satisfactory cardiocograph was obtainable during the first stage this became increasingly difficult during the second stage. There is, however, biochemical evidence to suggest that the second twin is not subjected to the same stress as its sibling. Whether this is to its advantage or otherwise has not yet been established. This study showed no differences in the cord arterial blood pH between the first and second twins despite the higher incidence of low 1-minute and 5-minute Apgar scores in the second twin.

Thus induction of labour with expectation of vaginal delivery may be considered in high-risk twin pregnancy when delivery is considered essential before spontaneous onset of labour. Nevertheless, because these pregnancies have been identified as high risk, careful supervision and monitoring of labour is advocated.

We wish to thank Dr S. G. Reinach, Deputy Director of the Institute for Biostatistics of the South African Medical Research Council for statistical analysis and the Chief Medical Superintendent of King Edward VIII Hospital for permission to publish.

REFERENCES

Short-term precipitants of parasuicide in adolescents
L. SCHLEBUSCH

Summary
Despite extensive research, our knowledge about adolescent parasuicide, why its incidence is currently so high and how to predict it remains incomplete. In the past research often focused on aetiological factors and long-range prediction. In this article short-term aetiological variables relating to both immediate precipitants and psychiatric diagnoses in a sample of 159 adolescents who attempted suicide are explored. The findings should contribute to a clearer understanding of the build-up to the parasuicidal crisis, the consequent level of disturbance and its treatment.


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Current data show that there has been an increase in parasuicide among adolescents, although there are many statistical vagaries. Clinical research is equally unclear about the underlying presence or degree of mental disorders in these adolescents. Determining the extent of psychiatric disorders as well as general aetiological factors remains a major subject for research. Psychiatric disorders have been diagnosed in some patients, while family, interpersonal and school problems are commonly reported in others. 'Low-intent' adolescent patients often view a suicide attempt as an escape from tension. Some researchers feel that the unabated increase in self-destructive behaviour in adolescents is a silent indictment of their society. Adolescent parasuicide may herald progression to successful suicide, and many patients who eventually commit suicide have a history of parasuicide or psychiatric or psychological treatment. While accurate prediction of suicidal behaviour in the long term remains an almost impossible challenge, prevention of suicide can be effective over a short-term period ranging from minutes to days. This can be enhanced by a knowledge of both phenomenological aspects and prodromal symptoms of suicidal behaviour in the individual patient in relation to the immediate precipitants of such behaviour.

The present study augments another on parasuicides and discusses short- and long-term aetiological factors.
Patients and methods

This study, part of a larger project, was conducted in the Department of Psychiatry, Addington Hospital, Durban, between 1 January and 31 December 1983. During this period 567 patients were referred after parasuicide, but only 548 were seen, because some refused hospital treatment. The design of this study is described elsewhere. Of the patients seen, 159 (29%) were aged between 10 and 19 years. The data presented here are based on this group, which consisted of 39.6% coloured and 60.4% white patients.

DSM III criteria were used for psychiatric diagnostic purposes, following a clinical interview and mental status examination. Biographical and psychosocial information was elicited by means of a semistructured questionnaire. Where possible, information given by the patient was validated against data obtained from the family. The interview was conducted as soon as the patient's medical condition was stabilized, usually within 24-48 hours after the parasuicide.

Psychiatric disorders were diagnosed in slightly more than half of the patient sample (54.7%). The previously observed pattern of more females than males (73.6% as opposed to 26.4%) persisted, both for the specific disorders and for the overall subgroup with such disorders (Table I).

The most prevalent associated diagnosis was adjustment disorder of adolescence (54.0%), most of these subjects manifesting an anxious or depressed mood characterized by feelings of hopelessness, disturbance of conduct, or academic problems following previous adequate performance. This was followed by specific affective disorders (21.8%) or largely dysthymic disorder (depressive neurosis). None of the patients met the criteria for a bipolar affective disorder or a major depressive episode.

The third most common associated diagnosis was conduct disorders (16.1%). Most members of this group were socialized 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.

Almost half of the patient sample (45.3%) had no definite psychiatric disorder despite experiencing symptoms such as hopelessness (Table II). These patients were grouped under section V of the DSM III, i.e. conditions not attributable to a mental disorder that is a focus of treatment. Not all the patients could usefully be grouped into this category, e.g. ‘subintentional’ parasuicides, although they are discussed under the same heading.

Parent-child problems were the most common precipitants of parasuicide (29.2%). These mostly consisted of difficulties in relationships with either or both parents, disciplinary measures, staying out late or dating someone against parental wishes, all of which caused friction. Academic problems, including scholastic underachievement 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 patients in these two groups were in the care of a social or child welfare agency.

Other interpersonal problems (12.5%) mainly centred around difficulties with romantic partners, such as a recent termination of a relationship, fear of pregnancy, recent dissension between partners or parental disapproval of a partner. A few patients were socially isolated from peers or had difficulty in establishing friendships. Marital problems constituted the fourth most common problem area (8.3%); most 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 and bickering which affected the patient. Only 3 patients were married (4.2% of the sample); all were girls in late adolescence and all were experiencing marital conflict.

A few patients (7.0%) were seen after what they claimed was an ‘accidental’ (i.e. subintentional) parasuicide, and 1 epileptic patient who did not comply with his medical treatment was admitted to hospital after a suspected overdose of anticonvulsants.

Analysis of their medical files revealed that the patients had generally been in good physical health just before the parasuicide.

### Table I. Distribution of Psychiatric Disorders (DSM III Criteria) in Adolescent Parasuicides

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Adjustment disorders</td>
<td>10</td>
<td>21.3</td>
<td>37</td>
</tr>
<tr>
<td>Affective disorders</td>
<td>5</td>
<td>26.3</td>
<td>14</td>
</tr>
<tr>
<td>Conduct disorders</td>
<td>7</td>
<td>50.0</td>
<td>7</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>1</td>
<td>14.3</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>26.4</td>
<td>64</td>
</tr>
</tbody>
</table>

### Table II. Conditions Not Attributable to Mental Disorder in Adolescent Parasuicides

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Parent-child problems</td>
<td>5</td>
<td>23.8</td>
<td>16</td>
</tr>
<tr>
<td>Academic problems</td>
<td>3</td>
<td>18.8</td>
<td>13</td>
</tr>
<tr>
<td>Other specified family circumstances</td>
<td>3</td>
<td>21.4</td>
<td>11</td>
</tr>
<tr>
<td>Other interpersonal problems</td>
<td>2</td>
<td>22.2</td>
<td>7</td>
</tr>
<tr>
<td>Marital problems</td>
<td>2</td>
<td>33.3</td>
<td>4</td>
</tr>
<tr>
<td>Subintentional treatment</td>
<td>4</td>
<td>80.0</td>
<td>1</td>
</tr>
<tr>
<td>Non-compliance with medical treatment</td>
<td>—</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>26.4</td>
<td>53</td>
</tr>
</tbody>
</table>
Discussion

Prevention of suicide requires identification of populations at increased risk, accurate estimation of the degree of risk in a given patient at a specific time, and effective intervention.15 There is evidence, however, that identification of large groups of subjects at risk tends to be too general to be of practical use. On the other hand, suicidal intent in a given patient is not constant; it may surface abruptly and abate after a few days with or without a suicidal act.16,17

One study17 commenting on long-range versus short-range prediction arrives at the inescapable conclusion that, despite all our current demographic knowledge about patients at risk, we cannot successfully predict who will eventually commit suicide. It appears that the same is true for parasuicide.

Consideration of the short-term precipitants of parasuicide in each individual patient against the background of a thorough knowledge of phenomenological aspects of parasuicide is of more immediate practical use. It requires a set of concepts and skills different from those involved in long-range prediction, and, as in suicide, it presupposes the identification of an existing suicidal crisis which prevents detailed quantitative suicide ratings in advance.17 It further facilitates insight into two continua of personality functioning, i.e. the patient's current level of distress and desire to die. For purposes of psychotherapeutic intervention, current suicidal behaviour is better understood by determining how perturbed the patient is and how strong is the desire to die rather than by making a specific psychiatric diagnosis.19 This is relevant because reasons given by patients for taking overdoses do not always agree with the reasons attributed to them.20

The present findings are consistent with other studies, which found that some parasuicidal adolescents have psychiatric disorders,2–4 predominantly adjustment disorders.2–4 followed by affective disorders and conduct disorders including personality disorders.14 In a previous study of the same group of patients,1 we reported that a quarter of them had a history of a previous parasuicide, suicidal thoughts preceding the event, and prior psychological or psychiatric treatment. In addition, a significant number of our patients came from problem backgrounds, with a family history of psychiatric disorders and parasuicides by parents or siblings.1 In contrast to the findings of some,14 our patients were not commonly in poor physical health at the time of the parasuicide.

With regard to conditions not attributable to a mental disorder as a focus of treatment, our findings are in keeping with those of other studies.12–14 We found, however, that in most cases a notable quarrel with a person important in the patient's life had taken place hours or at most a day or two before the parasuicide and was the predominant immediate precipitant of the attempt irrespective of whether a psychiatric disorder was present or not. Patients often felt victimized or unfairly treated, particularly by parents, with whom inadequate communication prevailed. They had great difficulty in discussing these problems with their parents or with a mature adult, and were singularly unable to resolve them or cope emotionally. This tends to support the concept that parasuicidal behaviour is an age-related mode of solving a problem. A recent 9-year follow-up study of patients who had attempted self-poisoning as adolescents revealed that there was a sharp decline in such behaviour after the age of 18 years, with adequate functional adaptation attributed to multiple support systems, confirming the view that a suicide attempt with a low risk of death is an age-related stress response.21 While variables such as psychiatric disorders are important and may have acted as exacerbating factors in our sample, it would seem that these events are best understood in terms of the immediate precipitants.

Examination of short-range precipitants is of more immediate practical value for treatment than long-range prediction. If the circumstances and associated feelings during the period of minutes to days immediately preceding the act are identified for each patient, it becomes possible to recognize the build-up to the parasuicidal crisis. Causation remains complex and multifactorial,22 but the common denominators in the hours before the act, underlying the substrate of despair and hopelessness which the patient can neither endure nor discuss with a mature adult, can then be dealt with timeously. Although some conditions may have been present, untreated, for months or even years before the act, the urge to engage in a form of self-destructive behaviour surfaced at a moment of inability to resolve problems. The act of parasuicide, albeit manipulative at times, therefore becomes a method of solving a problem. To neglect treatment (described in detail elsewhere14–17) carries numerous risks; if a further attempt is triggered off by similar precipitants, which have not been dealt with adequately, there is no guarantee that the patient will survive again.

Permission to publish, obtained from the Director-General of the Department of National Health and Population Development and the Senior Medical Superintendent of Addington Hospital, Durban, is gratefully acknowledged.

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