had not been detected by HSG. This corresponds with a report by Cumming and Taylor who detected intra-uterine lesions consisting mainly of synechiae in 42% of all infertile patients. Mohr and Lindemann reported 59% of intra-uterine lesions in their infertile patients. All the above reports show a remarkable similarity in the high incidence of intra-uterine adhesions seen.

Because of this high incidence of adhesions, which are rarely detectable by HSG, it has been suggested that hysteroscopy should be a routine tool in the general work-up of the infertile patient. The above results, however, are in clear contrast with the findings in the present trial where only 1 patient out of 50 was found to have synechiae. In that patient, HSG had already shown an irregularity of the uterine wall. I can only speculate on the reason for this difference. One major difference between the USA and South Africa is the legal abortion rate there - every year 1.5 million legal abortions are performed. According to recently released figures about 45% of all teenage pregnancies in the USA end in abortion. Since there are 1 million such pregnancies a year, 450 000 must end in a legal abortion. This does not include illegal procedures, although this figure will probably be very small. Evacuation of a pregnant uterus in the first trimester is known to be a cause of endometritis, and intra-uterine adhesions can be the consequence. Once married these patients find themselves infertile and present for investigations. In South Africa this problem does not seem to be of comparable magnitude.

It therefore seems justifiable to use HSG as the initial screening procedure for our patients, and not to employ hysteroscopy routinely. It should be kept as a tool for further investigation in selected cases. The special indications for hysteroscopy in infertile patients are: (i) any irregularity of the uterine wall or any lesion of the uterine cavity found on HSG; (ii) cornual blockage (endometrial polyps are often found to be the cause); (iii) history of previous abortion; and (iv) history of any previous uterine operation — in such cases an assessment of endometrial height and regularity is worthwhile.

Hysteroscopy is a valuable tool for the investigation of the infertile female, but under present conditions in our unit HSG is still the main outpatient screening procedure, giving an excellent assessment in virtually all cases.

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A study of deliberate self-harm at a Pietermaritzburg general hospital

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Summary

The term 'non-fatal deliberate self-harm' (DSH) has evolved as a result of confusion surrounding the terms 'attempted suicide' and 'parasuicide'. While the latter two terms imply some relationship with suicidal intent and death wishes the term DSH does not and is therefore preferred. A study was undertaken to identify high-risk groups and significant precipitating factors for DSH. During the 12-month period ending 31 December 1985, 147 cases of DSH were seen by clinical psychologists at Northdale Hospital, Pietermaritzburg. Single people between 16 and 25 years and housewives constituted the high-risk groups. Authoritarian parenting and resultant conflict appeared to be a very significant precipitating factor in the former group.

While the terms 'attempted suicide' and 'parasuicide' have been used for years and have resulted in some confusion, a third more appropriate one has evolved. The term 'non-fatal deliberate self-harm' (DSH) has been introduced largely for its descriptive accuracy, the rationale being that both 'attempted suicide' and 'parasuicide' imply some relationship with suicidal intent and death wishes. However, this motivation is said to be present in only a minority of patients who survive acts of self-harm. It has also been argued that many such acts do not
merit the description 'attempted suicide' because they are undertaken for other purposes, e.g. manipulation of the environment.

The term non-fatal DSH as used in this report represents all instances of wilful self-poisoning or injury not resulting in death.

Patients and methods

This study was based on the clinical records of patients admitted to Northdale Hospital, Pietermaritzburg, after attempts at DSH. The hospital caters for the Indian and coloured communities (over 80,000 people).

During the 12-month period ending 31 December 1985, 147 DSH patients were admitted to hospital and all of these were seen by clinical psychologists, usually within 72 hours. The following details were incorporated into this study: age, sex, marital status, occupation, reason (precipitating factor), intentionality and method.

Results

Of the 147 subjects, 109 (74.1%) were female and 38 (25.9%) male, a ratio of 2.8:1. Of the females 39 (35.8%) were housewives. Eighty-nine patients (60.5%) were between 16 and 25 years of age (Fig. 1), nearly half of these being under 20 years. The marital status of the study population was: single 84 (57.1%); married 59 (40.1%); widowed, divorced and separated 4 (2.8%).

In the 16-25-year-old age group the major precipitating factors were conflict with parents over issues of perceived authoritarianism and problems with boyfriends/girlfriends.

In categorising intentionality the subject's perception of the consequences of the act was evaluated. An attempt was categorised as impulsive when it was a spontaneous acting-out of frustration. The manipulative category constituted those subjects who clearly indicated an absence of a death wish but admitted an intention to manipulate the environment. An act was interpreted as serious when a subject reported secretive planning and appeared distressed and problems with boyfriends/girlfriends.

The finding that females outnumbered males in the incidence of DSH cases correlates highly with previous studies.7 The ratio of 2.8:1 (females: males) is similar to that reported in a study in the Durban area.7

Of interest was the finding that most of the subjects were between the ages of 16 and 25 years, the major precipitating factors being familial conflict and problems with boyfriends/girlfriends. This trend has been reported by Stengel in the UK context.8 Overly restrictive parents also appeared to initiate conflict. Subjects indicated that they were not allowed to socialise unsupervised or maintain steady heterosexual relationships.

The under-representation of widowed, divorced and separated people (2.8%) contrasts with the finding of Minnaar et al.7 who reported 21% of their sample in this category. A possible explanation for this difference could be the extended-family system9 practised by the ethnic group mainly represented in our sample. It appears that when emotional trauma is experienced support is provided by the extended-family system which mediates against the 'helplessness syndrome' implicit in DSH.

The predominance of ingestion as a method of DSH can be partially accounted for by the ready availability of drugs and other toxic substances. It has also been argued that the use of ingestion, especially in patients of low intent, results from a wish to escape high levels of tension, similar to the act of becoming intoxicated.10

Conclusion

The two groups most at risk for DSH are single people between 16 and 25 years of age and housewives. Ingestion was the preferred method and appeared to be linked to intentionality. The finding that 85% of the sample made self-harm attempts in the absence of a death wish supports the use of the term 'non-fatal DSH'.

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

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