hamilton Rating Scale for Depression (HDRS), The Montgomery-Asberg Depression Scale (MADS), Goldberg's 28 factor General Health Questionnaire (GHQ) and the Beck Suicide Intent Scale. The William Slater assessment form is in part structured to assist in determining a clinical diagnosis for depression in adolescents and is based on DSM 1V criteria for depressive illness. It is also designed to elicit demographic information and other details relating to potential risk factors for attempted suicide. The rating scales for depression were used to inform the clinical diagnosis. These depressive and health rating scales are now widely used to substantiate and inform a clinical diagnosis of depression in adolescents.

Research methods

Hamilton Depression Rating Scale (HDRS)

This objective rating scale for depressive symptoms is documented as "the most widely used observer rating scale in psychiatry" (Beaumont, 1994). It has been proved to be a reliable and valid instrument in adolescent populations (Robbins *et al*, 1985), although no standardised

³ Please see Appendix I for a copy of the consent form

⁴ Please see Appendix 2 for copies of the instruments used in this study

interview questions or age related norms exist for this instrument. The HDRS was designed to assess the severity of depression. The original inventory comprises 23 items; however, the 17 item version is now the most widely used. Each item on this scale is scored from 0-4 or from 0-2. The total score - the sum of the individual items - can range from 0-64. Cut-off scores used in clinical trials for major depression range from 15 - 18 or greater. In this study the scores used to determine depression were based on the HDRS 21 item score inventory devised by DONMED pharmaceuticals⁵:

No depression	0 - 7
Minor depression	8 - 15
Major depression	16 - 22
Severe	23+

Montgomery-Asberg Depression Scale (MADS)

This instrument has been validated for use in an adolescent population. Like the Hamilton Depression Rating Scale (HDRS) it focuses on the core vegetative symptoms of depression such as mood, anxiety, sleeping difficulties, eating difficulties, diurnal mood variation and loss of energy. However, it is more comprehensive than the HDRS in that it contains additional items such as questions relating to concentration difficulties and loss of pleasure.

Scoring:

No depression	0 - 10
Mild depression	11 - 16
Moderate depression	17 - 25
Severe depression	26+

The benefits of incorporating both the HDRS and MADS into the assessment of depressive symptoms are twofold. Firstly, as these instruments contain different items, the range of constructs that are measured by using them together is broadened: this serves to strengthen the assessment. Secondly, the concurrent use of these two measures provides a more enriched perspective on the same phenomenon. This is because the HDRS relies on objective reporting, whereas the MADS relies more on the tester's clinical experience.

Neither of these scales is without shortcomings. Certain features of adolescent depression, such as hyperphagia and hypersomnia, are not adequately incorporated into either of these scales (as they were initially developed using adult depressive criteria). This is one of the reasons why the William Slater depressive symptom checklist is also incorporated into the assessment, as it contains elements specific to adolescent depression, including hypersomnia and hyperphagia, and other elements such as acting out behaviour, that are not met in either of the other scales. This checklist goes further than the above scales in its extensive focus on

⁵DONMED pharmaceuticals 133 10th street, Parkmore, 2196. USA.

the individual's depressive symptoms in a social context as they manifest in peer relations and behaviour at school and home.

Beck Depression Inventory (BDI)

The Beck Depression Inventory was originally developed by Beck, Ward, Mendelson, Mock and Erbaugh (1961) to assess the severity or intensity of depressive symptoms. The scale was subsequently revised by Beck (1978). This scale possesses high internal consistency and its validity has been demonstrated in a number of studies (Beck, Steer & Garbin, 1988). Although the use of self report depression inventories has been criticised with regard to time constraints and classification of subjects (Boyle, 1985), the BDI is still a popular screening device.

The Beck depression Inventory has been documented as valid instrument for determining depressive symptoms in adolescence and is used extensively in both research and clinical settings (Robbins *et al*, 1985; Strober *et al*, 1981; Ambrosini *et al*, 1991; Barrera *et al*, 1988 & Teri, 1982). This self report measure of depressive symptoms comprises 21 items. Each item consists of four alternative statements graded in intensity from 1 to 4 (mild to severe symptomatology). The total BDI score of sub items can range from 0 - 63. Norms standardised in previous studies for adolescent populations include:

Non-depressed	0 - 9
Mild Depression	10 - 15
Moderate depression	16 - 23
Severe depression	24 or more

A total of 16+ has been standardised in this population as an indicator of Major Depression (Strober *et al*, 1981).

Goldberg's 28 Factor General Health Questionnaire (GHQ)

The General Health Questionnaire was devised by D. Goldberg in the 1970s as a screening mechanism for use in community surveys, as a means of identifying potential psychiatric disorders. The full questionnaire has 140 items, covering the subject's subjective sense of his/her well-being in various physical health matters as well as eliciting information on his/her psychological state: much of the former was included in the form on the assumption that respondents "might be so upset by questions of [a psychiatric] sort that they might abandon the questionnaire" (Goldberg, 1972, p.41). In fact pilot studies established that this was not the case: it was possible, therefore, to devise much shorter versions of the GHQ with less emphasis on specific health issues. Different versions of the questionnaire have since been extrapolated: the 60-factor, the 30-factor, the 20-factor and more recently the 28-factor GHQ.

The GHQ is used specifically to establish psychiatric illnesses as opposed to personality traits: it therefore requires the respondent to focus on his or her feelings and symptoms over

the last two weeks. As it is very much a subjective assessment on the part of the respondent, and asks a non-specific range of questions, it is not a diagnostic instrument in its own right. A high score on the GHQ suggests a probability of something wrong with the patient, but does not provide a diagnosis. The instrument is therefore used to assist a clinical diagnosis. The questionnaire is able to correlate the presentation of somatic symptoms with an underlying affective disturbance that the patient may not have presented to the clinician.

The questionnaire sets out 28 questions with the option of four responses to each, ranging from A: a sense of complete health through B, C, to D: a sense of profound ill health. The test is scored out of 28, 1 point being assigned to every C and D answer, 0 points assigned to every A or B. Goldberg devised this scoring system as a means of excluding end-answer or middle-answer tendencies: the system is based on the underlying principle of the GHQ, that is, to establish differences from the individual's normal state of health. A and B answers suggest a normal state of health, C and D answers indicate a sense of ill health (Goldberg, 1972, p.37).

For the purposes of this study the scoring will be as follows:

Norm:	5: healthy range: 0-9
Ill:	10+

Beck Suicidal Intent Scale

The suicidal intent scale is designed to record data regarding the intensity of the suicide attempters wish to die at the time of the attempt. The scale is divided into three sections and contains twenty items. Each item consists of three alternative statements graded in intensity from 0 - 2. The scale is completed on the basis of retrospective data obtained from the patient and relevant observers. It is the task of the interviewer to gather adequate information pertaining to each item. The interviewer then selects the alternative that applies best. The total score consists of the summed scores for each item. The three sections of the scale are described as follows:

- 1) Circumstantial data i.e.. Circumstances related to suicidal attempt (items 1-9). This section focuses on the factual aspects of the attempt and the events surrounding it. The informant may be the patient and/or a relevant observer. Corroboration from other sources if possible is desirable.
- 2) Introspective data - the self report (items 10-15) component - is used to record retrospectively the patient's thoughts and feelings at the time of the attempt.
- 3) The last section (items 16-20) is unscored. These items yield information on other aspects of suicide such as risk factors, the patient's current feelings about the attempt, conceptions of death, and the relation of alcohol to the attempt (Beck *et al*, 1974).

The rating of intent ranges from zero (for example a faked suicide attempt in order to frighten somebody else) to low, medium and high. The scale is scored out of a maximum of 30.

No intent: 0-4

Low intent: 5-8

Moderate Intent: 9-12

High intent: 13-30.

William Slater Assessment Form

The demographic characteristics of the bulk of suicides are now fairly well identified (Beck *et al*, 1974). these include six demographic factors (risk in terms of a specific age, sex, race, marital status, living arrangement, employment status) and four personal historical factors (poor physical health, poor mental condition, medical care within six months, previous attempt or threat). Each of these factors have been found to be more strongly consistent in completed suicides than in the general population. The William Slater assessment form is designed to elicit these risk factors amongst others. The form is administered as part of an interview and has as its aim the collection of a clinical history and demographic information.

The form includes the following sections: Demographic information (Age, Gender, Race, Employment & Education); Information on clinical disorders and personality disorders (Affective disorders, eating and substance use disorders - based on DSM IV criteria); psychosocial information (sexual abuse, physical abuse, academic, familial and relationship dynamics and difficulties); Previous psychiatric contact, previous psychiatric medication and family history of psychiatric illness. The list of depressive symptoms included in this form have been selected and revised in accordance with trends in depressive symptomatology identified in adolescents seen at William Slater. This depressive symptom checklist assists the interviewer towards elucidating the symptoms of depression in the subject that are often difficult to access due to the strong element of masking of symptoms in this age group.

4.1.3. DATA ANALYSIS

The aims of this study are twofold. The first is to assess the correlation between depression and suicidality. The rating scales used in this study allow for a quantifiable response: the scores will be collated, allowing for a quantitative analysis of depressive symptoms, general health and suicidal behaviour and intent. The second goal involves an examination of the context in which parasuicides occur. Information relating to the second goal was also quantified and trends relating to risk factors for suicidal behaviour identified.

SECTION FIVE: RESULTS

5.1.1. ANALYSIS OF THE SUICIDAL BEHAVIOUR PATTERNS IN THE RESEARCH SAMPLE

A consistent pattern emerges out of the data on the suicide attempts of these 100 subjects. Almost without exception the event was triggered by a precipitant (97%): 71% of subjects also stated that the act was impulsive. The great majority - 64% - of these subjects had no predetermined plan of action for their suicide. Despite the reported impulsivity of the act, 68% of them declared that they had full intention of dying. A further 15% were unsure, while only 17% reported that they did not wish to die. This high declaration of intent for Attempt 3 must be seen in the context of the Beck Suicidal Intent Scale, which recorded as many as 42% of the entire sample with very low or no intent.

Table 3: Profile of Parasuicide Event: Attempts One, Two & Three

	Attempt Three % (n = 100)	Attempt Two % (n = 42)	Attempt One % (n = 18)
Disclosure	22	14	11
Precipitant	97	83	65
Impulsivity	71	88	70
Intoxicated	8	14	12
Plan	36	26	47
Intent	68 (15 unsure)	62 (9 unsure)	70 (6 unsure)
Discovery	99	71	67
Physical Interv	99	45	50
Med Interv	99	48	33
Psych Interv	100	5	6

An exceptionally high proportion - 42% - of subjects reported a parasuicide (Attempt 2) prior to the attempt under study (Attempt 3) and 18 had had yet another attempt (Attempt 1). for Attempt 1. The level of intent for attempt 2 and 3 was equally as high: 62% and 70%.

In keeping with other studies examining trends over a series of suicide attempts, it was found that the potential lethality of the method used increased with each attempt, as can be seen from the percentage of subjects requiring medical intervention. In the original attempt, 67% of the subjects (12 out of 18) were discovered; only six of these required serious medical attention. There was no psychological intervention for this group: only one of the 18 saw a social worker. In the second attempt, only seven of the subjects had any psychiatric or psychological intervention. 30 of the 42 second attempters were discovered and 20 of these

required medical intervention. In the third attempt, only one of the subjects had not required any medical intervention.

Method: The proportion of highly dangerous methods rises in these subjects' second attempt, with two out of 42 subjects jumping from high places, three attempting to hang themselves, and three of them attempting to die through reckless driving and throwing themselves in front of a car. It was interesting to note that the more violent methods were generally enacted by the male subjects.

Method	Attempt Three	Attempt Two	Attempt One
O/D	90	55	69
Slit wrists	3	17	24
Jumping	0	5	0
Hanging	3	7	0
Shooting	1	0	0
Other	3	16	5

Overdosing was the preferred method for all three attempts. In Attempt 3 the rate of overdose was 90%. In attempt 2, 55%, and in attempt 1, 69% of the subjects overdosed. In all cases the preferred overdose type included analgesics (particularly paracetamol), hypnotics, antidepressants and benzodiazepines. An important observation with regard to parasuicide methods in this sample was the frequency with which subjects used a family member's medication when making a suicide attempt. In such cases subjects reported taking asthma, epilepsy, diabetic and high blood pressure medication as well as medication prescribed to family members suffering from depressive anxiety and psychotic conditions. Research undertaken by Schlebusch (1985) has the same finding.

The range of parasuicide methods was broad. Apart from those methods discussed in the preceding two paragraphs subjects also used Jik, sunstroke pills, window cleaner, paraffin snailbait and vitamin and iron tablets. One patient swallowed one needle two pins and a nail over a three day period and another injected air into his veins. Another patient attempted drowning by swimming out to sea.

Disclosure: Most studies focusing on completed suicide in adolescents indicate that there is usually a high level of disclosure before the event. Shaffer in Sudak p236 found that 46% of his sample of suicide completers clearly indicated their intent before completing the act. In the present study it was found that the level of disclosure for Attempt 3 was 22%. Disclosure was even lower for the two previous attempts. Attempt 1 was 11%, and attempt 2 was 14%. These findings are significantly lower than those suggested by previous studies, however the

level of impulsivity in this study was very high - 71%, 70% and 88% respectively - which may account for the lack of disclosure.

Precipitating circumstances: 97% of the sample (Attempt 1) had had an upsetting experience which precipitated their suicide attempt. The percentages for attempt 2 and 3 were also high, 83% and 65% respectively. These included relationship difficulties with boyfriends or girlfriends, conflicts with parents (particularly between mother and daughter), unwanted pregnancies, parental restriction, family crisis, sudden removal of containment, and disciplinary crises in the school and work and home context. The breakup of a relationship, and arguments with a mother were the most common precipitating events. The nature of these precipitators is supported by other adolescent studies such as Neiger & Hopkins (1988). These findings were remarkably similar to those of other studies.

Plan: Most subjects across all three suicide attempts indicated that the sequence of their suicidal behaviour was impulsive and did not involve detailed pre-planned strategies. The percentages were; Attempt 1, 36%, Attempt 2, 26% and Attempt 3, 47%. A small group of subjects indicated that they had made plans within the three hours prior to the event. Others had made vague plans as to the general nature of their attempt which they reverted to when in crises.

Intent: Apart from a general question in the William Slater Assessment form, the level of intent of the subjects' suicide attempts was also examined through the administration of the Beck Suicide Intent Scale (SIS). While 68% of the subjects said that at the time of the event they had a strong intent to die, when intent was formally assessed on the SIS, a much lower percentage (41%) showed serious intent.

Level of Intent (SIS)	%
No Intent	26
Low Intent	16
Moderate Intent	17
Strong Intent	41

In response to the Suicide Intent question on the William Slater Assessment form 17% stated that at the time of their suicide event they had not wished to die: the SIS indicates that 26% or more undertook the attempt in such a manner as to restrict very clearly the chances of their dying from their actions.

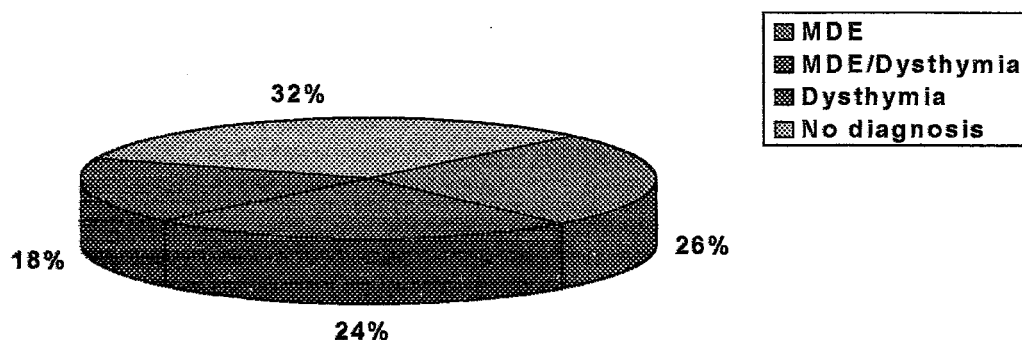
There are a number of reasons for this lower rate of intent registered by the SIS. This scale gives a score of high intent to long-term plans, disclosure, the presence of a suicide note, and other features not usually associated with an impulsive act. It also supposes a degree of insight which many of the younger subjects might be lacking. What emerges, however, is that at least 58% of the subjects had a high or moderate wish to die from their suicidal actions:

this is a high proportion and negates the often-held assumption that suicidal behaviour is more of a "gesture" than a serious event.

5.1.2. THE INCIDENCE OF DEPRESSIVE ILLNESS IDENTIFIED IN THE SAMPLE

89% of the subjects in this study showed depressive symptoms concurrent with other diagnoses. Of these, 68% had an Affective illness. 26% had a Major Depressive Episode (MDE); 24% had an MDE with dysthymia; and 18% had dysthymia.

AFFECTIVE DISORDERS (n=100)



The main aim of this study was to investigate the relationship between suicidal behaviour and depressive illness in adolescents. The hypothesis that the role of depressive illness in adolescent suicidal behaviour is more pervasive than is generally accepted, is confirmed by the above results. These results are in fact much higher than is generally found. Most research on suicidal behaviour in adolescents suggests that affective disorder is more highly correlated with completed suicides than with parasuicides. As discussed in the Aims of the Research, parasuicide is often misinterpreted as being associated to rebellious and oppositional behaviour, rather than an underlying depressive illness.

The reported rate of affective illness in any given parasuicide population varies greatly: for epidemiological studies the variation is between 19% to 42%; in inpatient studies the reported rate is 25% to 65%. Schlebusch, for instance, found specific affective disorders in 21.8% of his sample, most of which were dysthymic disorders. None of the subjects in the study by Schlebusch met the criteria for a major depressive episode (1985). The results of this present research, however, are supported by Goldney and Pilowsky (In Sudak *et al*,

1984, p.334) who reported that 50% to 75% of youngsters who make suicide attempts are depressed.

The procedures used to assess the prevalence of depressive symptoms involved a comprehensive psychological interview and diagnosis for each subject, focusing on both depressive and non-depressive symptomatology. The research design incorporated the use of specific instruments for the purpose of assessing depression and general health. The William Slater assessment form was designed to provide a broad psychological profile of each subject. This assessment form also contained a depressive symptom checklist, incorporating adolescent depressive features. The Hamilton and the Montgomery-Asberg depression inventories were used to assist in elucidating the presence of "masked" depressive symptomatology. The subjects were also asked to complete the Beck Depression Inventory - a self-appraisal of their own depressive status. The use of such instruments has become increasingly accepted as a method for verifying a diagnosis of clinical depression in an adolescent population. The General Health Questionnaire was also administered as an informing tool to substantiate the findings of the other instruments. A clinical diagnosis was given using the established DSM IV criteria and the above instruments were used to inform the clinical diagnosis of affective illness, if such a diagnosis was warranted.

Table 4: Results of the Depressive inventories and the General Health Questionnaire

Severity of depression	HDRS	MADS	BDI	GHQ
No	2	3	6	25
Mild	10	6	4	-
Moderate	34	21	16	75
Severe	54	70	74	-

These results of the depressive inventories and the GHQ bear out the high rate of affective illness clinically diagnosed according to DSM IV criteria in this sample. The self-report GHQ scores show that 75% of the sample indicated that they had an underlying psychiatric condition. Further corroboration was given by the subjects' self-report results on the BDI, which also suggested a high incidence of affective disorder. The objective measures of depression - the HDRS and MADS - correlated well with the self-report measures.

The depressive symptom checklist which forms part of the William Slater Assessment Form was analysed and the subject responses were tabulated as follows.

Table 5a

Neurovegetative features of depression	% "Yes"
Decreased appetite	66
Increased appetite	16
Decreased weight	62
Increased weight	13
Decreased energy levels	87
Decreased concentration	80
Sleep disturbance	86
Hypersomnia	39
Insomnia	83
Worries during insomnia	82
Ruminations during insomnia	76

The neurovegetative symptoms of depression form part of the standard criteria for a diagnosis of clinical depression in both adults and adolescents (DSM-IV). It can be seen from table 5a that most of the subjects in this sample reported a high degree of neurovegetative symptoms. These high scores were corroborated by the Depressive Inventories (HDRS, MADS and BDI).

Hypersomnia (excessive sleeping) and hyperphagia (excessive eating) are very seldom features of adult depression. In an adolescent population these features are more common. In this study hypersomnia was experienced by 39% of the sample and hyperphagia by 16%. Many of the parents of this sample group indicated at assessment that their children were eating and sleeping well without realising that this behaviour was in fact a part of an adolescent depression profile. The more typical profile of insomnia which is most commonly found in adult depression was also strongly evident in this age group.

The neurovegetative features of depression listed above are found in both adults and adolescents. The associated features of adolescent depression in particular as outlined by DSM-IV are tabulated below.

Table 5b

Associated features of depressed mood	% "Yes"
Decreased motivation	83
Anhedonia: No enjoyment/Less than before	29/55
Social withdrawal	78
Loneliness	81
Diurnal mood variation	85
Fall-off in academic performance	76 ⁶
Multiple Somatic symptoms	58
Irritability	88
Decreased self-image	76
Decreased self-esteem	81
Associated anxiety	89

Neiger *et al* (1988, p.474) described the suicidal adolescent as being usually dependent, accident prone, restless or bored, obnoxious (to receive attention), easily fatigued, having a disturbed sleeping pattern, pessimistic, angry, guilty, having difficulty concentrating, experiencing poor relationships and frequent mood swings, and feeling rejected, lonely, isolated, or restricted. This description is in fact an adequate description of a depressed adolescent. Most of the constructs outlined by Neiger were experienced by the large majority of the subjects in this study, as is shown by the above Table 4b. This table illustrates that a large proportion of the sample reported depressive symptoms which according to Neiger's description places them at high risk for suicide.

The DSM 1V criteria for associated features of depression includes irritability and social withdrawal as good indicators of adolescent depression. The percentages in this sample (88% and 78% respectively) were very high. In this study concerns relating to low self-esteem and poor self-image were experienced by a large number of the subjects. 76% subjects reported a decrease in self-image and 81% had a lowered self-esteem. This finding suggests that self esteem is also a good indicator of depressive illness in this age group. In this study low self-esteem emerged as a constant source of concern for the subjects. Many of them stated that they were unhappy about the the way they felt about themselves and the way they looked. While such feelings are a common feature of adolescent development, when seen in the context of suicidal behaviour these feelings become more significant.

⁶ Only 50 of the subjects in the sample were still at school: the percentage of 76% represents 38 subjects out of the 50.

Table 5c

Features of Acting Out Behaviour	% "Yes"
Acting out	37
Promiscuity	9
Disruptive at school	24
Oppositional behaviour	27
Dangerous/Risky behaviour	15
Absenteeism	50

37% of the subjects engaged in behaviour disruptive enough to be classified as "Acting Out". The onset of most acting out behaviour occurred during adolescence, rather than childhood. In this study it was found that onset in childhood correlated highly with Conduct Disorder traits. In most cases the acting out behaviour seen in this sample occurred simultaneously with the onset or exacerbation of depressive symptoms.

Much of the acting out behaviour can also be defined as self-destructive: in fact in many analyses suicidal behaviour itself has been documented as a form of acting out. The most prevalent form of acting out was absenteeism: this included instances of truancy from school or absenting from required attendance at work. A number of the subjects indicated that the absenteeism was a form of withdrawal, and normally occurred as a result of feeling unwell. Given that 58% of the subjects suffered from somatic complaints, these reported feelings of ill health are likely to be the result of somatising internal conflicts and emotions, which is a strong feature of adolescent depression.

Oppositional and Disruptive behaviour in the school or home environment frequently indicates an underlying depressive illness, suggesting again the externalisation of internal conflict. However, it should be noted that in many of the patients seen who were given a clinical diagnosis of depression, although absenteeism was high, other forms of acting out were low. This was particularly noticeable in young females who came from a highly restrictive Muslim or Roman Catholic family environment. In such cases, many of the options for acting out such as drinking and smoking and sexual acting out were less available to them, with the only readily available form of acting out being parasuicide itself. Dangerous or risky behaviour was a more typical acting out pattern of the males in the sample.

5.1.3. RISK FACTORS FOR PARASUICIDE IDENTIFIED IN THE SAMPLE

DEMOGRAPHIC FACTORS

The average age of the sample was 18 years 6 months (ranging from 13 to 25). A large proportion of the subjects had therefore recently completed or were still at school. Very

nearly all (95%) of the subjects were single. One of them was engaged, 3% were married and 1% were previously married, now divorced.

The ratio of males to females was 1:3 (25 males, 75 females). This accords exactly with previous studies which indicate that in an adolescent population three times as many females as males attempt suicide.

The study assigned three categories of racial classification: Black; Coloured and White. There were 12 Black, 78 Coloured, and 10 White subjects interviewed (giving a ratio of one white or black to eight coloureds). While the Coloured percentage might seem significantly high, it must be considered in the light of the fact that the coloured community forms the largest racial group in the Cape peninsula. (The ratio is 60 Coloureds to 20 Blacks and 20 Whites (i.e. a ratio of one white or black to three coloureds)). It can be seen however, that the coloured ratio in the sample is more than twice that of the general population. This is particularly unexpected as Groote Schuur Hospital is a tertiary care centre and therefore has a broad catchment area. One explanation for this imbalance with regard to white suicide attempters is that this group is more likely to see a private practitioner. In conclusion the variables influencing the range of racial groups attending Groote Schuur Ward C23 are multi-fold and it is not possible in this study to draw any definitive conclusion about the relative incidence of parasuicides in each of the racial groups.

SEXUAL ABUSE/PHYSICAL ABUSE

28% of the subjects had been sexually abused, with eight of these subjects suffering a second episode of abuse.

Of the 28% cases of sexual abuse, 6% had been abused by a family member, and 20% by either unknown strangers or family acquaintances and friends. 2% would not disclose the nature of their abuse or abusers. Yama (*et al*, 1993) found in their study on sexually abused depressed persons that the identity of the abuser - familial or non-familial - did not have a significant impact on the degree of depressive behaviour manifested by the subject (p.138). Similarly in this study the intensity of depressive symptoms and the degree of intent of the suicide attempt did not vary significantly according to type and perpetrator of the sexual abuse. Almost without exception these subjects scored high on the Depressive inventories.

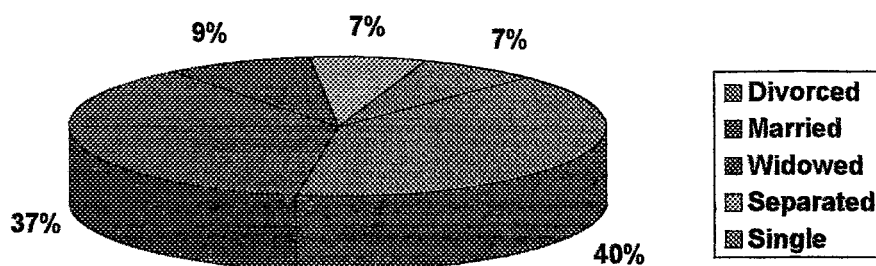
37% had been physically abused. These subjects showed on average a less extreme depressive reaction their situation than did those who had been sexually abused. Although previous studies have noted a correlation between the persistence and degree of the abuse and the intensity of the depressive symptoms, this did not appear to hold true of this study, except in cases where the physical abuse occurred together with sexual abuse.

The proportion of sexually and physically abused persons in this sample is significantly high, which confirms the findings of other studies that these are high risk factors for suicidal behaviour.

PSYCHOSOCIAL FACTORS

Parental status: 37% of the subjects' biological parents were still married; of the remainder 9% were widowed, 7% were single, 7% were separated, and 40% were divorced. The average age of the subjects at the time of their parent's divorce was 8 years and 3 months. Most recent studies on parental status as a risk factor for depression and/or suicidal behaviour are agreed that divorce *per se* is not a major influence on the child's or adolescent's psychological well-being: ongoing parental conflict is (Sudak *et al*, 1984). However, the earlier a divorce occurs - the earlier one of the parental figures is removed from the immediate environment of the child - the more serious the effect is (Fergusson *et al*, 1994). The fact that the average age at which this sample experienced parental divorce is 8 years is significant, therefore, in that they were young enough to suffer negative consequences. The likelihood of children between 5 and 10 developing a conduct or oppositional disorder, or a depressive disorder, is very nearly doubled if the parents are divorced in this time: the rate is three-fold if the child is under five (*ibid.*, p.1126). The likelihood of substance abuse is also greatly increased in both these age groups.

PARENTAL STATUS (n=100)



Living status: Approximately one quarter (28%) of the subjects still lived in their nuclear family. 22% lived in a reconstituted family and 16% lived in an extended family. 9% were independent, and a further 4% lived in boarding houses, University residences, places of safety and reformatories. These findings are consistent with those of Sudak (*et al*, 1984) who indicate that a nuclear family context is not necessarily a guarantee of stability. However, the majority of subjects in this study have come from broken or very disrupted homes and have frequently experienced the loss of one or both parents, or a significant other. This loss was the result of death of a parent, sibling, girlfriend or boyfriend in 10% of the sample. The high proportion of disrupted home environments is in accord with the findings of Deykin *et al* (1985) and Neiger *et al* (1988). However, this study shows that reconstituted and extended family conditions also have a significant effect - 38% of subjects lived in such circumstances. Frequently there was conflict with an extended family member or step-parent; overcrowded living conditions was also a prominent feature. Absent parents, conflictual relationships between family members and general insecurity in the home emerged consistently as enduring stressors.

LIVING STATUS (n=100)

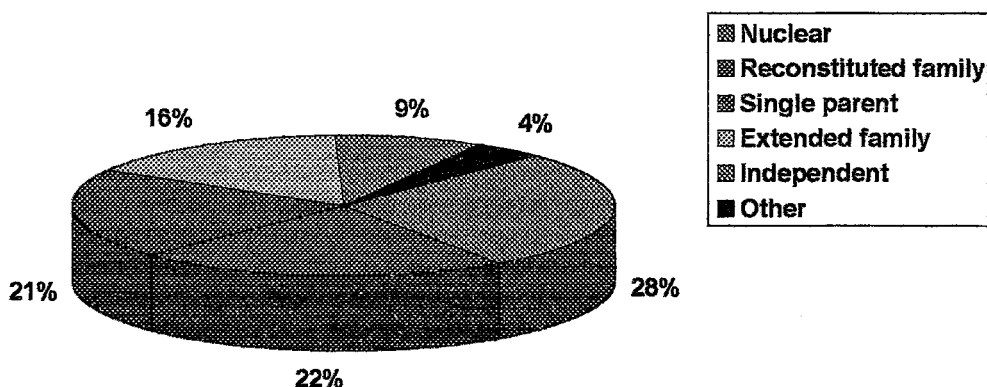
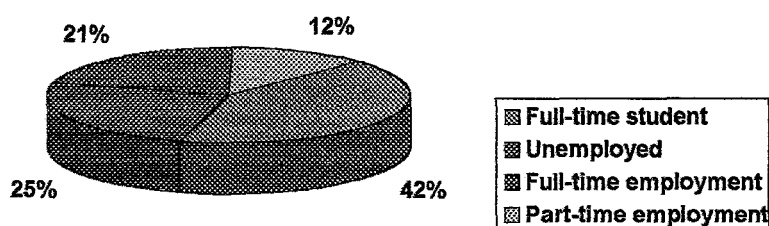


Table 6: Psychosocial Stressors

Family stressors	%
Parental divorce	40
Marital conflict	12
Conflict with family members	44
Disrupted home life	22
Absent family member	22
Death of close relative or friend	10
Sexual abuse	27
Physical abuse	36

Educational and Employment status: Most of the subjects (76%) had a secondary school education, however, only 42% were still attending school. Many subjects had left school before matriculating: in fact only 21% had matriculated, 2% of these having gone on to a tertiary education and 1% had a diploma. 3% were educated at primary school only.

EMPLOYMENT STATUS (n=100)



21% of the subjects had full-time employment, including one subject who was self-employed. 12% of subjects were employed part-time, and the remaining quarter had no employment. This high proportion of unemployed subjects becomes even more significant when considered in the context of school-leavers: of the 58% who had left school and might expect to have a job, 43% had no employment. Financial difficulties were cited by 29% of the subjects as being a matter of concern.

Other stressors	%
Financial difficulties/Unemployment	29
Academic problems	19
High parental expectations	4
Restrictive home environment	14
Dependent parent	3
Serious parental illness	2
Recent moves	6

Religious status. Only 3% of the subjects claimed to have no religion. The remainder, were brought up in a wide range of religious affiliations although many of them (40%) were non-practicing. A fifth of the subjects were Muslim. There was also a high proportion of Roman Catholics and Anglicans. Restriction in the home environment was often associated with strong religious practices.

Peer relationship difficulties. Many of the subjects experienced difficulties in their relations with their peer group, and marked social isolation as a consequence. Given that the values of the peer group, rather than those of the family, become important during adolescence, it follows that any disruption in peer interactions during this stage of development has a significant emotional effect on the adolescent. Many subjects were experiencing difficulties in their family environment as well as with their peers and therefore had no support (24%). In this study it was found that individuals who felt different on the level of their sexual orientation (6%) or physical appearance, disfigurement or health condition (23%) felt unaccepted by their peers. Pregnancy or having a child (13%), previous parasuicides (42%) and illegitimacy (8%) were perceived by these individuals as stigmatizing.

Peer group stressors	%
Problems with peers	11
Social Isolation, no support	24
Pregnancy, stress of motherhood	13
Miscarriage	3
Physical disfigurement	6
Sexual orientation problems	6
Illegitimate	8
Difficulties in romantic relationship	36

One aspect of peer relations difficulties that occurred frequently as a psychosocial stressor was romantic relationships. 36% of the subjects reported conflict or a breakup with their boyfriend or girlfriend as an acute stressor.

A number of the subjects were having coping difficulties at school (19%). This was often linked to high personal and parental expectations with regard to academic performance. Given that only 50% of the sample were still at school, this figure represents nearly a half of these subjects. This stressor, which is frequently the consequence of depressive illness, emerges as a strong risk factor for suicidal behaviour.

PHYSICAL ILLNESS

23% of the sample suffered from a physical illness serious enough to affect the over-all functioning of the individual concerned. Previous studies have been ambivalent on the effect

that poor health has on suicidal behaviour in adolescents. The findings of this study suggest very strongly that ill health is a risk factor for such behaviour. This is in accordance with the research results of both Garfinkel *et al* and Hawton, O'Grady and Osborne which demonstrated that adolescent suicide attempters had higher rates of current medical illness (30 to 50%) than age-matched peers (In Sudak *et al*, 1984).

9% of the sample suffered from a disfiguring (although physically non-serious) condition: these included burn scars, giantism, blindness in one eye, hearing problems and physical crippledness. When interviewed, these subjects all stated that their condition had a large negative impact on their interpersonal relationships. Other subjects suffered from chronic respiratory disorders and cardiac problems. There was one case of epilepsy. Although varying in intensity, in all the cases subjects indicated that their physical illness impacted on their social and emotional well-being.

PSYCHIATRIC DISORDER (AXIS 1) & PERSONALITY FACTORS (AXIS 2)

In this study a total of 86 of the subjects were diagnosed with a psychiatric illness on Axis 1 and/or Axis 2.. 72 had an Axis 1 diagnosis. Of the 28 subjects who did not qualify for an Axis 1 diagnosis, 21 did have depressive symptoms. Five subjects had a personality disorder and 49 had personality disorder traits. Most of the subjects who had an Axis 1 diagnosis also had a diagnosis on Axis 2. The high percentage of Axis 1 diagnoses accords with the results of the General Health Questionnaire, which is specifically designed to identify non personality-related psychiatric disorders. 75% of the subjects had a self-reported score of higher than 10 on the GHQ, which puts them in the "Ill" category.

30% of the subjects had previously consulted a psychiatric resource on both an outpatient and inpatient basis and 26% had received some form of psychotropic medication in the past. Medication was usually prescribed for antidepressant or anxiolytic purposes. Previous psychiatric contact has been shown to be a risk factor for suicidal behaviour: this is not unexpected in the light of previous studies diagnosing as many as 90% of suicide attempters with some psychiatric illness (Fergusson & Lynskey, 1995). The similar figure found in this study of 86% becomes particularly meaningful when seen in the context of the average level of psychiatric disorder in a non-suicidal adolescent population: Fergusson and Lynskey assess this level to be approximately 35% (p.616).

The most common psychiatric illness was Affective Disorder (68%), with 26 subjects having a Major Depressive Episode; 24 subjects having a Major Depressive Episode with Dysthymia, and 18 subjects having Dysthymia alone. Despite the fact that only 68% of the sample were given a formal diagnosis of Affective illness, the Hamilton, the Montgomery-Asberg and Beck depression inventories respectively showed moderate depressive symptoms in approximately 89% of the subjects. These tests showed a very strong correlation with each other.

Table 7: Axis 1 Psychiatric disorders identified in the sample

Axis 1	Count
MDE	26
MDE & dysthymia	24
Dysthymia	18
Depressive symptoms	21
Adjustment disorder depressed mood (acute)	1
Adjustment disorder mixed anxiety & depressed mood (chronic)	1
Eating disorder	2
Bulimic symptoms	8
Substance dependence	6
Generalised anxiety disorder (with some depressive symptoms)	1
Post traumatic symptoms	2
Oppositional defiant traits	4
Schizophrenia in remission	1
No diagnosis	7

Anxiety disorders were recorded in very few of the subjects, with only one Generalised Anxiety Disorder and three with a high anxiety component to a major depressive episode. There were also two subjects suffering from Post Traumatic Stress Disorder symptoms. Despite the low number of anxiety disorders diagnosed, it should be noted that 89% of the subjects stated on the William Slater Depression checklist that they had recently been experiencing high levels of anxiety.

Adjustment Disorder has been cited in a number of studies as a risk factor for suicidal behaviour, but only two subjects were given this diagnosis. Similarly, only six subjects qualified for a diagnosis of Substance dependence, although reported behaviour gathered by the William Slater Assessment Form showed a high degree of substance use (for instance, 42% of the subjects were using alcohol).

There were ten subjects suffering from an eating disorder, eight of which had bulimic behaviour and two having anorexia. These findings are in keeping with other studies which show that these disorders are seen more frequently now than in the past. Eating disorders are often associated with co-morbid psychiatric illness. Given the high percentage of psychiatric illness in this sample, a rate of 10% of subjects with an eating disorder is not unusual. At the William Slater Centre for Adolescents it was found that out of a sample of 215 parasuicide patients 18% had an eating disorder.

The hypothesis in much of the literature that suicidal behaviour in adolescents has a high correlation with Cluster B personality disorders and traits (Brent *et al*, 1994) is supported by the findings in this research. A total of 37 out of the 54 subjects with an Axis 2 diagnosis had a Cluster B condition. The most frequent diagnosis of this Cluster was Histrionic traits (12%). 6% had Borderline Personality disorder traits and a further two subjects a Borderline Personality Disorder. One subject had mixed Borderline-Histrionic traits and a further four had mixed Borderline-Antisocial traits. Narcissistic Personality traits were present in three subjects. Contrary to the findings in other studies (for example Schlebush's research in Durban, 1985), there were very few Conduct Disorders or Conduct Disorder traits: only four subjects (two for each diagnosis) manifested these disorders. However, there were four subjects with Antisocial traits and one with an Antisocial Personality Disorder. What also emerged was a large degree of acting out behaviour concurrent with depressive symptoms. In four subjects this warranted a diagnosis of Oppositional-Defiant behaviour on Axis 1.

Table 8: Axis 2 Personality disorders identified in the sample

Axis 2	Count
Schizoid personality disorder traits	1
Schizotypal personality disorder traits	1
Antisocial personality disorder	1
Antisocial personality disorder traits	3
Borderline/antisocial personality disorder traits	4
Borderline personality disorder	2
Borderline personality disorder traits	7
Conduct Disorder	2
Conduct Disorder traits	2
Histrionic personality disorder traits	13
Narcissistic personality disorder traits	3
Avoidant personality disorder traits	6
Dependent personality disorder traits	19
Passive aggressive personality disorder traits	1
Borderline intellectual functioning	2
Deferred	46

Most of the Cluster B personality disorders were found in conjunction with an Axis 1 diagnosis, specifically an Affective disorder. This accords with Brent *et al*'s findings that comorbid Borderline traits and Affective disorder are common features of adolescent suicidality (1994, p.1081).

There was a total of 25 subjects with a Cluster C diagnosis: this included 19 subjects with Dependent personality traits and six with Avoidant traits. None of these patients qualified for

a diagnosis of a Dependent or Avoidant Disorder. However, a large proportion showed a fear of being shamed or humiliated, rejected, or criticised. They viewed themselves as socially inept, personality unappealing and inferior to others. They were reluctant to take personal risks. Many of them showed a strong need for reassurance and difficulties with decisions. They had a strong need of care and support from others and a fear of being left to take care of themselves. Such fears and concerns are best understood developmentally as part of adolescence. They are likely to be strongly related to unusually disruptive and non-supportive home environments.

Family history of psychiatric illness

The General health of the parent (or close relation) of 28 of the adolescent suicide attempters who presented at C23 in this study was assessed. This was done by asking the parent/relation who accompanied the patient to fill out Goldberg's 28 factor general health questionnaire. The results showed that 16 (57%) of these parent/close relations indicated their general health was normal and 12 (43%) indicated signs of an underlying psychiatric illness. The high percentage of underlying illness in this small sample was corroborated by reports from the subjects themselves. 67% of the subjects reported that one or more of their family members suffered from a psychiatric illness. These psychiatric illnesses were for the most part alcohol or other substance abuse related. A large proportion were also related to depression and anxiety conditions. 5% of the patient's family members suffered from epilepsy and 7% reported that a family member had attempted suicide, a further 3% reporting family members who had completed suicide. Female members of the family were usually described as suffering from a depressive illness whilst male members often had substance abuse, particularly alcohol abuse. A study by Pfeffer (In Sudak *et al*, 1984) also found a high correlation between familial psychiatric illness and youthful parasuicides. In Pfeffer's research the fathers of the parasuicides were significantly more depressed, had lower self-esteem and consumed more alcohol than did the fathers of the control non-parasuicide group. Similarly, the mothers of the attempters appeared significantly more anxious, had more suicidal ideation, and consumed more alcohol than the mothers of non-attempters (p.175).

In this study, it was found that the proportion of male family members abusing alcohol was far higher than the female rate of abuse. However, females, especially mothers, appeared to be using significant quantities of "over the counter" medicines. The high rate of alcoholism in fathers may well be an indicator of self-medication against depressive symptoms. Given such an interpretation, it appears that there was a high rate of depressive symptoms in the parents of suicide attempters. These findings are corroborated by research done by Garfinkel, Froese and Hood (1982, In Sudak *et al*, 1984) that found a rate of psychiatric disturbance, including alcoholism, of up to 50% in the parents of adolescent suicide attempters (p.310).

It was interesting to note that of the 12 parents/close relations of suicide attempters who achieved high scores on the General Health Questionnaire, 9 correlated with high scoring

adolescents. In fact the scores of these 9 adolescent attempters with ill parents were all above 20, well above the average of the majority of the sample. Of the 16 parents who were well, only 9 had ill adolescents who attempted suicide. This indicates that adolescents who come from families where at least one member shows signs of an underlying psychiatric illness are more likely to show marked signs of a psychiatric illness themselves.

Very few of the subjects cited any serious psychotic illness in the family, although a number reported "strange behaviour". Whilst the incidence of diagnosed psychiatric disorders within the family appeared low, there was a high rate of depressive and alcoholic conditions identified in these family members. This low rate of diagnosis and treatment of such conditions suggests a reluctance or inability on the part of the family to recognise depressive symptoms or substance dependence behaviour as disorders requiring professional intervention. Psychiatric symptoms in the family such as substance use or suicidal behaviour may serve not only to increase conflict and stressors, but also provide a model of coping for the adolescent, as is suggested by Hawton (In Roy, 1986).

SUBSTANCE ABUSE

Substance use in this sample was high, however, the level of substance abuse was moderate. 66% of the subjects smoked, and 42% used alcohol, this includes 12% who abused alcohol. 17% of the sample used or had experienced cannabis, 7% had used or were using mandrax, one person took cocaine, two took LSD, and one abused an unspecified psycho-active substance. One subject was dependent on painkillers such as Propain and "Grandpa's". Other studies show that the rates of alcohol and drug use in adolescent suicide attempters is high (37%): this accords with the 42% of substance users recorded here.

Only eight of the subjects were intoxicated at the time of their suicide attempt. This finding differs from many other studies, which have found a high correlation between intoxication and a suicidal event. It is, however, supported by research at the William Slater Centre for Adolescents, which also found that very few of a parasuicide sample of 215 subjects were intoxicated at the time of the parasuicide event. It was interesting to note that of these eight intoxicated subjects, six were using serious substances such as alcohol, mandrax, cocaine and LSD on a persistent basis. This suggests a correlation between the continuous abuse of such substances and intoxication at the time of the suicidal event.

SECTION SIX: DISCUSSION

6.1. DISCUSSION OF FINDINGS

The results of this study demonstrate a clear correlation - 68% - between affective illness and suicidal behaviour. This percentage of affective disorders supports the research hypothesis that the prevalence of such disorders in a population of adolescents who attempt suicide is significantly high and at the same time greater than has been reported by other studies of a similar nature in this country. Reports of the prevalence of affective disorder in an adolescent parasuicide population vary considerably: this is best explained by the difficulties of recognising depressive disorders in this age group. Shaffer (In Sudak *et al*, 1984, p.153) states that depressive features in adolescents differ from those found in adults. Antisocial behaviour and "getting into trouble" are significant features in adolescents and children which have not been reported in adults. The relatively low rate of affective disorder diagnosed in suicide attempters of this age group is likely to be due to recognition difficulties, rather than diagnostic deficiencies. As has been stated, adolescent depression not only manifests differently but is often masked.

The broader implications of these findings are that a very high percentage of suicidal behaviour in adolescents is the result of a serious underlying affective illness. All too often such behaviour is interpreted as age-appropriate, self-indulgent and attention-seeking. Educationalists and health care practitioners need to be aware that all forms of suicidal behaviour should be taken very seriously as this behaviour is often a reliable indicator of depression. Whilst it is acknowledged that acting out and oppositional behaviour can be misleading, and make depression difficult to recognise, it is also clear that educationalists and health practitioners working in this age group need more information in this area. In this sample, 42% of the subjects had had a previous parasuicide. It was noted that of these 42 subjects only seven (17%) had had any psychological or psychiatric intervention, despite the fact that nearly 50% had required medical treatment. This suggests that a high proportion of adolescents are attempting suicide but, most probably for the reason outlined above, are not being taken seriously.

While most of the individuals diagnosed with an affective illness had co-occurrent personality traits, it is believed that the depression is the primary diagnosis, and the most influential factor in determining risk of suicidal behaviour. There are several reasons for this proposition, first of which is the fact that depressive disorders form the biggest single diagnosis in the study. Furthermore, there is a high correlation between the severity of the depressive illness and the seriousness of the suicidal intent. Those with a diagnosis of dysthymia were significantly more intent on dying than those with only a personality disorder; those with a moderate or severe MDE showed their suicidal intent to be extremely high. An interesting finding in this study was the high proportion (24%) of subjects with an MDE also has a dysthymic disorder. This suggests that a common profile of affective illness in this age group is a long-standing dysthymia with an intensification of symptoms culminating in an MDE and associated suicidal behaviour. Observation of a sequential relationship between dysthymia and a major depressive disorder is supported by a study done by Freidman *et al* (In Sudak *et al*, 1984, p.215). The presence of an Affective disorder emerged as a very strong indicator for suicidal behaviour. When this affective disorder was associated co-morbidly with a Personality disorder trait it was found that the potential for



suicidal actions increased. Both Histrionic and Borderline traits were common in this sample of parasuicides: in a large percentage of cases these personality traits were co-occurent with an Affective disorder, and these subjects indicated strong intent in their suicide attempt.

An important observation that emerged in the course of the interview was that those individuals who reported a recent onset of depressive symptoms showed a simultaneous profile of acting out behaviour. This included behaviour such as having recently started drinking and smoking, sexual acting out, and difficulties of an oppositional-defiant nature in the home and school environment.

The high degree of Conduct Disorder diagnosed by some studies is likely to be based on this element of acting out which is so prominent in adolescents who also have depressive symptoms. In fact a close examination of apparent Conduct Disorder in the context of suicidal behaviour may well reveal a underlying or masked depressive symptomatology. In this study, although there were some subjects diagnosed with clear Conduct Disorder or Antisocial, a large proportion of the sample (37%) exhibited features of acting-out behaviour. However, these individuals also presented with depressive symptoms. Furthermore, it was found that acting out behaviour was more frequently a feature of an Affective disorder, rather than a Personality disorder. It was usually possible to distinguish between the two types of disorder on the basis of the age of onset. Those individuals who showed features of acting out behaviour since childhood were more likely to be diagnosed with a conduct disorder or antisocial disorder; whereas those who had exhibited such behaviour only since adolescence were more likely to be considered for a diagnosis of affective illness. The co-occurrence of depressive features and acting out behaviour is found also in a study by Shaffer: in his sample of suicidal adolescents 75% showed a simultaneous presentation of "antisocial" and/or affective symptoms (In Sudak *et al*, 1984, p.148). It has been suggested by Toolan (In Sudak *et al*, 1984) that self-destructive behaviour of all kinds - that is, acting out behaviour - is linked to suicidal behaviour. He suggests that all self-destructive behaviour is at least subconsciously suicidal.

Analysis of the data collected from this study indicates that the type of person most at risk to suicidal behaviour in the Greater Cape Town area is the 18 year old Coloured woman with a long-standing affective disorder and co-occurring personality disorder traits, living in a disruptive and unsupportive home environment with little or no income and an educational level below that of Matric. Risk for depression and suicidal behaviour further increases when sexual and/or physical abuse has been experienced, and when some form of substance use is present. There is often acting out associated with an exacerbation of depressive symptoms, typically evident in the home or the school environment: parasuicide is frequently a part of this acting out process.

The suicidal event is normally unplanned, impulsive and precipitated by situational circumstances - most commonly an argument with a family member or significant other. For this reason, it is always very difficult to predict when an adolescent who fits the profile of the above high risk group will attempt suicide. The profile which emerges is that affective illness increases the likelihood of an impulsively excessive response to precipitants which in the absence of such a disorder would have a low stress impact on the individual. A further implication of the impulsivity of the act is that very frequently no disclosure of intention

takes place prior to the event. It must be noted that standard scales of assessing suicide intent such as the SIS proved inadequate in this study as they were not able to make provision for high intent within the context of excessive impulsivity. Most individuals indicated that although the act was impulsive, their level of intent at the time of the event was high.

The most frequent method chosen by most suicide attempters was an overdose. A large proportion of these overdoses included the taking of medication belonging to family members of the patient. Given that a significant number of these family members suffered from a psychiatric or physical condition requiring prescribed medication the possible consequences of overdosing on this medication are serious.

This above profile of the adolescent most at risk for suicidal behaviour should form the basis for designing intervention and prevention strategies. There is a strong need for a Suicide Probability Questionnaire which contains the constructs discussed in this profile, and which can be easily administered by family members, primary care workers and educationalists. Adolescent depression and associated parasuicide represents a growing concern for secondary school personnel (Maag, Rutherford & Parks, 1988). It is these personnel who are in a position to play a strategic role in the early identification of depression. This is borne out by the fact that over 65% of referrals to the William Slater Centre (over a period of three years) derive from such primary level referral sources (Berard *et al* unpublished). If adequate techniques for the identification of suicide intent were available to teachers, guidance teachers, and other primary level workers, this would ensure early intervention and thus prevention of many adolescent suicides.

6.2. LIMITATIONS AND SUGGESTION FOR FURTHER RESEARCH

When considering the high percentage of psychiatric disorder that occurred in the context of this sample of suicide attempters, it is important to note that the sample comprises a group of individuals whose attempts of suicide were deemed serious enough by the referral source to warrant medical intervention at a tertiary hospital. This suggests that these individuals were likely to present with more serious psychiatric conditions. Further research should be undertaken in secondary and primary health care situations to establish the generalisability of the findings of this study.

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SECTION SEVEN**APPENDICES**

PATIENT CONSENT FORM

Information

This study does not form part of the overall management and treatment procedures of this ward (*psychiatric emergencies unit: C23*). Subjects are requested to participate in this exercise, but are not compelled to do so. Those individuals who choose to participate will be assured of confidentiality.

This study forms part of a Masters thesis in Clinical psychology.

I _____ (print name), hereby consent to participate in this study.

I confirm that I understand the purpose of this study and my involvement in this process.

PATIENTS SIGNATURE

DATE

D.O.B.

PARENT/GUARDIAN

DATE

RESEARCHER'S SIGNATURE

DATE

**Parasuicide record C23 (psychiatric emergencies) Groote Schuur
Hospital.
12 May 1995 - 22 September 1995**

No	Date	Initial	Age	M/F	N/O	Race	Refer	Management
1	12/5	TM	19	M	N	B	E/U	O/D - D/C home. TCA 1/52
2	12/5	MH	17	F	N	C	C22	O/D - D/C Home: No F/U
3	12/5	TM	16	M	N	B	C17	O/D - D/C Home: TCA 16/5/95 J2
4	15/5	LL	21	F	O	W	Self	Post O/D - VMH
5	15/5	MC	17	F	O	C	R/A	Suicide attempt - Admit C23
6	15/5	LVN	19	F	N	C	Som	O/D - D/C Home: F/U C/Group
7	20/5	SW	16	O	F	C	E/U	O/D D/C Home F/U Crisis Group
8	20/5	KC	15	F	N	C	E/U	O/D D/C Home No F/U
9	20/5	TW	13	F	N	C	E/U	O/D D/C Home: No F/U
10	22/5	LW	19	M	N	C	E/U	O/D D/C Home: F/U Crisis Group
11	23/5	RJ	20	F	N	C	E/U	O/D Admit C23
12	23/7	AJ	22	M	N	C	E/U	O/D D/C Home
13	24/5	ST	17	M	O	B	C5	Parasuicide/Ingestion - Admit C23
14	26/5	CH	17	F	N	C	E/U	O/D D/C Home F/U LGH
15	31/5	SS	19	M	N	B	Som	O/D Admit C23 Ref VMH
16	02/6	TF	16	F	N	C	E/U	O/D D/C Home FU WSH
17	02/6	TJ	19	F	N	C	C17	O/D D/C FU C23
18	03/6	RS	16	F	N	C	E/U	O/D D/C Home No F/U
19	05/6	MK	20	M	N	C	E/U	O/D D/C Home No F/U
20	05/6	LM	16	F	N	C	E/U	O/D D/C Home No F/U
21	06/6	MA	24	F	N	C	E/U	O/D Admit C23
22	7/06	EM	20	F	O	C	E/U	O/D D/C Home F/U J2
23	9/06	JK	22	F	N	C	E/U	O/D D/C Home F/U C23
24	9/06	VW	23	F	N	C	E/U	Post O/D D/C Home: TCA
25	11/6	LC	23	M	O	W	Som	Suicide attempt Admit C23
26	12/6	DM	25	F	N	C	E/U	O/D D/C Home No F/U
27	14/6	SP	15	M	N	C	E/U	O/D D/C Home F/U C23 Ref Sons
28	15/6	DT	22	F	N	C	E/U	O/D D/C Home Ref to NICRO
29	20/6	GM	20	F	N	B	Con	Parasuicide D/C F/U 27/6/95
30	21/6	AD	23	M	N	C	E/U	O/D D/C Home TCA
31	22/6	MS	23	F	N	C	E/U	O/D D/C Home Tca
32	22/6	AS	17	M	N	C	E/U	O/D D/C Home
33	22/6	RW	18	M	O	W	E/U	Suicide attempt D/C Home TCA
34	22/6	CDP	15	F	N	W	CHS	Suicide Attempt F/U WSH
35	26/6	BG	18	F	N	B	E/U	O/D D/C Home No F/U
36	27/6	LB	23	M	N	W	GP	Parasuicide D/C Home TCA
37	28/6	ST	17	M	N	B	E/U	Paraffin O/D D/C Home TCA
38	29/6	MVDS	19	F	N	C	G5	O/D Back to G5

40	1/7	RL	19	F	N	C	E/U	O/D D/C Home F/U C23
41	1/7	SB	19	F	O	C	E/U	O/D Admit C 23
42	4/7	CP	20	F	N	C	E/U	O/D D/C Home
43	4/7	TLJ	19	F	N	C	E/U	O/D D/C Home
44	6/7	KD	21	M	N	C	E/U	Suicide Attempt Admit C23
45	7/7	TC	21	F	N	C	E/U	O/D Admit C23
46	10/7	RS	15	F	N	C	E/U	O/D D/C Home Ref Shawco FUC23
47	11/7	SVDP	16	F	N	C	E/U	O/D FU Crisis Group C23
48	13/7	LDP	24	M	N	W	E/U	Suicide attempt Ref C12 (stitches)
49	14/7	CA	15	F	N	C	E/U	O/D D/C Home No FU
50	15/7	ZS	18	M	N	C	T unit	Parasuicide (hanging) Admit C23
51	16/7	AR	20	F	O	W	E/U	O/D (Acrinium) D/C Home FU C23
52	17/7	LDP	24	M	O	W	E/U	Suicide attempt(s wrists)AdmitC23
53	18/7	BL	15	F	N	C	E/U	O/D Ref J2
54	19/7	KW	19	F	N	C	E/U	O/D Sedated Admit C23
55	19/7	CR	18	F	N	C	C17	O/D D/C Home F/U Crisis Group
56	20/7	RB	21	F	N	C	E/U	O/D D/C Home F/U LGH OPD
57	21/7	CW	20	F	N	C	E/U	O/D D/C Home F/U WSH
58	21/7	AL	22	M	N	C	E/U	O/D D/C Home
59	22/7	NDB	15	F	N	C	C17	O/D D/C Home F/U Crisis Group
60	22/7	AS	17	F	N	C	E/U	O/D Ref C15 Holding Area
61	24/7	CS	15	F	N	C	E/U	O/D D/C Home TCA 25/7
62	25/7	NH	13	F	N	C	E/U	O/D Admit C23
63	27/7	CH	16	F	N	C	E/U	O/D D/C Home
64	27/7	TT	24	F	O	C	S/H	O/D D/C Home
65	3/8	SJ	15	F	N	C	G6	O/D D/C Home No FU
66	6/8	YA	15	F	N	C	C22	O/D Theophyllin D/C Home - WSH
67	17/8	LA	16	F	O	C	E/U	O/D D/C Home Fu C23 C/ Group
68	20/8	AL	24	M	N	W	E/U	O/D Admit C23
69	21/8	TR	19	F	N	C	G5	O/D Back to G8 TCA
70	22/8	FG	16	F	N	C	E/U	Post OD D/C Home FU C23
71	28/8	NK	24	F	N	C	E/U	O/D D/C Home FU C23
72	26/8	CD	16	F	O	W	E/U	O/D D/C Home WSH Patient
73	29/8	SDB	17	F	N	C	Self	O/D Admit C23
74	4/9	MF	19	M	N	W	E/U	O/D Admit C23
75	5/9	EZ	23	M	O	B	E/U	O/D D/C Home FU VMH
76	7/9	DF	19	F	N	C	C17	O/D Admit C23
77	11/9	RP	17	F	N	C	P/sch	Parasuicide D/C Home
78	11/9	HG	22	F	O	C	Som	O/D D/C Home
79	12/9	FJ	20	F	N	C	E/U	O/D D/C Home FU Hanover P DH
80	12/9	MS	19	F	N	C	E/U	O/D D/C Home FU LGH OPD
81	12/9	NM	19	F	N	B	C17	O/D FU Khayelitsha DH
82	12/9	NL	24	F	O	C	Self	O/D D/C Home FU J2

81	12/9	NM	19	F	N	B	C17	O/D FU Khayelitsha DH
82	12/9	NL	24	F	O	C	Self	O/D D/C Home FU J2
83	13/9	LC	17	F	N	C	E/U	O/D Admit C23
84	14/9	FL	21	M	N	C	Aval	O/D Sub Abuse D/C Home TCA
85	14/9	SB	14	F	N	C	E/U	O/D D/C Home C Gr TCA C23
86	14/9	MOR	13	F	N	C	E/U	O/D D/C Home No FU
87	14/9	ZM	18	F	N	C	E/U	O/D Anxiety D/C Home
88	14/9	CP	19	F	N	C	E/U	O/D D/C FU C23
89	15/9	GP	17	F	N	C	E/U	O/D D/C FU LGH
90	15/9	SJ	22	F	N	C	C17	O/D D/C Home Fu LGH OPD
91	15/9	TD	20	M	N	C	C17	O/D D/C Home FU Crisis Group
92	15/9	SN	13	F	N	C	E/U	O/D D/C Home Crisis Group
93	16/9	CF	23	F	N	C	Som	Parasuicide D/C FU Crisis Group
94	18/9	TA	16	F	N	C	E/U	O/D Admit C23
95	18/9	PW	22	M	N	W	E/U	O/D D/C Home FU J2
96	18/9	NA	22	F	O	C	E/U	O/D Admit C23
97	19/9	TK	21	F	N	B	E/U	O/D Admit C23
98	22/9	BM	22	F	N	B	E/U	O/D D/C FU C23
99	22/9	JA	14	F	O	W	E/U	O/D D/C FU C23
100	22/9	CR	16	F	O	W	E/U	O/D D/C FU C23

WILLIAM SLATER ADOLESCENT CENTRE

ASSESSMENT FORM

A. DEMOGRAPHIC DATA

FILE NUMBER: _____

1. ASSESSMENT DATE: _____ ADMISSION DATE: _____
DISCHARGE DATE: _____
2. SURNAME: _____ FIRST NAME: _____
3. AGE: _____ DOB: _____
4. SEX: M (1) F (2)
5. RACE: A (1) B (2) M (3) W (4)
6. HOME LANGUAGE: ENGLISH (1)/ AFRIKAANS (2)/ XHOSA (3)/ OTHER (4)
7. PARENTAL STATUS AT THE TIME OF ASSESSMENT:
MARRIED (1)/ DIVORCED (2)/ SEPARATED (3)/ WIDOWED (4)/
SINGLE (5)/ FOSTER/ADOPTIVE (6)/ COHABITATION (7)
8. AGE AT TIME OF SEPARATION/ DIVORCE: _____
9. MARITAL STATUS: SINGLE (1)/ MARRIED (2)/ DIVORCED (3)/
WIDOWED (4)
DETAILS: _____
10. SINGLE STATUS: RELATIONSHIP (1) NO RELATIONSHIP (2)
11. PREVIOUS SUSTAINED RELATIONSHIP: YES (1)/ NO (2)
(ie > 6 months)

Details: _____

12. LIVING STATUS: NUCLEAR FAMILY (1) SINGLE PARENT (2)
RECONSTITUTED FAMILY (3)
INDEPENDENT (4) FOSTER/ADOPTIVE PARENT(S)(5)
EXTENDED FAMILY (6) / PLACE OF SAFETY /
CHILDRENS HOME (7)/ BOARDING HOUSE (8)

Details: _____

13. EDUCATIONAL STATUS: NO FORMAL EDUCATION (1)
PRIMARY (2)
SECONDARY (3) MATRIC (4)
TERTIARY [TRADE] (5)
[DIPLOMA] (6) DEGREE (7)

Details: _____

14. EMPLOYMENT STATUS: FULL TIME EMPLOYMENT (1)
SELF EMPLOYMENT (2)
PART TIME EMPLOYMENT (3)
GRANT (4)
FULL-TIME STUDENT/SCHOLAR (5)
F-T STUDENT/SCHOLAR/P-T EMPLOY(6)
UNEMPLOYED (7)

DETAILS: _____

15. RELIGIOUS STATUS: TYPE: _____
NONE (1) PRACTISING (2)
NON-PRACTISING (3)

16. PREVIOUS PSYCHIATRIC CONTACT: NONE (1) INPATIENT (2)
OUTPATIENT (3)
INPATIENT AND OUTPATIENT (4)

Details: _____

17. PREVIOUS PSYCHOTROPIC MEDICATION: YES (1)/ NO (2)

Details: _____

18. REFERRAL SOURCE: CATEGORY:

PP(01)/ PCP(02)/ PO(03)/ SOC/AG(04)/ GT(05)/ RXH(06)/ GSH(07)/
VH(08)/ FAMILY/FRIEND/ SELF (09)/ MD (10)/ GP (11)/ PRIMARY LEVEL
INSTITUTIONS eg day hospitals (12)/ SECONDARY LEVEL INSTITUTIONS eg
Victoria, Somerset (13)/ MISC (14)

DETAILS: Name: _____
 Prof: _____
 Dept: _____
 Institution: _____

19. KNOWN FAMILY HISTORY OF PSYCH. ILLNESS: YES (1)/NO (2)

IF YES: FAMILY MEMBERS INVOLVED AND ASSOCIATED
DIAGNOSIS IF AVAILABLE.

Mother	_____
Father	_____
Sibling	_____
Aunt/Uncle	_____
Grandparents	_____
Extended family	_____
Other	_____

Details: _____

B. DEPRESSION

1. CLINICAL DEPRESSION PRESENT AS DETERMINED BY DSM IV CRITERIA:
YES (1)/ NO (2)
2. CLINICIANS IMPRESSION OF MASKING OF DEPRESSION (ie is there a strong element of denial of symptomatology):
YES (1)/ NO (2)
3. DURATION OF CLINICAL DEPRESSION: _____ MONTHS
4. DEPRESSION SYMPTOMS RECORDED: YES (1)/ NO (2)
 - PERSISTENT (ie daily) YES (1)/ NO (2)
 - DECREASED APPETITE: YES (1)/ NO (2)
 - INCREASED APPETITE: YES (1)/ NO (2)
 - DECREASED WEIGHT: YES (1)/ NO (2)
 - INCREASED WEIGHT: YES (1)/ NO (2)
 - DECREASED ENERGY LEVELS: YES (1)/ NO (2)
 - DECREASED MOTIVATION: YES (1)/ NO (2)
 - ENJOYMENT (Anhedonia): NONE (1)/ LESS THAN BEFORE (2)/ SAME (3)
 - SOCIAL WITHDRWAL: YES (1)/ NO (2)
 - LONELINESS: YES (1)/ NO (2)
 - SLEEP DISTURBANCE: YES (1)/ NO (2)
 - HYPERSOMNIA: YES (1)/ NO (2)
 - DURATION: _____ HOURS PER DAY

INSOMNIA: YES (1)/ NO (2)

INITIAL: YES (1)/ NO (2)

MIDDLE: YES (1)/ NO (2)

TERMINAL: YES (1)/ NO (2)

WHEN AWAKE DO THEY HAVE: [THIS RELATES ONLY TO INSOMNIA]

WORRIES YES (1)/ NO (2)

RUMINATIONS YES (1)/ NO (2)

DIURNAL MOOD V.: YES (1)/ NO (2)

SUICIDAL IDEATION: YES (1)/ NO (2) (SEE BELOW U/SUICIDE)

PARASUICIDE: YES (1)/ NO (2) (SEE BELOW U/SUICIDE)

TEARFULNESS: YES (1)/ NO (2)

SENSITIVITY: YES (1)/ NO (2)

IRRITABILITY: YES (1)/ NO (2)

DECREASED CONCENTRATION: YES (1)/ NO (2)

DECREASED ATTENTION SPAN: YES (1)/ NO (2)

DISTRACTIBILITY: YES (1)/ NO (2)

FALL-OFF IN ACADEMIC PERFORMANCE: YES (1)/ NO (2)

DAYDREAMING YES (1)/ NO (2)

FORGETFULNESS YES (1)/ NO (2)

DECREASED SELF IMAGE: YES (1)/ NO (2)

DECREASED SELF ESTEEM: YES (1)/ NO (2)

MULTIPLE SOMATIC SYMPTOMS: YES (1)/ NO (2)

FUTURE OUTLOOK: EXTREMELY POOR (1)/ POOR (2)/
POSITIVE (3)/ UNCERTAIN (4)

ASSOCIATED ANXIETY: YES (1)/ NO (2)

ACTING OUT: YES (1)/ NO (2)

IF YES: SINCE ADOLESCENTS ONLY (1)/
SINCE CHILDHOOD (2)

SUBSTANCE ABUSE: YES (1)/ NO (2)

"PROMISCUITY": YES (1)/ NO (2)

EXCESSIVE CLUBBING/PARTYING: YES (1)/ NO (2)

DISRUPTIVE IN SCHOOL: YES (1)/ NO (2)

OPPOSITIONAL BEHAV: YES (1)/ NO (2)

"STEALING": YES (1)/ NO (2)

DESTRUCTIVE BEHAV.: YES (1)/ NO (2)

DANGEROUS/RISKY BEHAV.: YES (1)/ NO (2)

ABSENTEEISM: YES (1)/ NO (2)

DETAILS: _____

C. SUICIDE

1. CURRENT SUICIDAL IDEATION: YES (1)/ NO (2)
2. DEATH THOUGHTS: YES (1)/ NO (2)
(ie life not worth living, no point to life, rather be dead)

3. DURATION: _____ MONTHS

4. FREQUENCY OF DEATH THOUGHTS:
MONTHLY (occassional) (1)/ WEEKLY (frequent) (2)/
DAILY (persistent) (3)/ RARELY (4)

5. ACTIVE SUICIDAL IDEATION: YES (1)/ NO (2)

DURATION: _____ MONTHS

FREQUENCY OF ACTIVE SUICIDAL IDEATION:
MONTHLY (occassional) (1)/ WEEKLY (frequent) (2)/
DAILY (persistent) (3)/ RARELY (4)

METHOD: None (1)/ OD (1)/ Slitting wrists (2)/ Gassing (3)/
Hanging (4)/ Shooting (5)/ Jumping (6)/ Posioning (7)/
Other (8) _____.

PLAN: YES (1)/ NO (2).

INTENT: YES (1)/ NO (2) / UNSURE (3).

DISCLOSURE: No-one (1)/ Professional (1)/ Family (2)/
Friend (3)

PREVIOUS PARASUICIDE: YES (1)/ NO (2).

PARASUICIDE

SINGLE EPISODE (1)/ MULTIPLE (2).

EPISODE 1

DATE (mnth/yr): _____

DISCLOSURE BEFORE EVENT: YES (1)/ NO (2)

IF YES: Stranger (1)
Friend (2)
Family (3)
Professional (4).

PRECIPITANT: YES (1)/ NO (2)

IMPULSIVE ACT: YES (1)/ NO (2)

INTOXICATED: YES (1)/ NO (2)

IF YES: Cannabis (1)/ alcohol (2)/ other subst (3)/
combination (4)

METHOD USED: OD (1)/ Slitting wrists (2)/ Gassing (3)/
Hanging (4)/ Shooting (5)/ Jumping (6)/
Poisoning (7)/ Other (8).

OVERDOSE: Type: _____

Quantity: _____

PLAN: YES (1)/ NO (2)

INTENT: YES (1)/ NO (2)/ UNSURE (3).

DISCOVERED: YES (1)/ NO (2).

IF YES: Stranger (1)
Friend (2)
Family (3).

INTERVENTION: YES (1)/ NO (2).

PHYSICAL INTERVENTION: GP (1)/ Casualty (2)/ Hospitalisation (3)/
Other (4).

PSYCHOLOGICAL INTERVENTION: OPD Private (1)/ OPD State (2)/
IP Private (3)/ IP State (4).

DETAILS OF PARASUICIDE EPISODE: _____

EPISODE 2

DATE (mnth/yr): _____

DISCLOSURE BEFORE EVENT: YES (1)/ NO (2)

IF YES: Stranger (1)
Friend (2)
Family (3)
Professional (4).

PRECIPITANT: YES (1)/ NO (2)

IMPULSIVE ACT: YES (1)/ NO (2)

INTOXICATED: YES (1)/ NO (2)

IF YES: Cannabis (1)/ alcohol (2)/ other subst (3)/
combination (4)

METHOD USED: OD (1)/ Slitting wrists (2)/ Gassing (3)/
Hanging (4)/ Shooting (5)/ Jumping (6)/
Poisoning (7)/ Other (8).

OVERDOSE: Type: _____

Quantity: _____

PLAN: YES (1)/ NO (2)

INTENT: YES (1)/ NO (2)/ UNSURE (3).

DISCOVERED: YES (1)/ NO (2).

IF YES: Stranger (1)
Friend (2)
Family (3).

INTERVENTION: YES (1)/ NO (2).

PHYSICAL INTERVENTION: GP (1)/ Casualty (2)/ Hospitalisation (3)/
Other (4).

PSYCHOLOGICAL INTERVENTION: OPD Private (1)/ OPD State (2)/
IP Private (3)/ IP State (4).

DETAILS OF PARASUICIDE EPISODE: _____

EPISODE 3

DATE (mnth/yr): _____

DISCLOSURE BEFORE EVENT: YES (1)/ NO (2)

IF YES: Stranger (1)
Friend (2)
Family (3)
Professional (4).

PRECIPITANT: YES (1)/ NO (2)

IMPULSIVE ACT: YES (1)/ NO (2)

INTOXICATED: YES (1)/ NO (2)

IF YES: Cannabis (1)/ alcohol (2)/ other subst (3)/
combination (4)

METHOD USED: OD (1)/ Slitting wrists (2)/ Gassing (3)/
Hanging (4)/ Shooting (5)/ Jumping (6)/
Poisoning (7)/ Other (8).

OVERDOSE:

Type: _____

Quantity: _____

PLAN:

YES (1)/ NO (2)

INTENT:

YES (1)/ NO (2)/ UNSURE (3).

DISCOVERED:

YES (1)/ NO (2).

IF YES:

Stranger (1)

Friend (2)

Family (3).

INTERVENTION:

YES (1)/ NO (2).

PHYSICAL INTERVENTION:

GP (1)/ Casualty (2)/ Hospitalisation (3)/
Other (4).

PSYCHOLOGICAL INTERVENTION:

OPD Private (1)/ OPD State (2)/
IP Private (3)/ IP State (4).

DETAILS OF PARASUICIDE EPISODE: _____

OTHER EPISODES (Use above format on separate page provided)

D. EATING DISORDERS

HEIGHT: _____ MASS: _____ BMI: (M/H²): _____

EATING DISORDER: YES (1)/ NO (2).

BINGEING: YES (1)/ NO (2).

DURATION: _____ MONTHS

FREQ: DAILY (1)/WEEKLY (2)/ MONTHLY (3)

No. of times: per day/week/month (please circle): _____

"LOSS OF CONTROL" YES (1)/ NO (2)

Details: _____

SELF INDUCED VOMITING: YES (1)/ NO (2).

Details: _____

FURTHER PURGING: NO (1)/ LAX (2)/ DIURETICS (3)/ BOTH 2 & 3 (4).

Details: _____

EXERCISE: NO (1)/ MODERATE (2)/ EXCESSIVE (3).

Details: _____

DIETING: YES (1)/ NO (2)

STARVATION: YES (1)/ NO (2)

APPETITE SUPPRESSANTS: YES (1)/ NO (2)

Details: _____

ANOREXIA: YES (1)/ NO (2)/ PREV HIST (3).

Details: _____

DISTORTED BODY IMAGE: YES (1)/ NO (2)

IF YES: SIZE (1)/ WEIGHT (2)

SATISFACTION: YES (1)/ NO (2)

Details: _____

E. SUBSTANCE ABUSE

CIGARETTES: YES (1)/ NO (2)

PREVIOUS USE: YES (1)/ NO (2)

AGE AT ONSET: _____

DURATION: _____ MONTHS

QUANTITY: _____ PER DAY

REASON: ESCAPE (1)/ RELAX (2)/ PEER PRESS (3)/ BOREDOM (4)/
OTHER (5)

Details: _____

ALCOHOL USE: YES (1)/ NO (2)

AGE AT ONSET: _____

DURATION: _____ MONTHS

TYPE OF ALCOHOL:	BEER	YES (1)/ NO (2)
	WINE	YES (1)/ NO (2)
	SPIRITS	YES (1)/ NO (2)
	LIQUEUR	YES (1)/ NO (2)

QUANTITY: _____ per day/ week/ month (plse circle)

ALCOHOL ABUSE: YES (1)/ NO (2)

AGE AT ONSET: _____

TYPE OF USE: EPISODIC (weekly) (1)/ CONTINUOUS (daily) (2)/
DEPENDENCY (3)

DURATION: _____ MONTHS

PLACE PURCHASED: BOTTLE STORE YES (1)/ NO (2)
SHABEEN YES (1)/ NO (2)
PUB YES (1)/ NO (2)

TYPE OF ALCOHOL: BEER YES (1)/ NO (2)
WINE YES (1)/ NO (2)
SPIRITS YES (1)/ NO (2)
LIQUEUR YES (1)/ NO (2)

QUANTITY (max per session): _____

VENUE: PARTIES YES (1)/ NO (2)
PUBS YES (1)/ NO (2)
NIGHTCLUBS YES (1)/ NO (2)
AT HOME YES (1)/ NO (2)
FRIENDS PLACE YES (1)/ NO (2)

DRINKING CONTEXT: ALONE YES (1)/ NO (2)
SOCIALLY YES (1)/ NO (2)
BOTH YES (1)/ NO (2)

REASON: ESCAPE YES (1)/ NO (2)
RELAX YES (1)/ NO (2)
PEER PRESSURE YES (1)/ NO (2)
BOREDOM YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

DETAILS: _____

REMISSION: YES (1)/ NO (2)

CANNABIS: YES (1)/ NO (2)

AGE AT ONSET: _____

TYPE OF USE: EXPERIMENTAL (1)/ EPISODIC (2)/ CONTINUOUS (3)/
DEPENDENCY (4)

DURATION: _____ MONTHS
SOURCE: FRIEND YES (1)/ NO (2)
MERCHANT YES (1)/ NO (2)
FAMILY YES (1)/ NO (2)

VENUE: PARTIES YES (1)/ NO (2)
HOME YES (1)/ NO (2)
FRIENDS PLACE YES (1)/ NO (2)
CLUBS YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

CONTEXT: ALONE YES (1)/ NO (2)
SOCIALLY YES (1)/ NO (2)
BOTH YES (1)/ NO (2)

REASON: ESCAPE YES (1)/ NO (2)
RELAX YES (1)/ NO (2)
PEER PRESSURE YES (1)/ NO (2)
BOREDOM YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

REMISSION: YES (1)/ NO (2)

DETAILS: _____

LSD: YES (1)/ NO (2)

AGE AT ONSET: _____

TYPE OF USE: EXPERIMENTAL (1)/ EPISODIC (2)/ CONTINUOUS (3)/
DEPENDENCY (4)

DURATION: _____ MONTHS

SOURCE: FRIEND YES (1)/ NO (2)
MERCHANT YES (1)/ NO (2)
FAMILY YES (1)/ NO (2)

QUANTITY: CAPS PER DAY
/WEEK
/MONTH
>MONTHLY (infrequently)

VENUE: PARTIES YES (1)/ NO (2)
HOME YES (1)/ NO (2)
FRIENDS PLACE YES (1)/ NO (2)
CLUBS YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

CONTEXT: ALONE YES (1)/ NO (2)
SOCIALLY YES (1)/ NO (2)
BOTH YES (1)/ NO (2)

REASON: ESCAPE YES (1)/ NO (2)
RELAX YES (1)/ NO (2)
PEER PRESSURE YES (1)/ NO (2)
BOREDOM YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

REMISSION: YES (1)/ NO (2)

OTHER: YES (1)/ NO (2)

TYPE(S): _____

AGE OF ONSET: _____

TYPE OF USE: EXPERIMENTAL (1)/ EPISODIC (2)/ CONTINUOUS (3)/
DEPENDENCY (4)

DURATION: _____ MONTHS

SOURCE: FRIEND YES (1)/ NO (2)
MERCHANT YES (1)/ NO (2)
FAMILY YES (1)/ NO (2)

QUANTITY: / DAY
/ WEEK
/ MONTH
/ > MONTHLY (infrequently)

VENUE: PARTIES YES (1)/ NO (2)
HOME YES (1)/ NO (2)
FRIENDS PLACE YES (1)/ NO (2)
CLUBS YES (1)/ NO (2)
OTHER YES (1)/ NO (2)

CONTEXT: ALONE YES (1)/ NO (2)
SOCIALLY YES (1)/ NO (2)
BOTH YES (1)/ NO (2)

REASON: ESCAPE YES (1)/ NO (2)
 RELAX YES (1)/ NO (2)
 PEER PRESSURE YES (1)/ NO (2)
 BOREDOM YES (1)/ NO (2)
 OTHER YES (1)/ NO (2)

REMISSION: YES (1)/ NO (2)

DETAILS: _____

TYPE(S): _____

AGE OF ONSET: _____

TYPE OF USE: EXPERIMENTAL (1)/ EPISODIC (2)/ CONTINUOUS (3)/
 DEPENDENCY (4)

DURATION: _____ MONTHS

SOURCE: FRIEND YES (1)/ NO (2)
 MERCHANT YES (1)/ NO (2)
 FAMILY YES (1)/ NO (2)

QUANTITY: / DAY
 / WEEK
 / MONTH
 / > MONTHLY (infrequently)

VENUE: PARTIES YES (1)/ NO (2)
 HOME YES (1)/ NO (2)
 FRIENDS PLACE YES (1)/ NO (2)
 CLUBS YES (1)/ NO (2)
 OTHER YES (1)/ NO (2)

CONTEXT: ALONE YES (1)/ NO (2)
 SOCIALLY YES (1)/ NO (2)
 BOTH YES (1)/ NO (2)

REASON:	ESCAPE	YES (1)/ NO (2)
	RELAX	YES (1)/ NO (2)
	PEER PRESSURE	YES (1)/ NO (2)
	BOREDOM	YES (1)/ NO (2)
	OTHER	YES (1)/ NO (2)

REMISSION:	YES (1)/ NO (2)
------------	-----------------

F. SEXUAL HABITS

ORIENTATION: HOMOSEXUAL (1)/ HETEROSEXUAL (2)/ BISEXUAL (3)/
 UNSURE (4)

MONOGOMOUS RELATIONSHIP: YES (1)/ NO (2)

DURATION: _____

PAST HISTORY:

PAST INTERCOURSE: YES (1)/ NO (2)

AGE AT ONSET: _____

PAST NO. OF SEXUAL PARTNERS: _____

Details: _____

STD: YES (1)/ NO (2)

STD TYPE: _____

PREGNANCY: YES (1)/ NO (2)

NO. OF PREGNANCIES: _____

TERM. OF PREGNANCY: YES (1)/ NO (2)

TOP FREQUENCY: _____

TOP VENUE: GSH (1)/ PRIVATE (2)/ COMBINATION (3)

Details: _____

CONTRACEPTION: YES (1)/ NO (2)

OC PREVIOUSLY ()/AT PRESENT ()

IUD PREVIOUSLY ()/AT PRESENT ()

DEPOT PREVIOUSLY ()/AT PRESENT ()

CONDOM PREVIOUSLY ()/AT PRESENT ()

OTHER PREVIOUSLY ()/AT PRESENT ()

Details: _____

G. SEXUAL ABUSE

SEXUAL ABUSE: YES (1)/ NO (2)

NUMBER OF EPISODES: _____

EPISODE 1

AGE AT ONSET: _____

DURATION: SINGLE INCIDENT (1)/ EPISODIC (2)/ CONTINUOUS (3).
[Continuous is defined as more than one incident occurring regularly over a period of at least one month by the same person.]

TYPE: FULL PENETRATION (1)/ EROTIC KISSING (2)/
EROTIC TOUCHING (3)/ GENITAL TOUCHING [VICTIM'S] (4)
GENITAL TOUCHING [OFFENDER'S] (5)/ EXPOSITION (6)/
DIGITAL PENETRATION (7)/ OROGENITAL (8)/ UNSURE (9)

NO. OF OFFENDERS: BY ONE INDIVIDUAL (1)/
MORE THAN ONE INDIVIDUAL (2)/
GANG RAPE (3)

TYPE OF OFFENDERS:

INDIVIDUAL 1: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 2: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 3: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

MORE THAN 3 INDIVIDUALS PER EPISODE ()

DISCLOSURE TO CAREGIVER eg. Parent/ Guardian:
NO (1)/ AT THE TIME (2)/ DELAY (3)/ PROLONGED DELAY (4)

DISCLOSURE TO PROFESSIONAL: AT THE TIME (1)/ DELAY (2)/ PROLONGED
DELAY (3)/ AT ASSESSMENT (4)

DISCLOSURE TO FRIEND: NONE (1)/ AT THE TIME (2)/ DELAY (3)/
PROLONGED DELAY (4)

Details:

COURT CASE: YES (1)/ NO (2)/ PENDING (3)

SATISFACTORY OUTCOME: YES (1)/ NO (2)

DETAILS OF THE EVENT: _____

EPISODE 2

AGE AT ONSET: _____

DURATION: SINGLE INCIDENT (1)/ EPISODIC (2)/ CONTINUOUS (3).
[Continuous is defined as more than one incident occurring regularly over
a period of at least one month by the same person.]

TYPE: FULL PENETRATION (1)/ EROTIC KISSING (2)/
EROTIC TOUCHING (3)/ GENITAL TOUCHING [VICTIM'S] (4)
GENITAL TOUCHING [OFFENDER'S] (5)/ EXPOSITION (6)/
DIGITAL PENETRATION (7)/ OROGENITAL (8)/ UNSURE (9)

NO. OF OFFENDERS: BY ONE INDIVIDUAL (1)/
MORE THAN ONE INDIVIDUAL (2)/
GANG RAPE (3)

TYPE OF OFFENDERS:

INDIVIDUAL 1: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 2: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 3: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

MORE THAN 3 INDIVIDUALS PER EPISODE ()

DISCLOSURE TO CAREGIVER eg. Parent/ Guardian:
NO (1)/ AT THE TIME (2)/ DELAY (3)/ PROLONGED DELAY (4)

DISCLOSURE TO PROFESSIONAL: AT THE TIME (1)/ DELAY (2)/ PROLONGED
DELAY (3)/ AT ASSESSMENT (4)

DISCLOSURE TO FRIEND: NONE (1)/ AT THE TIME (2)/ DELAY (3)/
PROLONGED DELAY (4)

Details: _____

COURT CASE: YES (1)/ NO (2)/ PENDING (3)

SATISFACTORY OUTCOME: YES (1)/ NO (2)

DETAILS OF THE EVENT: _____

EPISODE 3

AGE AT ONSET: _____

DURATION: SINGLE INCIDENT (1)/ EPISODIC (2)/ CONTINUOUS (3).
[Continuous is defined as more than one incident occurring regularly over a period of at least one month by the same person.]

TYPE: FULL PENETRATION (1)/ EROTIC KISSING (2)/
EROTIC TOUCHING (3)/ GENITAL TOUCHING [VICTIM'S] (4)
GENITAL TOUCHING [OFFENDER'S] (5)/ EXPOSITION (6)/
DIGITAL PENETRATION (7)/ OROGENITAL (8)/ UNSURE (9)

NO. OF OFFENDERS: BY ONE INDIVIDUAL (1)/
MORE THAN ONE INDIVIDUAL (2)/
GANG RAPE (3)

TYPE OF OFFENDERS:

INDIVIDUAL 1: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 2: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

INDIVIDUAL 3: FAMILIAL (1) *Specify:* _____
NON FAMILIAL KNOWN (2)/
NON FAMILIAL UNKNOWN (3).

MORE THAN 3 INDIVIDUALS PER EPISODE ()

DISCLOSURE TO CAREGIVER eg. Parent/ Guardian:
NO (1)/ AT THE TIME (2)/ DELAY (3)/ PROLONGED DELAY (4)

DISCLOSURE TO PROFESSIONAL: AT THE TIME (1)/ DELAY (2)/ PROLONGED
DELAY (3)/ AT ASSESSMENT (4)

DISCLOSURE TO FRIEND: NONE (1)/ AT THE TIME (2)/ DELAY (3)/
PROLONGED DELAY (4)

Details: _____

COURT CASE: YES (1)/ NO (2)/ PENDING (3)

SATISFACTORY OUTCOME: YES (1)/ NO (2)

DETAILS OF THE EVENT: _____

H. PHYSICAL ABUSE

PHYSICAL ABUSE: YES (1)/ NO (2)

AGE OF ONSET: _____

DURATION: _____

PERPETRATOR: MOTHER (1)/ FATHER (2)/ BROTHER (3)/ SISTER (4)/
STEP-FATHER (5)/ STEP-MOTHER (6)/ AUNT/UNCLE (7)/
GRANDPARENT (8)/ HUSBAND (9)/NON-FAMILIAL (10)

DISCLOSURE TO CAREGIVER: NO (1)/ AT THE TIME (2)/ DELAY (3)/
PROLONGED DELAY (4)

DISCLOSURE TO PROFESSIONAL: AT THE TIME (1)/ DELAY (2)/
PROLONGED DELAY (3)/ AT ASSESS. (4)

DISCLOSURE TO THIRD PARTY: NO (1)/ AT THE TIME (2)/ DELAY (3)/
PROLONGED DELAY (4)

Details: _____

I. DIAGNOSIS

According to DSM IV criteria

AXIS I

AXIS II

AXIS III

AXIS IV (ACUTE, CHRONIC & ENDURING)

AXIS V

POOR (1) /FAIR (2) /SATISFACTORY (3) /GOOD (4)

ASSESSMENT

SUITABLE (1)

SUITABLE BUT UNMOTIVATED / UNSURE (2)

SUITABLE PRE ADMISSION PROGRAMME (3)

UNSUITABLE (4)

COMMENTS

APRIL 1995

The Beck Suicidal Intent Scale

Name _____ Date _____

A. Objective circumstances related to suicide attempt

1. Isolation:

- 0 - Somebody present
- 1 - Somebody nearby, or in visual or vocal contact (as by phone)
- 2 - No one nearby, or in visual or vocal contact.

2. Timing:

- 0 - Timed so that intervention is probable
- 1 - Timed so that intervention is not likely
- 2 - Timed so that intervention is highly unlikely

3. Precautions against discovery and/or intervention:

- 0 - No precautions
- 1 - Passive precautions, such as avoiding others but doing nothing to prevent their intervention (alone in room with unlocked door).
- 2 - Active precautions (locked door).

4. Acting to get help during/after attempt:

- 0 - Notified potential helper regarding attempt
- 1 - Contacted but did not specifically notify potential helper regarding attempt
- 2 - Did not contact or notify potential helper

5. Final acts in anticipation of death:

- 0 - None
- 1 - Patient thought about making or made some arrangements in anticipation of death
- 2 - Definite plans made (Changes in will. giving gifts, taking out insurance)

6. Degree of planning for suicide attempt:

- 0 - No preparation
- 1 - Minimal or moderate preparation
- 2 - Extensive preparation

7. Suicide note:

- 0 - Absence of note
- 1 - Note written but torn up or note thought about
- 2 - Presence of note

8. Overt communication of intent before the act:

- 0 - None
- 1 - Equivocal communication
- 2 - Unequivocal communication

9. Alleged purpose of attempt:

- 0 - Mainly to change, manipulate environment (get attention, revenge)
- 1 - Components of "0" and "2"
- 2 - Mainly to remove self from environment (to escape, solve problems)

B. Self report**10. Expectations regarding fatality of act:**

- 0 - Patient thought that death was unlikely or didn't think about it
- 1 - Patient thought that death was possible but not probable
- 2 - Patient thought that death was probable or certain

11. Conception of method's lethality:

- 0 - Patient did less to him/herself than thought would be lethal, or patient didn't think about it
- 1 - Patient wasn't sure, or thought what he/she did might be lethal
- 2 - Act equaled or exceeded what patient thought would be lethal

12. Seriousness of attempt:

- 0 - Patient did not consider act to be a serious attempt to end his/her life
- 1 - Patient was uncertain whether act was a serious attempt to end his/her life.
- 2 - Patient considered act to be a serious attempt to end his/her life

13 Attitude toward living/dying

- 0 - Patient did not want to die
- 1 - Components of "0" and "2"
- 2 - Patient wanted to die

14. Conception of medical rescuability:

- 0 - Patient thought that death would be unlikely if he/she received medical attention
- 1 - Patient was uncertain whether death could be averted by medical attention
- 2 - Patient was certain of death even if he/she received medical attention

15. Degree of premeditation:

- 0 - None - impulsive
- 1 - Suicide contemplated for three hours or less prior to attempt
- 2 - Suicide contemplated for more than three hours prior to attempt

B.D.I

NAME: _____

DATE: _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling **OVER THE PAST FOUR WEEKS INCLUDING TODAY**. Circle the number beside the statement you picked. Be sure to read all the statements in each group before making your choice.

Please remember to complete both sides of the pages. Thank you.

1. 0 I do not feel sad.
 1 I feel sad.
 2 I am sad all the time and I can't snap out of it.
 3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
 1 I feel discouraged about the future.
 2 I feel I have nothing to look forward to.
 3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
 1 I feel I have failed more than the average person.
 2 As I look back on my life, all I can see is a lot of failures.
 3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
 1 I don't enjoy things the way I used to.
 2 I don't get real satisfaction out of anything anymore.
 3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
 1 I feel guilty a good part of the time.
 2 I feel quite guilty most of the time.
 3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
 1 I feel I may be punished.
 2 I expect to be punished.
 3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted in myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all any more.
14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance and they make me look unattractive.
3 I feel that I am ugly or repulsive looking.

- 15 0 I can work about as well as before.
 1 It takes an extra effort to get started at doing something.
 2 I have to push myself very hard to do anything.
 3 I can't do any work at all.
- 16 0 I can sleep as well as usual.
 1 I don't sleep as well as I used to.
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
- 17 0 I don't get more tired than usual.
 1 I get tired more easily than I used to.
 2 I get tired from doing almost anything.
 3 I am too tired to do anything.
- 18 0 My appetite is no worse than normal.
 1 My appetite is not as good as it used to be.
 2 My appetite is much worse now.
 3 I have no appetite at all any more.
- 19 0 I haven't lost much weight, if any, lately.
 1 I have lost more than 5 pounds.
 2 I have lost more than 10 pounds.
 3 I have lost more than 15 pounds.
- 20 0 I am no more worried about my health than usual.
 1 I am worried about physical problems such as aches and pains; or upset stomach;
 or constipation.
 2 I am very worried about physical problems and it's hard to think of much else.
 3 I am so worried about my physical problems, that I cannot think about anything else.
- 21 0 I have not noticed any recent change in my interest in sex.
 1 I am less interested in sex than I used to be.
 2 I am much less interested in sex now.
 3 I have lost interest in sex completely.

HAMILTON RATING SCALE FOR DEPRESSION

1. **Depressed Mood: (Sadness, hopelessness, worthlessness)**
Have you been feeling down or sad lately? (1)
If so, do you feel like this the whole time? Has this worsened recently? (2)
Recently have you felt useless, hopeless or a failure? (3) Do you ever feel very depressed about your situation? (4) If you had to grade your mood would you say you were mildly, moderately or severely depressed?

0 = Feeling happy and fine, no depressed mood
1 = Depressed mood but not persistent - these feelings indicated only on questioning
2 = Persistent depressed mood - feeling states spontaneously reported verbally
3 = Sense of uselessness, failure - communicates feeling states non-verbally
4 = Totally hopeless, severe depressed mood - patient reports VIRTUALLY ONLY these feelings states in verbal and non-verbal communication.
2. **Feelings of guilt:** Do you feel very negative about yourself? Do you repeatedly put yourself down? (1) Do you feel its because of you that bad things happen to you and others around you? (2) Do you feel totally to blame for everything that has happened in your life? [Present illness is a punishment] (3) Guilt reaching delusional properties [Hears accusatory or denunciatory voices and/or visual hallucinations] (4)
3. **Suicidal impulses:** Have you ever felt that life is not worth living? (1) If so, have you ever considered doing anything about it? Have you ever actually thought of killing yourself or wish that you were dead? (2) If so, how would you do it? Do you think you could go through with it? Have you ever tried before? Do you have a plan of action? What's stopping you? (3) If intent is positive or if there have been recent serious attempts (4)
4. **Insomnia early:** Do you have trouble falling asleep when you go to bed at night? How long before you fall asleep? Does this happen occasionally/ most nights? (1) Do you find that you just toss and turn and lie awake thinking about your worries? [Complains of nightly difficulty falling asleep] (2)
5. **Insomnia middle:** Do you ever wake up in the middle of the night? If so, at what time and do you find it difficult to get back to sleep? How long do you stay awake for? (1) Is this a persistent problem - perhaps most nights? Do the same thoughts and worries persistently trouble you? (2)
(Restless and disturbed during the night = 1; Waking during the night, getting out of bed = 2)

6. **Insomnia late:** Do you find that you wake up earlier than expected but can go back to sleep? (1) Early in the morning are you unable to go back to sleep? Do thoughts and worries trouble you? (2)
(Often wake much earlier than would like to = 2; Happy with waking pattern = 0)
7. **Work and activities:** Do you find that you are tired, listless and lack energy most of the time? (1) Do you find you have little motivation for work or study? Do you find you get little pleasure out of things you do? Do you find that even the smallest decision is difficult to make? (2) Are you spending little time on things you should be doing? Is there a marked fall off in scholastic/ academic performance? Have you withdrawn from sporting/ extramural activities/socially? Do you find you are withdrawing more and more from friends and family and prefer being on your own a lot of the time? (3) If not at school/ work or if at home are you unable to do anything; totally incapacitated by present illness (4)
8. **Retardation:** (Observation about speech by clinician)
Processes normal = 0
Speech slow and retarded = 1
Markedly slow in responding = 2
Difficult focusing on interview; difficult obtaining information because patient is so depressed = 3
Complete stupor = 4
9. **Agitation:** (Observation by clinician)
Relaxed, can concentrate = 0
Patient is overtly fidgety = 1
'Plays with' hands, hair, nailbiting = 2
Moving about; can't sit still = 3
Walking around = 4
10. **Anxiety psyche:** Do you feel anxious a lot of the time? Do you find you have become increasingly irritable/ agitated? (1) Is it something specific that makes you anxious or not? Do you tend to worry about minor matters a long time in advance? (2) Do you find you avoid things because of your anxiety? Do you become extremely apprehensive about anything you have to do (eg daily tasks such as going to school/ work, etc (3) Have you always found things like exams anxiety provoking? Are these feelings recent or have you always felt like this? Do these feelings affect your ability to concentrate on a task? Extreme anxiety (4)
11. **Anxiety somatic:** Recently when you have become anxious, do you find any of the following: dry mouth, increased indigestion, diarrhoea, abdominal cramps, palpitations, headaches, fast breathing, sighing, increased urinary frequency, sweating.
(Determine mild/ moderate/ severe by the level of incapacity of the symptoms)
Absent = 0; Mild = 1; Moderate = 2; Severe = 3; Incapacitating = 4

12. **Somatic symptoms gastro-intestinal:** Have you noticed a fall off in your appetite? If no, have you noticed recent weight loss (document amount and over what time period); Are your clothes more loose fitting than before? (1) Marked diminishment in appetite with marked weight loss, and associated constipation with need for medication for GI symptoms (2)
13. **Somatic symptoms general:** Heaviness in limbs, back or head. Do you find that you suffer from headaches, backache, chest pain, or generalised muscular aches and pains? Loss of energy and fatiguability.. (Most of the symptoms = 2; None of the symptoms = 0)
14. **Genital symptoms:** (ascertain whether or not the individual has a sexual partner) Symptoms such as loss of libido. Menstrual disturbance. Do you find that you are no longer interested in sex/ sexual thoughts and feelings? (1) Have you had a total lack of interest in sex since the onset of the depression? Do you find sexual contact pleasurable? Do you find that you persistently make excuses to avoid sexual contact? (2)
15. **Hypochondriasis:** Do you have any medical problems? Are there any persistent symptoms that make you feel that something is seriously wrong? [Self-absorption] (1) Do you have headaches, etc that are continually with you? (2) Have you had any formal investigations for these complaints? Have you gone to the doctor regularly about these problems? [Preoccupation with health] (3) If so, what are the results? Do you believe the doctors if they say that nothing is wrong? (4)
16. **Loss of weight:**
0 = No weight loss; 1 = Probable weight loss associated with present illness
2 = Definite (according to patient) weight loss
17. **Insight:** What do you think these feelings you are having mean? Do you think you are depressed and that you might need help? Full insight; acknowledgement of depression (0) Patient acknowledges illness but attributes cause to bad food, climate, overwork, need for rest (1) Patient denies being ill at all; No insight into state of mental health, not psychological problem and do not need help (2)

Hamilton Rating Scale for Depression

Patient:

Grading scores

(0-4): 0: Absent 1: Mild 2: Moderate 3: Severe 4: Very severe
(0-2): 0: Absent 1: Slight or doubtful 2: Clearly present

Item No.	Item	Grading range	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
			Date	Date	Date	Date	Date	Date
1	Depressed mood	(0-4)						
2	Feelings of guilt	(0-4)						
3	Suicidal impulses	(0-4)						
4	Insomnia early	(0-2)						
5	Insomnia middle	(0-2)						
6	Insomnia late	(0-2)						
7	Work and activities	(0-4)						
8	Retardation	(0-4)						
9	Agitation	(0-4)						
10	Anxiety psychic	(0-4)						
11	Anxiety somatic	(0-4)						
12	Somatic symptoms: gastro-intestinal	(0-2)						
13	Somatic symptoms: general	(0-2)						
14	Genital symptoms	(0-2)						
15	Hypochondriasis	(0-4)						
16	Loss of weight	(0-2)						
17	Insight	(0-2)						
18	Diurnal variation	(0-2)						
19	Depersonalization and derealization	(0-4)						
20	Paranoid symptoms	(0-4)						
21	Obsessional and compulsive symptoms	(0-2)						
Total								

Total score: 0-7: no depression
8-15: minor depression
16 or more: major depression

Treatment details

Visit 1:

Visit 4:

Visit 2:

Visit 5:

Visit 3:

Visit 6:

S5

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THE STANDARD IN ANTIDEPRESSANT THERAPY



MONTGOMERY-ASBERG DEPRESSION RATING SCALE

CLIENT NAME:..... DATE:...../...../.....

RECORD NUMBER..... RATER..... PERIOD RATED.....

The rating should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. If definite answers cannot be elicited from the patient, all relevant clues as well as information from other sources should be used as a bases for the rating, in line with customary clinical practice. The time frame (one week, three weeks etc.) should be recorded at the top.

1. APPARENT SADNESS

Representing despondency, gloom and despair (more than just ordinary transient low spirits) reflected by speech, facial expression and posture. Rate by depth and inability to brighten up.

- 0 No sadness
- 1
- 2 Looks dispirited but does brighten up without difficulty
- 3
- 4 Appears sad and unhappy most of the time
- 5
- 6 Looks miserable most of the time. Extremely despondent

2. REPORTED SADNESS

Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or the feeling of being beyond help and without hope. Rate according to intensity, duration and the extent to which the mood is influenced by events.

- 0 Occasional sadness in keeping with circumstances
- 1
- 2 Sad or low but brightens up without difficulty
- 3
- 4 Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.
- 5
- 6 Continuous or unvarying sadness, misery or despondency.

3. INNER TENSION

Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.

- 0 Placid. Only fleeting inner tension
- 1
- 2 Occasional feelings of edginess and ill defined discomfort
- 3
- 4 Continuous feeling of discomfort or inner tension which patient can only master with some difficulty
- 5
- 6 Unrelenting dread or anguish.

4. REDUCED SLEEP

Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well.

- 0 Sleeps as usual
- 1
- 2 Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep
- 3
- 4 Sleep reduced or broken by at least two hours
- 5
- 6 Less than two or three hours sleep

5. REDUCED APPETITE

Represents the feeling of a loss of appetite compared with when well. Rate by loss of desire for food or the need to force oneself to eat.

- 0 Normal or increased appetite
- 1
- 2 Slightly reduced appetite
- 3
- 4 No appetite. Food is tasteless
- 5
- 6 Needs persuasion to eat at all

6. CONCENTRATION DIFFICULTIES

Representing difficulties collecting one's thoughts mounting to incapacitating lack of concentration. Rate according to intensity, frequency and degree of incapacity produced.

- 0 No difficulties concentrating
- 1
- 2 Occasional difficulties in collecting one's thoughts
- 3
- 4 Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation
- 5
- 6 Unable to read or converse without great difficulty

continues...

7. LASSITUDE

Represents a difficulty getting started or slowness initiating and performing everyday activities.

- | | |
|---|--|
| 0 | <i>Hardly any difficulties getting started or slowness initiating and performing everyday activities</i> |
| 1 | |
| 2 | <i>Difficulties in starting activities</i> |
| 3 | |
| 4 | <i>Difficulties in starting simple routine activities which are carried out with effort</i> |
| 5 | |
| 6 | <i>Complete lassitude. Unable to do anything without help</i> |
-

8. INABILITY TO FEEL

Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.

- | | |
|---|---|
| 0 | <i>Normal interest in the surroundings and other people</i> |
| 1 | |
| 2 | <i>Reduced ability to enjoy usual interests</i> |
| 3 | |
| 4 | <i>Loss of interest in the surroundings. Loss of feelings for friends or acquaintances</i> |
| 5 | |
| 6 | <i>The experience of being emotionally paralysed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends</i> |

9. PESSIMISTIC THOUGHTS

Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin.

- | | |
|---|--|
| 0 | <i>No pessimistic thoughts</i> |
| 1 | |
| 2 | <i>Fluctuating ideas of failure, self-reproach or self deprecation.</i> |
| 3 | |
| 4 | <i>Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future.</i> |
| 5 | |
| 6 | <i>Delusions of ruin, remorse or unredeemable sin. Self-accusations which are absurd and unshakable.</i> |
-

10. SUICIDAL THOUGHTS

Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts and preparation for suicide.

- | | |
|---|--|
| 0 | <i>Enjoys life or takes it as it comes</i> |
| 1 | |
| 2 | <i>Weary of life. Only fleeting suicidal thoughts</i> |
| 3 | |
| 4 | <i>Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention</i> |
| 5 | |
| 6 | <i>Explicit plans for suicide when there is an opportunity. Active preparation for suicide</i> |

COMMENTS (if any).

GENERAL HEALTH QUESTIONNAIRE

NAME: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____

Please read this carefully.

We would like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by circling or underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

- | | | | | | |
|-----|---|-------------------|--------------------|------------------------|-----------------------|
| A1. | Been feeling perfectly well and in good health? | Better than usual | Same as usual | Worse than usual | Much worse than usual |
| A2. | Been feeling in need of a good tonic? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A3. | Been feeling run down and out of sorts? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A4. | Felt that you are ill? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A5. | Been getting any pains in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| A6. | Been getting a feeling of tightness or pressure in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |

A7.	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1.	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2.	Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3.	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4.	Been getting edge and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5.	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6.	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7.	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
C1.	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2.	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3.	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4.	Been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied

C5.	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6.	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7.	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
D1.	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2.	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3.	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4.	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5.	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6.	Found yourself wishing you were dead and away from it all?	Not at all at all	No more than usual	Rather more than usual	Much more than usual
D7.	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A _____ B _____ C _____ D _____ TOTAL _____

