Research Report

Suicide and Attempted Suicide Among the Shona

It has long been apparent that suicide and attempted suicide are relatively rare in Shona Society. It has also been noticed that the usual method was by hanging, and that other methods such as mutilation were seldom encountered. Rittey and Castle (1972) have analysed the Attorney-General's figures for such deaths amongst Africans and Europeans in Rhodesia by standardising the rates instead of using crude rates which are usually quoted in this connection. They showed clearly that the rate in Africans was significantly lower than in Europeans. These figures, however, do not tell us where the deaths occurred or the reason for them.

The Shona people constitute the largest ethnic group of Rhodesia and number about four million. About one million are working in urban and periurban areas, whilst the rest live in their traditional tribal lands under their chiefs, relatively untouched by the Western world. Each tribesman is entitled to a sufficient share of the land which may not be alienated. Although the economy may not be strictly subsistent, it is fairly traditional; consequently there is relatively little material differentiation but a great deal of mutual dependence. Marriage tends to be a very stable institution, and the large size of families reinforces a sense of interdependence. This feeling is further strengthened by the patrilineal structure of Shona society in which most males of a tribal grouping are felt to be the descendents of the original ancestor.

This link with ancestors is doubly strong, even with those Shona who adhere to Christianity, for protection from the casualties of life is expected from the ancestral spirits (*vadzimu*). Indeed in the eyes of the Shona no one should die; life is everlasting provided a person does not lose the protection of his *vadzimu*. Except perhaps in the aged, death is said to be due to the loss of protection of these spirits or to the spells of a witch. Suicide is felt to be a most unnatural death and the Shona explain its rare occurrence as due to an angry spirit (*ngozi*) of a person who was murdered who visits the guilty family in search of revenge, causing one death after another until the family agrees to compensate the bereaved one.

It long appeared that among the Bantu-speaking peoples of Africa suicide and attempted suicide were rarer than in western society; but it was only in 1937 that Laubscher documented this fact. He circularised magistrates in the tribal territories in the Eastern Cape to ascertain the number of cases of suicide reported to their officials during a two-year period. In an area with a population of 868 944 there were 14 cases of suicide and four attempted suicides in two years, giving a rate of less than 1 per 100 000. Laubscher was so struck by its rarity that he concluded there had to be some serious psychic despondence before such an act was committed.

Similarly Dembowitz (1954) found that the suicide rate was low among mentally disordered people from West Africa, as did Asuni (1962 and 1967) in Nigeria. Asuni's first study was based on coroners' reports over a four year period (1957-60) in the Western region of

Nigeria. He divided his cases into two groups, those in the 15-19 years age-group and those from 50 years onwards. Most of them were of the traditional faith but a few were Muslim or Christian. There were far more male than female cases, and hanging was the most common mode of suicide, accounting for about fifty per cent of the total cases. The incidence of suicide in his series was less than one in 100 000.

His second study was on attempted suicide. Over a period of a month he collected 29 cases out of a population of 393 800. Eighteen of them were male and eleven female. He commented on the rarity of attempted suicide in this society. No less than thirteen of the subjects had some mental disorder, seven of whom had depression or schizophrenia. The methods used were interesting: 16 slashed their bodies, 10 took drugs, 1 tried to hang and 1 to drown.

Methods

It was decided three years ago to study the subject of suicide and attempted suicide among Rhodesian Africans by interviewing the friends and relations of all suicides brought to Harare Hospital for treatment or autopsy. Also interviewed were those patients who had been admitted for attempted suicide, as well as their relatives and close friends who appeared with them. As far as is known, this approach has not been tried before. Harare Hospital is in a fortunate position in this regard as it is the only one in which autopsies are performed for a large area of Mashonaland and anyone who has attempted to kill himself is brought in to 'outpatients' for emergency treatment. It is true that not every person who has attempted suicide is brought in, but generally such cases are rushed to this central hospital. In addition to the assistance from the families concerned, valuable information was obtained from the African policemen who brought them to hospital. These men invariably went out of their way to check information or follow up points that needed to be clarified.

This investigation began in July 1970, and although it is still continuing, all the cases that appeared to the end of June 1972, are surveyed in this research report. At the same time, the superintendent of the European Hospital in Salisbury supplied the figures and details of cases of attempted suicide brought to the Casualty Department there in order to evaluate any difference in frequency over the same period between the two races.

Results

Suicides (mainly urban)

For the period July 1970, to the end of June 1972, forty-four cases of suicide were dealt with at the mortuary at Harare Hospital. Thirty-nine of these were male (88 per cent) and five female. Thirty-six of these cases (82 per cent) were connected with an urban or European environment, having lived either in a township or close by on a European farm; and only eight came from more traditional environments in Tribal Trust Lands. However, only one of the forty-four was an educated person, and all the others were more traditional in outlook despite the fact that most of them lived in an urban area or in close contact with one.

In analysing these cases, no particular seasonal variation is noticeable. The most common means of suicide was hanging (38, i.e., 86 per cent); 2 jumped from heights, 1 was run over by a train, 1 died by fire, 1 by drowning and 1 was gassed. In thirteen of the cases, it was not possible to find a cause; in each of these, the individual was reported as being normal and the relations and friends knew of no factor that seemed to be responsible. The following table records the possible reasons for the suicides:

Table I

CAUSATIVE FACTORS IN FORTY-FOUR SUICIDES IN SALISBURY AND REGION

Reason	*Number*
Wife/husband difficulties	4
Boy/girl troubles	1
Debt (gambling)	6
Fear of consequences of some action (e.g., police arrest)	4
Physical illness	3
Possible physical illness	1
Mental illness	5
Possible mental illness	2
Witchcraft accusation	2
Drink	1
Possibly drink	1
Tired of life	1
No apparent reason	13
TOTAL	44

For the thirty-six cases connected with an urban or peri-urban environment, it is possible to analyse ages accurately. The great majority were between 20 and 50 years of age. The youngest case was sixteen years of age, and there were three over seventy who were res-

pectively ill, bereaved and tired of living. In none of these cases was there evidence of previous attempts:

Table II

AGE OF THIRTY-SIX SUICIDES IN SALISBURY URBAN OR PERIURBAN AREA

Years of Age	*Number*
0- 9	0
10-19	2
20-29	8
30-39	14
40-49	6
50-59	2
60-69	1
70-79	2
80 and over	1

Of these cases, five were foreign Africans, three from Malawi and two from Moçambique.

Suicides in Tribal Trust Lands

During this period attention was also given to the number of deaths in Tribal Trust Lands, where the people live with what can be regarded as a largely traditional outlook. Figures were obtained from the districts of Katarere, Wedza and Cinamora.

At Katarere in the North Inyanga area near the Moçambique border, with a population of about 40 000 people, there appeared to have been four suicides between the years 1968 and 1972 (three men and one woman). The crude rate was 2,5 deaths per 100 000.

The information from Wedza was more detailed. Between 1964 and 1971, in an area with a population of 45 000, eleven suicides were recorded (crude rate 3,49 per 100 000). Of these cases, seven were male and four female. Nine hanged themselves and two died by fire. Six of the suicides occurred in the cold months of the year and three in the warm weather. The ages of the males ranged from 16 to 60 years and in the females from 28 to 50 years. The alleged reasons for suicide are as follows:

Table III

SUICIDES IN WEDZA (1964-1971)

Domestic disputes	4
Mental illness	2
Possible depression	1
Physical illness	1
Accusations of adultery	1
No apparent reason	2
TOTAL	11

At Cinhamora, about 30 miles from Salisbury, with a population of 19 000, six cases of suicide were reported to the chief — three male and three female (crude rate 5,26). The following table gives details about these six cases (1966-1972):

Table IV

SUICIDES IN CINHAMORA

Sex	*Age*	*Method*	*Reason*
Male	44	Hanging	Said he was falsely accused of hiding the names of people who had burnt the Chief's house
Male	18	Hanging	Eloped with a girl and his family would not allow him to live with her in his area
Female	38	Hanging	Scolded by her husband
Female	16	Hanging	Not allowed to marry her lover
Male	32	Hanging	Embezzlement of money at Post Office
Male	51	Hanging	After murdering his two wives

Comparison of Suicide Rates

The crude suicide rate in Salisbury with an African population of approximately 320 000 and 36 cases in two years was 5,6 per 100 000, whereas that in the three Tribal Trust Lands (with a total population of 105 000) was 3,4. It would thus appear that, allowing for the difficulties in comparing the urban and rural populations, there is no significant increase statistically in the suicide rate in the urban areas.

Attempted Suicide in the Salisbury Area

Thirty-five people were examined in the period in which this study was undertaken. Twenty-nine were female and six male. Thirty came from an urban environment and five from a traditional or rural one. They appeared to be of a younger age group than those who succeeded in committing suicide. Thirty-five (66 per cent) were below 30 years of age in contrast to 15 (34 per cent) out of 44 suicides.

Table V

ATTEMPTED SUICIDES IN SALISBURY AREA (July 1970-June 1972)

Method	*Number who employed it*
Tablets	6
Swallowed noxious agent (dettol, javel, needle, glass, caustic soda	19
Hanging	6
Cut throat	2
Set on fire	1
Jumping from height	1

Thirteen of this series had a fairly good education. Polygamous marriages had a bearing on three of the attempted suicides. One, a nursing sister, attempted to end her life when her husband took another wife. Another woman, a second wife, attempted suicide because she was jealous of the first wife. A husband tried to take his life when he found his second wife in bed with another man. Infidelity or a sexual reason was responsible for 16 out of the 35 attempts, and fourteen of them were single. Drink might have been a factor in one case of attempted suicide, but in this instance there was also argument over the bride-price.

Attempted Suicide in Rural Areas

Attempted suicide appears to be very rare in traditional areas; and this is confirmed by various sources of information — the medical profession, missionary bodies, and Africans working at the Chief's court (*dare*). In these areas, only one case was traced.

Table VI

ATTEMPTED SUICIDES IN RURAL AREAS

Area	*Sources of Information*	*Period*	*Number*
Wedza	Dr. Macintosh	1964-71	0
Katerere	Dr. Brien and Sister Dolores	1968-72	0
Cinhamora	Chief's Dare	1966-72	1
TOTAL			1

Comparison of Attempted Suicide Rates

In the Salisbury urban and periurban areas there were thirty cases of attempted suicide, if one excludes the five brought into Harare from the countryside. The crude rate, therefore, was 4,7 per 100 000. This shows how very much greater was the occurrence of attempted suicide in the urban areas.

For comparative purposes the figures for attempted suicides amongst Europeans, were also obtained. As the Salisbury Central Hospital is the only centre catering for such emergencies its figures provide a good idea of the extent of its occurrence in European society. The European population of Greater Salisbury is 105 000 as compared with 320 000 Africans. In the year 1970 the number of patients admitted to the Outpatients Department, having attempted suicide was 59 (40 female and 19 male). Tablets were taken (mostly barbiturates, tranquillizers or aspirins) by 49; of the remainder, 3 attempted suicide by gunshot, 4 by slashed wrists, 1 by stab wounds of abdomen and 2 by carbon monoxide (B. Laidler, Personal Communication, Salisbury Central Hospital). This represents an attempted suicide rate of about 56 per 100 000 for Europeans, and is to be compared with the African rate in Salisbury of 4,7 per 100 000.

Discussion

The traditional Shona are aware of the occurrence of suicide and attempted suicide. In Shona mythology we learn the story of Vanyamita, the great tribal spirit of the people of the Mangwende Tribal Trust Land. Untold years ago, when she was alive on this earth, she married but bore no children. She pined for some of her own. Her husband's other wives were more fortunate and Vanyamita gave their children the loving care of a mother. She grew very fond of them and they of her until their own mothers became jealous of the love they bore her and they were removed from all contact with her. One day Vanyamita and the children disappeared. People hunted for them until eventually they were drawn to a large pool of water, on the surface of which floated the bodies of Vanyamita and the two little girls, whose hands were still clasped in hers. Today the clansmen of Mangwende still go to the pool of Vanyamita every year to pray to their guardian spirit.

Nevertheless in the traditional background of the Shona, suicide and attempted suicide are uncommon. The more traditional the people, the more attached they are to their ancestors, the greater are the bonds between them and their living families and the less these tragedies occur. When the senior tribal medium at Katarere was asked about the occurrence of the occasional suicide in his area, he replied that in former days it was very rare but nowadays, because people are unable to move from one piece of land to another when the first has been worked out, the problems arising from land shortage may, on occasions, result in suicide amongst the Shona.

The other explanation for suicide, mentioned earlier, that it is due to an aggrieved spirit or *ngozi* is still universally believed in traditional society, although when Shona put an end to their lives, the same factors exist that are found in Western Society. For, living in tribal conditions is not necessarily free of want or anxiety, and rural people are as liable to have argu-

ments and disappointments as those who live in a western environment or influence. Hence the appearance in the Tables as causes of suicide, of illness (especially mental), acute anxiety due to loss of wealth or debt, upsets between a male and a female, quarrels, old age and weariness of life. In fact no real difference in causation between the two races can be seen, and it is interesting to note that more males than females commit suicide in Shona society as in western society. It can be argued that in the tribal lands, weapons and instruments of death are less available than in the towns, where drugs, carbon monoxide and weapons are more handy than in isolated places. This may well be a factor; yet sharp instruments, like knives, are procurable and fire, pools of water and heights from which to jump are not rare.

This study shows that the risk of suicide of the urban Shona is not significantly different from the rural Shona living in a more traditional background. This does not mean that the numbers will not grow, for, just as happened with the American Negro, one can expect far more cases as the links with their traditional background lessen and disappear. At the present time almost all the Shona in the Salisbury urban area have close links with the tribal areas and there is a constant to and fro movement between the urban and rural areas.

The causes of suicide amongst African townsmen are much the same as in towns elsewhere in the world, except that very few have previously attempted to take their lives. Again a few seem to have had mental disorders like depression. In the European, alcoholism figures fairly predominantly but in the Shona it does not appear to be important.

The large number of cases (13) in whom there appeared to be no reason for the taking of life is of interest. The relations and friends were surprised at what had happened: no one suspected that anything was wrong, even up to the last time they saw them. There is no obvious explanation for this, but Carothers (1948) refers to the episodes of attempted suicide as a cultural factor which he terms 'frenzied anxiety', in which those attempting suicide are of quiet disposition and their aggression is turned inwards. Perhaps this state may develop suddenly in one living in a new environment, different to the one he knew.

Lambo (1962) speaks of a 'malignant anxiety' which appears to be very similar to the 'frenzied' one of Carothers. However, in the cases in which the cause of suicide was not known, there was no account of a preceding state of frenzy or acute mental confusion. But this acute disturbance in which an individual may run amok is well known, and there is on record a case of attempted suicide in a young man who believed he was possessed by his ancestral spirit (Gelfand, 1971).

The obvious increase in the number of attempted suicides in the towns, compared to the number in rural and traditional areas of Rhodesia, shows that the urban pattern is assuming a similar picture to that in Western society in which younger persons, usually female, involved in some of the acute problems to which people of this age are exposed, try to take their lives. Disappointments in love, arguments between husband and wife, mainly over fidelity and relative matters, seem to be the most pressing of these problems. Attempts or repeated attempts by those suffering from a mental aberration are apparently rare. The marked difference in the two series is nevertheless surprising. In suicides the cases are mostly male and of an older age group, whereas attempted suicide occurred mainly in a younger group, mostly in females. Except for a few who resort to the rope, it seems likely that most of the attempted suicides do not really want to die.

In traditional Shona society living in its own homelands, we find a very integrated society in which the group is united by a common purpose. If the members of a community are strongly bound to it and therefore to each other, the integration is deep. But if an individual is inadequately associated with the others, in taking part in the institution, he is said by Durkheim to be in a position of anomy (lawlessness) and if such a person takes his life, this is what Durkheim refers to as *anomic suicide*. Perhaps Durkheim's law of suicide might be quoted here: 'Suicide varies inversely with the degree of integration of the original groups of which the individual forms a part'. Therefore we might well explain the rise in attempted suicides in Shona society by the growth of western environment, pressures, especially individualism, the introduction of a new economy with which the African must comply, and the loss of their association with a stable integrated group of people. The more this process progresses, the more attempts at suicide can be

expected. Even in the present situation in Rhodesia, suicide and attempted suicide are much less in the African than in the white man, but the more complete the break with the traditional background, the more of these tragedies are likely to occur.

Summary

1. Although suicide is significantly less among the Shona-speaking people than in European society, no significant difference in the suicide rate between the Shona living in the Salisbury urban and periurban area and those in three selected Tribal Trust Lands was found.
2. The number of cases of attempted suicide was far more common in Salisbury than in the selected Tribal Trust Lands.
3. The frequency of attempted suicide among the European population of Salisbury was significantly greater than among that of the Shona.
4. Reasons for these differences are discussed.

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