SUICIDE IN KENYA: DETERMINANTS AND IMPACT ON THE VICTIMS AND THE FAMILY

By

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This Thesis is my original work and has not been presented for a degree in any other University.

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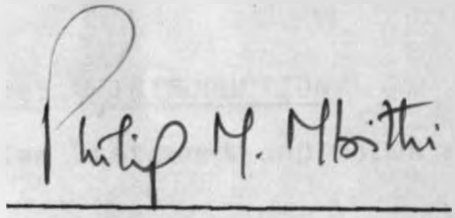
This Thesis has been submitted for examination with our approval as University Supervisors.



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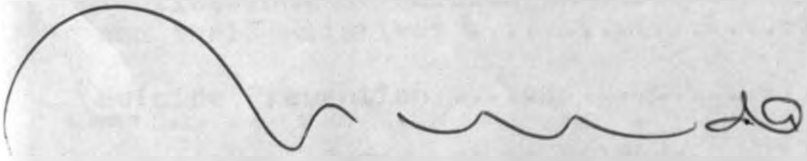

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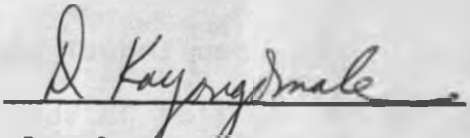

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A B S T R A C T

This study on suicide and attempted suicide was carried out in Nairobi. The main purposes of the study were (1) to investigate the extent and nature of suicide in Kenya in general and Nairobi in particular (2) to look at the relationship between suicidal acts and the African life style, that is, the extended family systems, polygamous marriages and place of residence (3) to investigate the relationship between current Kenyan social problems and suicide (4) to find out the impact of suicide on the family of the individuals committed suicide and finally to sensitize the Kenyan people to the fact that suicide is really a cry for help and its survivors need other forms of treatment rather than punishment.

The theoretical rationale of this study was that the determinants of suicide are multifactorial as possed to deterministic. The latter holds that human beings are subjected and subservient to some powerful forces over which the individual has no control.

The study covered a 5 year period (1975-1979) and included:-

(1) 203 individual cases of suicide reported in the newspapers (Daily Nation) during 1975-1979;

(2) 56 cases of individuals who had killed themselves as shown in police records;

(3) 117 individuals who had attempted suicide;

(4) 79 individuals as a control group;

(5) 30 cases of family members or relatives of individuals who had committed or attempted suicide; and

(6) 25 case studies of individuals who had attempted suicide and 5 cases of individuals who had succeeded in killing themselves as reported by their relatives;

Purposive and stratified random sampling techniques were used to arrive at the samples. Multivariate tables and Chi-square tests were used to analyse the data.

The most significant finding of this study was that suicide is on increase in Nairobi and the rate of increase is infact higher than the rate of population increase. The rate of population increase in Nairobi during 1975-1979 was 7.5 per cent while that of the successful and attempted at that time were 300 and 550 per cent respectively.

The study also indicated that there were more suicidal attempts than successful suicides in Nairobi at the time. The majority of those who attempted suicide were found to be young, unemployed, had some

formal education and were married women, most of whom were housewives. The majority of those who succeeded in killing themselves were older, employed and most of them were married men.

In addition to that those who attempted suicide came from places far from Nairobi (long distance migration) and were generally dissatisfied with their marriage, occupation, income, education, place of residence and life achievement. The individuals who succeeded in killing themselves came from places near Nairobi (short distance migration) and either stayed alone or with their ralatives, while those who attempted suicide either stayed with spouses and children or parents and relatives.

The majority of those who attempted suicide did so because of poor relationships with spouses, disagreements with parents, losses and mental and physical problems. Those who succeeded in killing themselves did so because of problems with spouses, unemployment and poverty.

The methods employed in suicide varied with the type of suicide. Those who succeeded in killing themselves used violent methods while those who attempted to do so used non-violent methods. The items used depended on availability.

The majority of individuals who were involved in suicidal acts did so during the months when there was shortage in protein and calorific food supply and

the periods of peak labour demand in most parts of Kenya. The months were found to be January-March; July-September; October-December for attempted suicide and April-June and October-December for successful suicide.

The findings showed that very few of those who attempted suicide had attended the psychiatric clinic at Kenyatta National Hospital when referred. The majority of the relatives of suicide victims tended to be resentful of the victims and felt that they had been let down.

In conclusion, this study has shown that suicide is on the increase in Nairobi and this, has nothing to do with population increase of this city. It has also shown that factors that may lead people in Kenya to commit suicide are varied including poor family relationships, unemployment, the African life style and losses. Throughout the study, suicide came out as a way of communicating problems while infact creating many more problems for the family members left behind.

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INTRODUCTION

> "But to enumerate these things were endless: I have given the rule, where a man cannot fitly play his own part. If he have not a friend, he may quit the stage".
>
> Francis Bacan, 1607.

PROBLEM STATEMENT AND FOCUS OF THE STUDY

Suicide in the developed world has been thoroughly searched and a number of observations made. It has been observed that the motives and causes of suicide are multifactorial. Thus situations of unemployment, poverty, family disorganization, abuse of alcohol, strained relationships, loneliness, loss, overcrowding, ill health, mental illness, physical pain, deformity and other forms of deprivations may lead one to suicide.

There is general agreement that suicide is a highly condemned act and its victims get very little support and sympathy from the community. Although suicidal acts may be considered by some as way of communicating problems by certain individuals, they have also been seen as immoral by the society and the church. The society has denied such individuals burial rights and the state has punished them; all aimed at deterring the behaviour (Durkheim, 1968). Thus, in most societies the individual appeal of suicide has been

countered with humiliation and punishment by the society. To this Kagwa (1965) states that because of the lack of psychiatric orientation in education, police and welfare services, suicidal cases are treated as criminals and thus end up in prisons. According to Bohannan (1960), although in African societies suicide is recognized, it is believed that only supernatural interventions can place a person in that situation. Hence suicidal acts are considered as irrational acts and not volitional. In Africa the suicidal act is also looked at as a contagious disease as a result the tree or the hut on which suicide is committed or attempted is destroyed or burned. The body of a suicide victim is feared and no member of the same clan is allowed to touch the body lest its ghost enters him and he is also tempted to commit suicide. Orley (1970) found that among the Baganda, the body of a person who has committed suicide is hastily buried in the bush far from the homestead or traditional burial ground in a disrespectful manner and nobody can inherit any belongings from such a person. Orley's observation also holds true for some parts of Kenya. In Kenya, those individuals who have attempted suicide are taken to a court of law and charged with an offence of trying to kill themselves. In Kenya the Penal Code states that any person who attempts to kill himself is

guilty of a misdemeanor (The Penal Code, 1962). Although considered to be less serious than say a felony, the offender may be imprisoned for a maximum of one year. In most cases, however, they are put on probation. But even in those countries where the states no longer punish the suicidal survivors, the survivor is still regarded by the public as having either not carried out his suicide properly or not having been serious in his suicidal intentions (Douglas, 1967). Thus the public seems to take it for granted that the sole aim of the genuine attempt is self-destruction and so the dead one is successful while the survivor is unsuccessful. Consequently, the survivor is looked upon with scorn and sympathy for having failed in what the public considers a brave undertaking. Different survivors get different reception and sympathy from different sub-cultural groups. Thus in Ramon, et.al (1975) nurses were found to be generally more sympathetic to the survivors than the doctors who only showed sympathy to the depressed and professional survivors. Both the depressed and the professional suicide survivors were considered by the doctors to have been genuine in attempting suicide, since depression was seen as an illness that could lead one to suicide while a professional person was seen as a rational

person who must have a reason for trying to kill himself. The doctors must have considered the other categories of survivors to be manipulative and hence may not necessarily/been genuine in their attempts./have

Suicide is a world-wide phenomenon, although its rate has been changing over the years and varying from one country to another. With improved preventive measures on suicide and the disappearance of toxic domestic gas from British households, the British suicide rate has fallen from 12 to 8 per 100,000 people, while the suicide rate in United States of America has been on increase from 10 to 12 per 100,000 people, (Shneidman, 1976; Resnick and Hathorne, 1974; Stengel, 1967). Stengel (1967) feels that neither the development of scientific medicine nor the rise in the standard of living enjoyed in developed nations has curbed the loss of life through suicide. These conditions, it is felt have increased the tendency to self-destruction, an important cause of death which is potentially preventable. Thus the statement can be illustrated by the fact that in 1965 Sweden had a suicide rate of 18.9 per 100,000 and in 1967 this rate had gone up to 21.6 per 100,000 leading to 25 per 100,000 by 1970 (Shneidman, 1976, Resnik and Hathorne, 1974; World Health Organization 1968). According to Shneidman,

the high suicide rate in Sweden has been attributed to the consequences of an over-developed social welfare system (Shneidman, 1976). Apparently, in Sweden, the highly developed social welfare, where the state takes over individual responsibility from cradle to grave, has led to the alienation of the individual in handling his affairs. This in turn has led the individual to self-destructive activities since he sees no meaning in living with everything being done for him.

In developed nations, the total number of people who attempt suicide has been on increase and has been estimated to be 6 to 12 times that of successful suicide (Stengel, 1967). The suicide rates have been noticed to be higher in urban than rural areas in most European countries with the exception of Holland where the reverse is true (Sainsbury, 1955). In developing countries, Kenya included, suicidal acts are said to be rare practise and its incidence largely unknown (Asuni, 1962; Swift and Asuni, 1975; Bohannan, 1960; Farber, 1968; Kagwa, 1965; World Health Organisation, 1974). To this Farber (1968) argues and notes that in countries where it is customary for neighbours to help each other as it is in the developing countries and where there is rapid development the rate of suicide tends to be low. Other studies attribute the rarity of suicide in developing countries to the

fact that depressive illness is in developing countries not accompanied by feelings of guilt, unworthiness and self-reproach which may lead to the tendency of self-destruction (Asuni, 1962; Kagwa, 1965). But general consensus has it that suicide rates may be lower in developing nations because very few investigations have been done on suicide in these countries and so very little is known(Swift and Asuni, 1975; Bohannan, 1960; World Health Organisation, 1974). Bohannan (1960) had the following to say:

> "With the exception of a few studies, it seems fair to say that suicide situations in primitive societies are open to investigation, but have not been investigated. So we do not know what the suicide situation is in primitive society".

Inadequacy of suicide investigations in Africa may not be accidental considering that early studies on psychiatric illnesses showed very low prevalence in Africa (Carothers, 1953). Hence it is possible that suicide in Africa has been conceived in similar perspective. Nonetheless, it has not been long before the researchers have established that psychiatric diseases were actually in abundance in Africa (Tooth, 1950) and were under-reported because virtually all the earlier studies quoted above were based on hospital statistics.

Thus ignoring a large number of mentally ill people who never sought hospital treatment or came to the attention of the police or local chiefs for referral to the hospitals and yet continued to suffer silently. Further, it has been shown that in developing countries only violent patients get admitted to mental hospitals (German, 1969, 1972; Ndetei and Muhanji, 1979; Sidandi and Acuda, 1979). Therefore, it is quite possible that suicide being one of the psychiatric disorders is in plentiful in Africa, except the researchers have not given it adequate attention. With strong stigma attached to most psychiatric disorders, suicide included, it is quite possible that suicide would be underreported in Africa. Therefore, the presumed rarity of suicidal acts in Africa may be due to lack of systematic study of the problem as well as the stigma attached to it.

Thus while a lot of research work has been done in developed world on suicide, very little has been done in Africa. In Kenya, no significant study has been done to date and it is not known whether the observations that have been made in developed countries can hold true here. Besides with the scientific revolution and the technological advancement that have been penetrating Africa, insecticides, cleaning fluids and other poisons and psychotropic drugs have been getting

their way into Kenya and are now available in most households where they can be readily used. Therefore, it is only proper to find out how the abundance and the easy availability of the poisons and drugs have affected the incidence of suicide in Kenya. As such the first purpose of this study was to investigate the extent and nature of suicide in Kenya, mainly in Nairobi.

While the magnitude of the problems remains largely unknown, the few studies done in Africa to date tend to show that suicidal acts centre around the motives and causes found/other parts of the world. These/in include problems of relationships, prolonged illness, mental illness, loss, shame and other forms of frustrations in life. Nonetheless, impotence among men and infertility among women tend to figure more prominently in suicide in African society than in other societies. (Bohannan, 1960; Orley, 1970; Stengel, 1967). Considering that only two studies have so far been done in Africa, it is important that more studies should be done not only to determine the suicide rates but also to identify those factors that are involved in suicide in Africa. Therefore, the second purpose of the study was to look at differences between suicidal acts and the African life style, such as the extended family systems, polygamous marriages and place of residence.

In Kenya's transitional period, the major problems that have been emerging include crime, poverty, overcrowding in towns, family disorganization, unemployment, increasing individualism and alcohol abuse. Studies have indicated that societies where people keep to themselves (individualism, isolation) and those with few hopeful avenues and where there is inadequate self-discipline, suicide tends to prevail (Durkheim, 1951; Farber, 1968). Therefore, the third purpose of this study was to investigate relationship between suicide and current Kenyan social problems such as unemployment, family disorganization, that is, separation, divorce and marital problems, rural-urban migration and alcohol abuse.

According to literature, suicide is a highly condemned phenomenon. Suicide is seen to be an act of finality to the victim and often has a lasting effect on the relatives. The mourning processes of individuals who have committed suicide are different and help often accorded to the family is often not forth coming. Besides the moral support and the sympathy the relatives of the dead person expect from their kinsmen are hardly visible in situations where one has killed himself. Yet nobody knows what happens to the relatives of those individuals who kill themselves. Therefore, the fourth purpose of this study was to find out the impact suicide has on the family of individuals who commit suicide.

Several studies done in developed countries have reported that the survivors of suicide in most cases are not motivated to accept services offered. In most cases they remain uncooperative after their discharge from the hospital and at times even become hostile and ambivalent towards hospital or medical intervention (Bridges, et.al., 1966; Greer, et.al., 1967; Morgan et.al., 1976). Besides these individuals have the tendency to repeat suicide at times resulting in their death (Bagley, 1971; Dahlgren, 1945; Ettlinger, 1964; Pokorny, 1965). In Kenya, little is known of what happens to individuals who attempt suicide. Nonetheless, although in the developed countries, the states have recognised the "cry for help" nature of suicide and in fact terminated the laws that stressed the criminal nature of suicide, such changes have not been made in Kenya and individuals who survive suicide are still punishable by law. Thus the final purpose of this study was not only to find out what actually happens to the individuals who survive suicide, but also to sensitize Kenyan people to the fact that suicide is really a cry for help and its survivors need other forms of treatment rather than punishment.

Rationale:

Although researchers in developed countries have established that suicide is a "cry for help" and individuals who engage in suicidal acts are actually

alarming others of their problems, in Kenya, suicidal acts are still punishable and the appeal function of suicide seems not to be recognised. Hence it is not uncommon to read in the local newspapers that an individual who has attempted suicide has been either put on probation for 24 months or imprisoned for 18 months. Since no study has been done in Kenya it is possible that most people, especially the planners and the law executors know very little about reasons that lead people to suicide. As such it is hoped that this study will actually create some awareness of suicide situation in Kenya. Hence the educating the planners, administrators and law executors about the problems that make people commit suicide.

Kenya has been going through rapid development and in turn many changes have been taking place. These changes have brought urbanization which in turn has created other problems like unemployment, migration, over-crowding, loneliness, alcohol abuse, family disintegration, alienation and many other problems. Kenya has also experienced some technological advancement and the devises used in suicide like gas, poisons, drugs, guns and the like are now plentiful and readily available. It is important to know how all this has been affecting the people.

Therefore, this study may shed some light as to how these changes have affected Kenyan people.

Observations have been made that most people who attempt suicide hardly seek help after their attempts. In most cases individuals who attempt suicide remain uncooperative after discharge from the hospital and at times even become hostile and ambivalent towards hospital or medical intervention (Bridges, et.al., 1966; Greer, et.al., 1971; Morgan, et.al., 1976). Besides, these individuals have the tendency to repeat suicidal acts leading at times to their deaths (Bagley, 1971; Dahlgren, 1945; Ettlinger, 1964; Pokorny, 1965). Therefore, it is important to find out what actually happens to those individuals who try to kill themselves in Kenya in order to plan and work out meaningful programmes.

Suicide has remained one of the major causes of death in developed countries yet according to World Health Organisation suicide is one of the causes of death that is potentially preventable (World Health Organization, 1974). It is rather difficult to generalize the observations that have been made in other countries considering that no significant study has been done in Kenya. Thus this study will serve as a stimulant to other researchers to study in more detail the mortality and morbidity resulting from suicide.

The studies that have been done on suicide tend to show that suicide is on increase irrespective of preventive programmes developed in the Western countries. As such it is important to do studies of this nature in a different setting, mainly to be able to show the differences that may exist in different situations. Therefore, this study, it is hoped, would make some contribution to the study and management of suicide in general.

CHAPTER TWO

> "There is something in character of Everyman which cannot be altered. It is the skeleton of his character. Trying to change it, is like trying to train sheep to pull a car."
>
> G.C. Lichtenberg: Reflections, 1799.

REVIEW OF LITERATURE

Suicide has been viewed in many ways. It has been regarded as an expression of emotional distress or a cry for help. It has also been regarded as an expression of aggression against self or against significant others or as a result of mental illness. Most researchers see suicide as a human problem and observe that there is no period in history without its occurrences. To this Erwin Stengel has the following to say:

> "Suicide is ubiquitous. The belief that it does not occur in primitive societies has proved to be mistaken, there is no period in history without records of suicides. There are few if any individuals to whom the idea of suicide has never occurred," (Stengel, 1967).

The above statement normalizes suicide and sees it not only as an act, but as an idea that one can have without necessarily leading to overt self-destruction.

Causes and Social Factors Associated with Suicide

The causes of suicide are multifactorial - no one factor can explain suicide. As such most researchers in the field tend to look into factors associated with suicide rather than its causes. Besides these identified factors seem not to be conclusive as summarized in the following statement:

> "Besides the circumstances are almost infinite because they rather frequently accompany it. One man kills himself in the midst of affluence; another in the lap of poverty; one was unhappy in his home and another had just ended by divorce a marriage which was making him unhappy. In one case a soldier ends his life after having been punished for an offence he did not commit; in another, a criminal whose crime has remained unpunished kills himself. The most varied and even the most contradictory events of life may equally serve as pretexts for suicide, (Durkheim, 1951).

The above statement shows the complexity of suicide. This complexity has led researchers to associate the causation of suicide with social, psychological, mental and physical factors. At the social level, researchers of suicide have observed that individuals who commit or attempt suicide tend to have been through stressful experiences which do not arise from mental or physical illnesses. These include crises in personal and domestic relationships such as broken homes, marriages and love affairs;

loss of a job, loved ones and property; employment and financial problems; crime and fear of pursuit and prosecution; failure in life and the like (Batchelor, 1954; Davison, 1976; Harrington, et.al. 1959; Munro and Mc Culloch, 1969; Stengel, 1967).

The psychological explanation as to the causal factors of suicide is based on the individual's inborn wishes and his experiences in childhood (Munro, et.al. 1977; Sifneos, 1978: 483). They include situations where one involves in suicidal acts because one's wish to retaliate for real or apparent abandonment; one turns aggression inward, that is, one with the wish to murder another person ends up murdering himself; one attempts a re-union with a loved one who might have died; one dwells on rebirth fantasies and actually ends up killing himself to be born again and one has low-self esteem leading to self-punishment. (Munro and Mc Culloch, 1977; Resnik and Hathorne, 1974). Under the psychological factors one finds individuals who involve in suicidal acts because of personality problems. For example, individuals with impulsive behaviour have the tendency to kill or attempt to kill themselves (Shneidman, 1976).

Mental illness has been observed to be responsible for one-third of the cases of people who commit suicide (Stengel, 1967). According to researchers depression and schizophrenia can lead one to

self-destructive behaviour. For example, delusions in depression and hallucinations in schizophrenia may lead one to suicide (Barraclough, et.al., 1974). Under the discussion on mental illness, alcoholism has been observed to be another major cause of suicide. Individuals who abuse alcohol have been observed to commit suicide because they experience alcohol hallucinosis (imaginary voices abusing them and at times telling them to kill themselves) or because they get depressed after realizing that they have wasted their lives and hence it is not worth living. Nonetheless, alcoholism has been observed by researchers sometimes to be a symptom of underlying mental illness in particular, depression. In such a situation one engages himself in suicidal acts because of the underlying depression rather than alcohol (Shneidman, 1976).

At physical illness level, suicide has been observed to occur in situations where one has had a prolonged or chronic illness and therefore one wants to shorten one's physical pains or the state of uncertainty as to when one is likely to get well by actually killing oneself. Also in situations where one realizes that one has incurable diseases like cancer one may decide to kill oneself mainly to avoid the suffering and the state of hopelessness associated with such

diseases. Old age and many other forms of misfortunes like deformities can lead people to suicide (Barraclough, et.al. 1974; Stengel, 1967; Kreitman, 1973).

According to the few studies that have been done in Africa on suicide, the causes that have been identified seem to be at variance with what has been found in developed countries. In developed countries the causes have been stereotyped in terms of social disorganization, isolation, psychiatric, physical and other psychological problems. Such a stereotype does not exist in developing countries. For example, according to Bohannan's study the major cause of suicide among African women was found to be domestic strife of one kind or another, especially in polygamous families. Among the African men, he found factors like fear of loss of social status, fear of impotence, shame, revenge and vengeance to precipitate suicidal acts. In some cases he found that one could kill himself after a quarrel. In general, the causation of suicide was explained in terms of supernatural powers, in particular, ancestral or revenging spirits (Bohannan, 1960).

Suicide and Economic Factors

Studies have shown that social environments may include or perpetuate or aggravate the suicidal potential.

Observations have been made that suicide declines in periods of prosperity and full employment and increases during periods of business depression, unemployment and general misery (Dublin, 1963; Farber 1968; Henry, 1954; Sainsbury, 1955). Durkheim in his early work observed that economic crises have an aggravating effect on the suicidal tendency, for example, he states that the number of suicides immediately rose in Vienna when a financial crisis occurred in 1873 reaching its peak in 1874 (Durkheim, 1951). According to Durkheim when situations like economic disaster occur, individuals experience something like a declassification which suddenly casts them into lower state than their previous ones. The individual, it seems, drops quite a lot in this process and he has to start relearning new morals to cope with the new situation. Failure to adjust to the new life forced on them leads to suicide. Durkheim observed that the above is the same if the cause of the crisis is an abrupt growth of wealth and power (Durkheim, 1951). So situations where an individual finds himself with sudden wealth or power may actually lead one to suicide. Durkheim has the following to say:

> "Then, truly, as the conditions of life are changed, the standard according to which needs were regulated can no longer remain the same; .... The scale is upset; but a new scale cannot be immediately improvised. Time is required for the public conscience to reclassify men

> and things. So long as the social forces thus freed have not gained equilibrium, their respective values are unknown and so all regulation is lacking for a time,"(Durkheim, 1951:252).

Wealth according to Durkheim suggests the possibility of unlimited success leading to intolerable feelings of all limitations while poverty protects one against suicide because it is a restraint in itself. This observation suggests that sudden loss, that is, in terms of economic crisis and sudden acquisition of wealth with its accompanying power may actually weaken individual's desire to live while constant poverty, where one sees no way of extending his needs, hence being compelled to moderate his aspirations, may actually lead to individual's immunity to suicide.

Other researchers have tried to confirm Durkheim's observations and according to Henry's study, suicide tends to rise during the depression in business cycles and falls in prosperity (Henry, 1954). The study which was done in Chicago among various categories of American population showed that suicide increases during the final "pre-peak" half of business prosperity and only during years when the increase in the business index is very slight and not during years of 'abrupt' increase. In this study, the observations made by

Durkheim that abrupt speculative increases in the business cycle, that is, economic crises or prosperity interpreted in terms of the weakening of social control over behaviour and the unlimited desires were accompanied by increases in suicide were not substantiated. According to this study, during years of rapid rises in business index suicide tended to fall, and when suicide actually increased during the final phases of business expansion, the increase occurred mainly among women and not men. This trend was interpreted in terms of the lower status of females relative to males rather than the falls and rises of business cycle (Henry, 1954). According to Sainsbury (1955) suicide rates are increased by social conditions which lead to sudden fall in the standard of living and thus individuals who have the most to lose are the most likely to commit suicide. With these observations there tends to be a general agreement among researchers that conditions leading to economic insecurity such as unemployment, retirement, loss of the breadwinner and other general miseries increase suicidal tendencies (Dublin, 1963; Farber, 1968; Meer, 1976; Sainsbury,1955).

Suicide and Ecological Distribution

Research on the ecological distribution of suicide in the developed world has demonstrated that

suicide rates tend to favour the central business zones in the towns. Hence a number of studies have shown a correlation between high density and high suicide rate (Dublin, 1963; Henry, 1954; Kessel, 1965; Kreitman, 1973; Morgan et.al., 1975). The high density areas have been observed to be characterized by impersonality, lack of social cohesion and anomie leading to feelings of powerlessness and isolation. On the other hand suicide rates have been observed to be low in the periphery of the towns where life is supposed to be more neighbourly. In Meer's study, the suicide rates had no relation with central versus periphery. In her study done in Durban in South Africa, she observed that the suicide rates were higher in the poorer, lower-income, low education black residential areas characterised by slum dwellings while the more affluent, prestigious white zones in the city had lower suicide rates (Meer, 1976).

Research in the developed nations has also shown that suicide rates tend to be higher in urban areas than in rural areas (Bancroft et.al., 1975; Henry, 1954; McCarthy et.al., 1975; Sainsbury, 1955; Shneidman, 1976; Yap, 1958). The higher incidence of suicide in urban communities has been attributed to the greater risk of social isolation and anonymity of the life in big cities, compared with the closely-knit

village community. Thus Sainsbury (1955) observed that London had the highest suicide rate for the whole of England and Wales and in America he observed that the rates even increased with the size of the city. With the exception of Holland, where rural suicide rate is higher among the rural aged. Sainsbury interpreted the high suicide rates in the cities in terms of mobile populations, impersonality, transient relationships, minimal social cohesion, few shared values and common goals and isolation. He saw the communities in the rural areas to be closely knit with stable families and the individuals well integrated in the social order.

Studies done in western Nigeria did not support the above observations. The suicide rates were actually higher in the rural areas than in the urban settings (Asuni, 1962). According to Asuni (1962) the changes occuring in the region he studied were more disturbing to the rural than the urban community. Asuni saw migration to urban areas as a great disadvantage to the old generation. In the process of migrating to towns in order to secure employment by the young generation, the old generation tends to be left to their own resources in the rural communities and experiences isolation and loneliness,

a state that may lead to suicide. He also observed that the elders in the rural areas were starting to lose grips with the young generation and the young people were increasingly becoming dissatisfied with the old people. The extended family system, which was stronger and deeper in the rural areas was getting affected and this could explain the high suicide rates in the rural communities he studied.

In the same study, Asuni (1962) also noted that the social isolation experienced or stated by most researchers on suicide from developed countries was not prevalent in his region of study. He observed that even if one moved from one's home to the city, still one polarized according to the geographic origin. Therefore, one soon manages to establish other relationships described in terms of 'brother' and 'sisters'. Therefore, to Asuni, the design of African houses, the climatic conditions in Africa and the general patterns of the African lifestyle do not favour social isolation at all. To this he has the following to say:

> "Thanks to the generosity and hospitality of the Africans, a stranger is fairly and readily accepted and absorbed into a new community, especially if he speaks the same language ..... Doors and windows of houses are kept wide open and the living is more on an outdoor than an indoor affair,"(Asuni, 1962).

The observations made by Asuni are not peculiar to Nigeria, but exist in Kenya as well and need further investigation as it appears that some African values and life styles may actually have some prophylactic values against suicide.

Most researchers have observed that it is not the urbanization that may increase the rates of suicide, but it seems that some of the very undesirable features of urban life such as the large slum areas with degrading conditions are more associated with the breakdown of character which may lead to abnormal behaviour including suicide. These researchers tend to look at some of the effects the devastating environment may have in an individual and suicide is seen as one of the effects. According to Dublin (1968) the observation made above is hard to accommodate for several reasons. Firstly, maladjusted individuals who may be mentally disorganized with criminal and suicidal tendencies tend to be attracted to these very areas. Thus the anonymity of the big cities and the social disorganisation of the slum permit them to act out their irrational impulses. Secondly, the statistics of suicidal acts tend to vary greatly. For example, individuals from high income groups are over presented in successful suicide while those from low income groups are over presented in attempted suicide (Stengel, 1967).

Since the attempted suicide rates have been observed to be higher than the successful suicide rates, it is possible that the statistics for suicidal acts inadequately include individuals from higher income groups whose impulses and attempts to self-destruction may remain confidential and well covered. Such individuals are unlikely to attend public hospitals, and face trials in the court of law for suicide attempts and yet these are the places where the statistics on suicidal acts are often obtained.

Suicide and Age, Sex and Marital Status

The ages of those individuals who commit suicide tend to vary in western countries. It has been reported that older people make more successful suicide attempts. According to Durkheim (1951:100) suicide becomes more frequent as man advances in life. Thus quoting Legoyt's findings, Durkheim observes that from 1861-1875, there were in France per million children under 16 years of age 4.3 suicides by boys and 1.8 suicides by girls. According to Morselli, the figures were reported to be even lower in Italy, that is 1.25 for boys and 0.33 for girls (Durkheim, 1951). This led to the conclusion that suicide was extremely rare among the children. Thus according to Durkheim, suicide appears only in adulthood and tends to increase with the advancement of age. For example, from 1835 - 1844, there were per million adults over 65 years of age 274.2 suicides

by men and 83 7 suicides by women. (Durkheim, 1951: 101). Stengel (1967) observed that suicide rates of all persons aged 65 and / are almost 3 times as high /over as suicide rates for all persons in the age brackets under 45 years. On the other hand, the younger people within the age range of 25-45 years make more suicide attempts (Henry, 1954; Kessel, 1965; Kreitman, 1973; Stengel; 1967). Some researchers have stated that one of the reasons why developed and prosperous countries have higher suicide rates than underdeveloped countries is that life expectation is far longer in developed countries than in underdeveloped countries. Following this argument, one would expect higher rates of suicide attempts in developing countries than successful suicide rates. Asuni's study (1962) found no significant difference in age groups and so did not conform with other studies. According to Asuni (1962) the difference in age could not be explained in shorter expectation of life, but due to the fact that old age still commands great respect and the extended family grouping provides both emotional and physical support for the old. This made him conclude that in Africa there are other suicide-producing factors that may be different and needed to be looked into. It is possible that a low suicide rate

may conceal more human misery than is revealed by a high rate. However, according to Stengel (1967) the great medical discoveries of the time have benefited mainly the younger age groups and the diseases of the middle and old age still remain to be conquered. Thus the differences in life span in the developed and developing countries may still hold true especially when Asuni did his study. At that time the Africans over 65 years were probably too few for comparison with western countries where individuals over 65 years dominate.

Durkheim's early work on suicide observed that women were less likely to commit suicide than men and to every woman there were on the average four male suicides. The problem with Durkheim's observation is that he did not tell us in which category of suicide men are more represented than women. In most research done it seems that the sex composition of suicidal acts differs depending on whether one has committed or attempted suicide. Thus more women have been found to attempt suicide more often than men while completed suicide is more a masculine phenomenon in most developed countries. According to Whitlock et. al (1967) more women tend to attempt suicide as a reflection of higher incidence of neurotic illness in women; having fewer outlets

than men and are more lonely and isolated than menfolk who have opportunities outside to work out their domestic anxieties. The observation that more men actually kill themselves does not hold true in some parts of Africa where suicidal acts were mainly found among women (Bohannan, 1960) resulting from domestic problems while a smaller number of men committed suicide as husbands. Meer while studying suicide among different races in South Africa observed that among Africans women had higher suicide rates compared to their men counterparts (Meer, 1976). The study again was not explicit on the categories of suicide she was reporting. Nonetheless studies done in Africa tend to show that our women tend to participate in suicidal acts more than our men. The general observation that there is sex differences in suicidal acts has been changing. Thus Harrington (1959) in his study in Birmingham found that more than twice as many women as men were driven to suicide because of interpersonal conflicts. Yap (1959) observed that in Hong Kong, there was a high suicide rate among female and the curve rose sharply after the menopause. The explanation given was that culturally women are not permitted to retaliate against those who frustrate them, an explanation which has relevance in Kenyan situation. Stengel in his latest edition (1977) states that the gap between the sexes have been narrowing in some English cities implying that more women have been observed to kill themselves.

Suicide has been observed to be common among the single, widowed, separated and divorced individuals. Thus Durkheim quoting the early studies done by Bertillon and Morselli in the nineteenth century stated that marriage and family restrained individuals from suicide (Durkheim, 1951). Durkheim seemed to take Morselli's view that it is not marriage in itself that brings the suicidal immunity but the integrative force exerted on its members by the family. As such the frequency of suicide is not only less among the married, but it continues to diminish as each child is added to the family. He observes that childlessness may actually aggravate suicide among married women. This observation has been confirmed by researchers especially in Bohannan's study where he found that infertility has often led African women to suicide (Bohannan, 1960).

Although married persons seem to enjoy immunity against suicide, Durkheim observed that early marriages can have an aggravating influence on suicide especially as regards to men. That, it is only from 20 years onwards when married persons of both sexes enjoy some immunity against suicide But this immunity, he realized, changes with age and one may observe rise on suicide from 25 and 30 years (Durkheim, 1951). Widowed persons, Durkheim reported, committed more suicide than married persons but generally less than the unmarried

persons. Of all marital conditions he found divorce to be most distressing and married men in general found widowhood and divorce more distressing than married women. Comparing the findings from France, Italy and Sweden, Durkheim (1951) concluded that the man suffers when his marriage has to be terminated either through death or divorce. Durkheim explained this phenomenon that in most cases when women get married they gain less in marriage and during the dissolution of marriage they have little to lose Besides Durkheim saw married women as individuals whose sexual needs have less of a mental character because the women's mental lives are less developed! To this he has the following to say:

> "Being a more instinctive creature than man, woman has only to follow her instincts to find calmness and peace. She thus does not require so strict a social regulation as marriage",(Durkheim,1951:272).

According to Durkheim, the married woman's desires are limited. Thus what marriage has done to her is to instil restraint in her without any great advantages. Therefore, anything that makes the restraint flexible and lighter, such as divorce, widowhood and separation, can only better her situation. On the other hand Durkheim considered a man to survive the strictness able of marriage regime While he can get relief from the rigidity of marriage, the woman cannot. Hence when

marriage has to be dissolved, the married man becomes disadvantaged and becomes prone to suicide (Durkheim, 1951) Durkheim's observations tend to suggest that men whether in western or African society enjoy more privileges being married than their unmarried counterparts. They too enjoy these privileges in marriage more than married women These privileges have been observed to make married men more vulnerable to the extent that they may have the tendency to kill themselves in times of widowhood or divorce.

The observation that married men tend to be disadvantaged when marriage is dissolved or face problems is not appropriate in an African setting where married men actually enjoy privileges in marriage irrespective of its quality. For example, in Africa, a married man with, say, marital problem can easily pick up a second or a third wife and hence avoid committing suicide. Similarly, a divorced African man can easily acquire another wife with no stigma attached to his divorce An African woman in a similar situation having extremely restricted venues in marriage may actually end up killing herself. For example, the divorced African woman, may not see her divorce as something releasing her from all the burdens she had in marriage, but often is made by our society

to feel responsible for making her marriage fail To an African a "good woman" is the one who keeps her 'house together' (unites the family) irrespective of the behaviour of her husband. Hence in times of divorce or separation the African woman gets very little support and sympathy from the society, a situation that makes remarriages almost impossible for the African woman. This total rejection by members of the society may lead to isolation and guilt feelings and hence drive the African woman to suicidal acts.

Widowed and divorced persons with children were found to commit suicide less than those without children in Durkheim's study The study seemed to suggest that parenthood increases the immunity against suicide and the higher the family density the immunity against suicide. Durkheim's observation seemed to have been supported by Meer's study in Durban where she found that the immunity of women to suicide in marriage was derived from the state of motherhood (Meer, 1976).

The divorced individuals have been observed to have higher suicide rates than the widowed This difference may be explained in terms of social attitudes attached to divorce and widowhood. In cases where one is widowed, there is a collective attempt to give sympathy and support to one. According to Meer:

> "Although temporary in nature, the effect of public good will and positive sanction provides relatively permanent moral support. The widowed and orphaned, are subjects of public concern and sympathy", (Meer, 1976:83).

This state does not isolate the widowed hence throwing him to his own resources as has been observed by early researchers. In contrast divorce in most cases is exposed to public condemnation. Often the public opinion deplores divorce and blames the parties involved and even sociologists and psychologists have defined and analysed it as deviant behaviour, leaving no room for the sympathy and the support the divorced individual may need. Such an attitude enhances alienation and social isolation of the divorced individual and the individual may be exposed to suicide.

Although most suicide research tends to suggest that incidence of completed suicide among married people is low, Shneidman (1976) reports a study done by Worden, where it was found that most highly lethal attempts were in fact associated with those marriages in which there was emotional divorce and chronic inability to communicate with the partner. The partners were found to live together merely out of a habit. So far the studies done in parts of Africa are not clear on the above variables. Asuni (1962) found it even difficult to ascertain marital status

in his study as few people remain separated or divorced according to his observations.

Suicide and Religion

The degree of toleration of suicide in the society or the degree of its prohibition, contributes to either high or low rates of suicide (Faber, 1968). Thus in developed countries it has been reported that suicide rate is higher among Protestants than among Catholics or Jews or Moslems where suicide is not only highly condemned, but group support is provided and individual is not left very much to his own resources. Asuni's study did not support the above observation and reported that in fact pagans had higher rates of suicide than Christians and Moslems in Nigeria (Asuni, 1962).

By 1970s the role of religion on suicide became even more unclear and complex since it was realized that religious affiliations served both to inhibit and at times to facilitate suicide (Shneidman, 1976; Resnik and Hathorne, 1974). Therefore, although the individualistic Protestants tended to have higher suicide rates than others, the observation now has it that the differences in rates are the problems of research techniques. For example, McCarthy et.al. (1975) found that suicide was under-reported in Ireland,

one of the Roman Catholic countries with very low rates of suicide. Stengel (1977) observed that although, some Roman Catholic countries have low suicide rates other Catholic countries like Austria and Hungary are among the top five in the world with high suicide rates. As such religion is not seen as a reliable index in explaining the differences of suicide rates.

Thus according to researchers in the 1970s, the observations made that Catholic Church attaches individuals to the church as a social institution, providing emotional support which prevents tendencies to self-destruction, while the Protestant church detaches one by stress on one's own conscience, hence alienating him, are now appearing to be a myth. To Shneidman (1976) it appears that a person who is uneasy in his religion or in his irreligion or who changes his religion several times, is more likely to commit suicide not purely on religious ground but because of his general perturbation or lack of good self-concept. These observations made in developed world are very interesting and challenging and it would be equally interesting to find out what has been going on in Kenya in terms of religion and suicide. Meer (1976) in her study in Durban found that suicide was correlated to income and not groups. Thus the Hindus when compared to other religions like Moslems

and Christian actually tended to have higher rates of suicide. But when she compared different income groups within the Hindu group, she found that the majority of people with low incomes have higher rates compared with those with high incomes within the Hindu religion. This observation actually tends to indicate that religion alone may not prevent suicide and when considering suicide one has to search beyond it. In Kenya it is hard to make any observation as no study has been done.

Suicide and Seasonal Conditions

In temperate countries suicidal acts are at peak in late Spring and early Summer (Stengel, 1967). In Nigeria, it was found that suicide is at its lowest during May to July (Asuni, 1962). In Kenya, the observations made by the author at Kenyatta National Hospital tend to show the peak to be between February and March. The reasons for seasonal variations of suicidal acts are not well established in the literature. The only attempt by Farber states that in Japan many suicides are reported to occur when youths take their crucial examinations which determine their entire future lives (Faber, 1968). The early studies observed that suicides tend to occur during the time when there is maximum activity. Thus Durkheim (1951) found high rates on Mondays and Tuesdays which he considered in

his time to be the days of greatest economic activity in the week This explanation can be generalized in temperate countries where one gets extreme weather changes. During Winter, one would expect inactivity because of severe cold weather, but as Spring approaches one would expect the beginning of activities as the weather gets warm and nature starts to spring. It is then possible that a depressed person may actually not realise his misery during winter as the winter itself appears miserable, but during Spring with its jovial mood, a depressed person may actually realize that he cannot keep up with the pace of the activities and may decide to end his life.

The above observation is indeed uncertain in developing countries, Kenya included. For example, among the patients who are seen at Kenyatta National Hospital with suicide attempts, the majorit of them were students under 20 years (Muluka and Acuda in press). Therefore, it is possible that a large proportion of suicidal acts in Kenya may be school leavers or students who are either waiting for their examination results or have dropped from schools and have lost hope for the future. Hence the attempts may be related to those months just before the results for examinations are out especially when a student suspects that he has failed and during the times they learn that they have failed.

Methods Used in Suicide

Durkheim in his studies on suicide observed that the choice of means of suicide like the cause of suicide was determined by social factors. Thus according to Durkheim (1951) the choice of a particular method in suicide is primarily determined by availability of the means and current cultural conditions. Therefore, hanging is more common in rural communities than in the city and is more common in smaller cities and towns than in larger ones. This observation tends to suggest that the methods used in suicide depends very much on the technological advancement of a particular country. Hence one would expect less violent methods in advanced communities while violent methods would be favoured in less advanced communities. Research done in this area is not conclusive. However, quite a number of studies have supported Durkheim's observation and they tend to stress the fact that the methods used in suicide vary a great deal. These methods are not only related to the advancement of a particular society, but depends much on the type of suicide. Thus in fatal suicide more dangerous and violent methods are used while non-fatal groups (suicide attempts) use less violent methods. These researchers have indicated that in attempted suicide poisons are mostly used while in fatal suicide hanging, shooting, drowning and domestic

gas are commonly used (Kreitman, 1973; Stengel, 1967). The researchers have also observed that in developed countries men use more violent methods than women. Therefore, the use of guns, knives and other dangerous weapons is known to be among men. The problem with this observation is that it is in these same countries where men tend to kill themselves more than women while the majority of women tend to attempt suicide. This naturally means that if men have to kill themselves then there is a need for the use of more violent methods for them to succeed, while the women in their attempt to call for help (using suicide as a cry for help) may actually use less violent methods as their intention is not to kill themselves.

According to Dublin the methods used in suicide are determined by culture, social status, profession, education and economics (Dublin, 1963). Thus according to Dublin, poor and uneducated people tend to use substances that are inexpensive and readily available such as cleaning fluids, insecticides and rat poisons, while the educated and sophisticated people generally turn to barbiturates. In African studies the methods used tend to be those devices available and familiar to local situations. Thus the studies done in Africa found that hanging, shooting, stabbing, burning and drowning are quite common (Asuni, 1962; Bohannan, 1960;

Meer, 1976). In Africa violent methods are used irrespective of sex. But with that it seems that the suicide methods are changing with the general development taking place in Africa. For example, in Kenya, none of the patients seen at Kenyatta National Hospital tried to commit suicide with a rope. All of them either used insecticides or iodine or commonly available psychotropic drugs such as valium, antidepressants and barbiturates. Other methods that have been observed in Africa are jumping from heights, lacerating and jumping from or into moving vehicles and trains. This again is related to the advancement that has been taking place in Africa especially the availability of tall buildings, knives and razors; improved forms of communication and the like.

In developed countries the easy availability of drugs was found to be a major factor in determining the method used in suicide. Thus Kessel (1965) illustrating his disappointment at the easy access to drugs, gave an example of a sobbing girl who managed to obtain 200 asprins from 6 chemists shops she visited within a mile of each other in Edinburgh and Ettlinger et al (1955) in their study highly recommended that only small amounts of drugs should be prescribed to patients. The easily availability of domestic gas in most homes in the cold countries also led to the

coal gas being the commonest method of committing suicide until the psychotropic drugs became easily available, then drugs especially the antidepressants became the commonest method.

Implications of Suicide on Victims and their Relatives.

Suicide has been viewed from varying perspectives by different groups and from time to time. At times suicide has been seen as an individual's right and individuals like Cicero and Stoics (Resnik and Hathorne, 1974) maintained that a man was a master of his own fate and has to choose his own way of dying as he chooses his way of living. Although suicide was allowed, they observed that an individual should not kill himself in order to escape suffering. There are those who hold intermediate positions in relation to suicide and see suicide as an act acceptable where an individual feels humiliated. This group felt that in situations where one finds life unbearable either through misfortunes or defeat, one can actually kill oneself. Individuals like Socrates could accept suicidal acts in situations where an individual has to maintain his honour in case that individual has to lose all that he has established throughout his life. Therefore, suicide was indeed allowed under extreme conditions and it could only be

condemned if it was used to show violence to another person's free will.

Yet there are those who view human life as sacred and therefore, feel that life should not be tempered with, hence they highly condemn suicide. During the Greco-Roman era, suicide was condemned because the act was seen as an abandonment of God's and civic responsibility (Resnik and Hathorne,1974). So suicide was seen as depriving the state of soldiers and other useful members of the society. Most religions in general, tend to outrightly condemn suicide with strong belief that life comes from God and therefore only God who gives it should take it. If suicide occurs, it is considered a sinful act and the victim is assumed goes to hell after death. In most religions the burial rights of a person who has killed himself are modified and in certain situations the church may actually refrain from the participation in the burial.

However, there are some few religions and religious practices that indeed encourage mass suicide. For example, the Buddhism encourages suicide through its practices of resignation and withdrawal. The recent mass suicide among a religious sect in new Guyana is one of the few examples where religion actually promoted suicide.

Whatever views people hold about suicide, it seems that suicide in most societies, according to literature tends to disturb the societal homeostasis and as such it is a highly condemned phenomenon. According to Swift and Asuni (1975):

> "Suicide is an act of terrible finality for the victim and often has a lasting effect on the relatives since many people blame themselves when a friend or a relative commits suicide."

Orley (1970) reporting his findings on suicide among Baganda in Uganda, states that Baganda people consider suicide to be 'a most terrible act'.

With condemnation or no condemnation, an area of concern would be "what happens to those individuals who survive suicidal attempts as well what happens to families and relatives of those who have attempted and committed suicide?"

Survivors of Suicide

In developed countries, individuals who have not succeeded in killing themselves are often taken to the hospital for treatment after which they are referred to psychiatric clinics. In these countries there are ample centres where individuals who have tried to kill themselves are referred to for counselling. In Kenya the survivors of suicide sometimes are either taken to hospital directly or are taken before a court

of law charged with an offence of attempting to kill themselves. The main reason for taking the victim to hospital in Kenya seems to be either to save life if the attempt was serious or to help the victim avoid the arrest by police and subsequent charges in court. Among the suicide attempters who presented at Kenyatta National Hospital between February and March 1977 only one ended up in court and was put on probation for 6 months. The rest of the cases were well protected by medical personnel who dischargedthe patient with diagnosis of "accidental poisoning" rather than suicide attempt. Because of the punishment associated with suicide in Kenya, some of the suicide cases admitted at the Kenyatta National Hospital, vehemently denied the fact that they tried to kill themselves and claim the act was accidental (Personal experience), although very high doses of insecticides had been found in the stomach wash outs and blood system. Although in most countries suicide is no longer an offence, in Kenya the act is considered an offence punishable by the laws of Kenya.

In general the fate of people who have made suicidal attempts is quite gloomy. In Kenya as stated above one faces the law and hence punishment, otherwise one perishes because of the medical scene, since there is very little follow up system (personal experience).

In developed countries, although there are preventive programmes like the samaritans and suicide preventive centres, where the telephone system and other forms of methods of interventions are used, most survivors of suicide tend to repeat the act resulting at times to fatal outcome. According to Wold et.al. (1973) the current suicide prevention activities are based largely on the mode of crisis intervention. These preventive measures tend to be limited since the causes of suicide at times fluctuate and at times there is confusion on emergency crisis or risks, that is, the danger of immediate acts of irreparable destruction with suicide risks and the chance that the caller may commit suicide in the future (e.g. making 40 calls to the centre). Observation at one of the Samaritans' Centres in London, shows that the centre's original objective that is suicide prevention, has changed and the centre now caters for all forms of problems for example the 'Brenda System',[1] (personal experience).

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1. 'Brenda system' is a programme within the Samaritans where individuals with sexual problems are talked to over the telephone and are advised to seek help by special trained staff known as "Brenda girls".

Follow up studies have shown that the incidence of suicide among people who attempt suicide is far higher than in general population (Bagley, 1971; Dahlgren, 1945; Ettlinger,1964; Pokorny, 1965). Dahlgren (1945) found that 10 per cent of the patients she studied had killed themselves within 10 years of their initial suicidal attempt. After a 12 year follow up, Ettlinger (1964) found that 13.2 per cent of her sample had committed suicide. Greer et.al. (1967) found that 37 per cent of the patients studied had made at least one further suicidal attempt within 4 years. These observations are hard to accept, but they do indicate that individuals who attempt to kill themselves succeed in killing themselves.

The interval between the first suicide attempt and the repeat of the act varies a great deal. Kessel et.al. (1965) found that repeated episodes tended to occur shortly after the initial episode and is usually within the first 2-3 months. Morgan et.al. (1976) found that further act of deliberate self-harm was committed by 26 men and 41 women within 12 months of the initial attempt, while Pokorny (1965) reported that the period of highest risk for further attempt was the first 2 years following the initial suicidal behaviour. This led Pokorny to conclude that suicidal behaviour is one of the strongest indicators of future suicide; therefore more relevant than psychiatric

diagnostic grouping as a predictor of future suicide.

Although psychological adjustment and the factor that influence outcome of suicidal acts are less well documented, it has been observed in developed countries that most patients who attempt suicide fail to cooperate with treatment, a situation which makes the work of a mental health team and anybody offering services to the suicide survivors most difficult. Bridges et.al. (1966) found that 13 per cent of their sample studied failed to cooperate with treatment. Greer et.al. (1967) found that 33 per cent of patients in their follow up study had ambivalent or hostile attitude towards medical intervention while Morgan et.al. (1976) found the patients studied to be poor in keeping appointments and in 155 patients offered treatment only 68 patients completed the treatment.

Patients' failure to cooperate with treatment is disheartening especially when some studies have shown that patients who only had one or two interviews after attempting suicide, tended to be worse than those of more intensively treated (Greer et.al. 1971). In his study 37 per cent of the untreated patients made further attempts and 45 per cent killed themselves within 18 months a thing that made Greer and his associates conclude that the untreated patients are particularly

vulnerable to repeat and increase the probability of eventual suicide. These studies actually tend to suggest that most survivors of suicide end up killing themselves irrespective of the availability of psychiatric services in developed nations. This is consistent with the fact that if suicide attempts are meant to be a cry for help, then the improvement of the environment under which the victim lives needs to be a priority, if the victim has to survive. Failure to go for treatment because perhaps lack of motivation, the environment remains unmodified leading to the survivors' subsequent attempts or death. Studies in developing countries, Kenya included are not clear on what actually happens to survivors of suicide and needs to be looked into. But rough observations made at the psychiatric clinic at Kenyatta National Hospital indicate that less than 5 per cent of those given appointment to the psychiatric clinic after ressucitation at the casualty keep their appointments with the psychiatrists (Prof.Acuda's and Dr. Mengech's personal experience).

Family Members of the Survivors

For the family members of attempters, the act may call for a change of attitude towards the victim member leading to reshaping and changing the family relationships. This evaluation of family systems in

general, may enhance family solidarity and subsequent harmony in the family. This process may be entirely different to the family members who actually have lost a member through the suicidal act. One would in actual fact expect a total life change for those who are left behind in a successful suicide.

The family members of the deceased often face practical problems informing relatives and friends of the deceased about the death. They also arrange for the burial and later plan how to organise the finances and property of the deceased. In normal circumstances, the resources of the neighbours, relatives, friends, the church and sometimes the entire clan or the community are mobilized to help the family members in the above arrangements and plans. The mourning and burial process of someone who has killed h' self often does not follow the above pattern in most societies according to literature. For example, according to Orley (1970) in Uganda and some parts of Africa, a person who has killed himself is buried hastily and relatives are usually not willing to inherit from him. His body is considered to be contagious and he is supposed not to be touched unless under special conditions. The dead man is supposed to be shown disrespect and in some cases as among the Baganda in Uganda his property is burnt (Orley, 1970). One would agree that the dead person actually does not

live to experience the disrespect often shown to him. Therefore, he is not directly affected The people affected with this disrespect are the family members who have to bear the shame that one of their members has killed himself Besides, it is the family members who have to bear the burden of actually burying the man and burning his property. This whole process is anxiety-provoking and generating in the family members. It may put the family members in an extreme awkward situation when they have once more to meet their friends and other people after the burial.

According to Johnson (1973) the external support the relatives of a dead person get is not forthcoming in a situation where one has killed himself. The neighbours and relatives may be sensitive about the way individual died and they may even feel that the family drove him into it and hence be unable to offer genuine sympathy. This process leads to mutual avoidance where the neighbours, relatives and friends gossip about the death and fear meeting the family members of the deceased in case they mention something they are not supposed to say. On the other hand, the family members may be so ashamed and upset that they may be unable to accept support when it is offered.

This way they are unlikely to be confronted by the relatives and friends asking them what had happened Unfortunately, this mutual avoidance, in most cases, leaves the family members very much alone, depending quite a lot on their own resources.

The family members of an individual who has killed himself do not only shut themselves from relatives, friends and neighbours, but often get haunted in their minds with numerous questions as to why one of them had to kill himself. In attempt to explain the event, the family members may have the tendency to blame one another. So the expected mutual support within the family members may be absent. This family feud may lead to a family member committing suicide in an attempt to expiate guilt or identify with the deceased.

The family members of an individual who has committed suicide deal not only with death and the accompanying grief and mourningprocesses, but with the very special inheritance of "death by suicide" This legacy will be handed on down to generations to come and its consequences are indeed familiar in times of marriages and any other forms of family associations To the professionals, the family is seen as having been unsupportive to the deceased, having poor relationships and inadequate communication networks or has inherited some form of a depressive

illness leading to suicide. To the laymen, the family must have had a curse from the ancestors or are paying for their ancestors' sins or the family is unfortunate. To the family members, someone may be bewitching them to the extent that they may accuse the relatives or friends for being responsible for the misfortune or hold themselves responsible for the death of the deceased. Whatever it is, it seems that nobody in developed and developing countries Kenya included, regards suicide as a natural form of death and therefore, someone must be held responsible for the causation of the act. In most cases it is the family that gets the responsibility for causing the death.

According to Goffman (1961) stigmatization creates some sort of a class based on inferiority mechanisms. The stigmatized individuals are made to feel less human, hence reducing their chances of enjoying living. This happens because the stigmatized person is unsure of how the 'normal' will identify and receive him. The uncertainty of the acceptance by the 'normal', limits the stigmatized person in his social interactions and associations, as he is often never sure of what the attitude of the new acquaintance will be. In a situation where one has killed himself, his relatives become unsure as to how they will be received by others in the

society, since suicide is one of those acts stigmatized in the society. This in a way creates a conflict to a relative of the deceased in self perception and how he thinks others perceive him. The discrepancy of identity may actually lead the relatives of the deceased to isolation since they may feel and see themselves as not being accepted by the world around them.

In most cases the family members of those who have either committed or attempted suicide have to be confronted with the police and the coroners for investigations. This confrontation is often unpleasant as the investigations often start with suspicion of some foul play. This approach only helps to reinforce the guilt feelings of the family members and actually leads to the under reporting of suicide as the relatives have to protect themselves by denying that there was any suicide.

In psychological terms, mourning is therapeutic in a sense that participation in the process of mourning relieves one of some stressful feelings one has after the loss of a loved one. Failure to do so has been shown to lead to guilt feelings and depression. Apparently in some parts of Uganda and West Africa the mourning processes of those who have killed themselves is very brief (Orley, 1970; Swift-

and Asuni, 1975). This form of mourning does not provide the relatives of the deceased with the opportunity to express their feelings hence releasing the steam of grief from their body system. On the whole burial and accompanied ceremonies are too brief and some relatives especially the junior members of the family may not even be allowed to attend. While one could argue that this form of burial would be economic for some African tribes where the mourners have the tendency to feast during the funeral period, it is worth observing that it can be detrimental to the effective functioning of some family members in the long run. Nonetheless, research on the effects suicide has on the family is inconclusive in Africa and demands for an exploration if the family members have to be helped.

Suicide Prevention

In most developed countries factors that can lead one to kill or want to kill oneself have been identified. For example, Kessel (1965) clearly indicated that the majority of suicidal acts tend to rise from strains within that setting which may be the family, the extended family group and the community as a whole. Since interpersonal relationships are involved, Kessel feels that it is important to thoroughly identify the three areas in relation

to suicide with an aim of finding the area of emphasis. It has been recognised that the suicidal acts are apparently an effective way of communication and like war, it is an attempted solution to an otherwise insoluble problem (Moss, et.al.1956). Stengel (1967) on the other hand, states that suicidal acts at times are seen as the most possible way an individual can exercise his freedom without interference in a sense that most people may derive comfort from the thought that they can kill themselves if life becomes impossible and cannot be tolerated.

Specifically Kreitman (1973) summarises that individuals trying to destroy themselves do so to relieve themselves from stressful situations, that is, loneliness, loss of a dear one, prolonged illness and the like; to try to secure attention of other people in their immediate environment; as a means of making others around them feel anxious or guilty and a way of expressing aggressive feelings on others; as a means of testing the benevolence of fate as in adolescents and as a way of killing oneself if life has proved intolerable. All these conditions, as observed by researchers, can be prevented and attempts have been made in developed countries to prevent them. The preventive work in developed countries is based on crisis intervention. Thus in Britain one gets the

Samaritans and in America there are suicide crisis centres. As reported by Wold (1973) most of these preventive services are indeed limited mainly because of the nature of suicide itself. It is extremely difficult to establish an emergency case as in certain cases people who may call for help may turn up to be individuals with personality disorders and the tendency to abuse the services offered. Likewise, genuine suicidal cases may be denied the services in the confusion of classifying them as personality disorders. Besides one needs motivation to take the services offered. Apparently in suicide such a motivation is not common.

With the above limitations, tangible observations have been made in the developed nations that can lead to accurate assessment of an individual likely to engage in suicidal activities. For example, it has been observed that individuals who commit suicide often give a warning of their intention to kill themselves which could either be verbally stated or written. Individuals who attempt suicide tend to remain near others, a behaviour that can be interpreted as an intention of survival (Douglas, 1965; Parnell, et.al 1957; Robins, et.al. 1959) In this type of suicidal behaviour it seems that the patient in most cases

allows for a possibility of rescue and at times the patient himself intervenes (Stengel, 1967). It has also been shown that people who attempt suicide present a highly vulnerable group with an excessive suicide risk Thus most people who attempt suicide eventually may actually end up killing themselves.

According to Beck et.al (1974) suicidal act causes crises and individuals engaged in the act are seen as those pointing accusing fingers at the family, the community and the mental health workers. In developed nations, the responsibility of detecting and preventing suicidal acts rests heavily on the mental health professionals and there has been no lack of recommendations on how to reduce the incidence of suicide. According to Stengel (1977) low moral standards and the decline of religious beliefs have been most frequently blamed for high suicide rate. This has led authors like Durkheim to see suicide as a social disease which could be easily overcome by preventing social isolation and by helping an individual be integrated within a group. Together with this the developed countries have embarked in community psychiatric services which have actually led to the reduction of suicide rates in some countries, for example, in Britain, where the suicide rate has dropped from 10 to 8 per 100,000

The above achievement is unheard of in developing countries where it is assumed that suicide is rare. Such assumptions have made authors like Giel and Harding (1976) to say that the respective roles of various professionals in the delivery of mental health care might be an issue in developed countries, but in many countries of the third world, Kenya included, where even the most basic health services are provided to not more than 15 per cent of the population, the debate about the respective roles of different professionals in the delivery of the mental health care to the community is not only impossible, but irrelevant. Thus, mental health care may not be a reality in the third world if not seen in the context of overall socio-economic development and that increased coverage can only be achieved through a considerable degree of community involvement and responsibility (Giel, et.al. 1976).

The involvement of the community into the delivery of mental health services is quite an interesting and controversial issue in developed countries. In the developed countries the participation of lay people in the prevention of suicide, that is, through voluntary organisations like the Samaritans, does create problems which must not be overlooked. According to

Stengel (1977), uneasiness has occasionally been felt among doctors in case lay people should take it upon themselves to deal with patients who are severely depressed or otherwise in need of psychiatric treatment. On the other hand, the lay people at times feel that the doctors (psychiatrists) tend to readily label patients unnecessarily. This at times, leads to lack of cooperation between the volunteers and the professionals to the disappointment of the observers from developing countries (personal experience). Such differences and views can be entertained in developed countries where there are many psychiatrists and other mental health workers and plenty of volunteers ready to offer their free services during their spare time. In Kenya with 4 psychiatrists at the time the study was done, and very few other mental health workers catering for a population of nearly 16 million people, the participation of the lay people and hence the community as a whole in the determination and prevention of suicide is not only vital for social and economic development, but long over due. The participation may not be possible without the determination of the degree of present involvement of the people in suicidal acts.

Theoretical Framework to Suicide

The theoretical explanations about suicide tend to be either sociological or psychological. Emile Durkheim (1951) whose work is prominent in the area,

favoured the sociological view while Sigmund Freud propounded the psychological view (Stengel, 1967; Munro, et.al. 1977; Bruno, 1980).

According to Durkheim, suicide although a highly personal act, can only be explained by the state of the society to which the individual belonged. Durkheim sees suicide in terms of integration and regulation. Thus he sees suicide to favour situations where individuals are either inadequately or over-adequately integrated into the society and the family life; and those situations where the society fails to regulate the behaviour of individuals. Therefore, his theory postulates that suicide rates are either high or low at some point along the integration and regulation continuum.

Durkheim differentiates three types of suicide based on the integration and regulation continuum and resulting from man's relationship to his society. The imbalance of integration is illustrated by what Durkheim calls egoistic and altruisic suicide, while anomic suicide illustrates the imbalance of regulation. According to Durkheim egoistic suicide occurs in those situations where an individual finds no basis for existence in life. The stronger the forces throwing the individual onto his own resources, the greater the suicide rate in that society (Durkheim, 1951). Thus egoism generates suicide because one

fails to be integrated in the society be it religion, family or marriage. Therefore, social events like religion and marriage may have some prophylactic effects upon suicide. To emphasise his point on the importance of one getting integrated in the society, Durkheim has the following to say on the family integration:

> "However poor one is and even solely from the point of view of personal interest, it is the worst of investments to substitute wealth for a portion of one's offspring," (Durkheim,1951:201)

Therefore, egoistic suicide may occur in those situations where one is not properly attached to his family, religion or any other groups in the society from which one could derive support and comfort.

While excessive individualism can lead to suicide, too little individualism can provide the same results. Durkheim called this altruisic suicide. Here suicide occurs because the basis for existence appears to be situated beyond one's life, so one kills oneself as either an obligation or honour to society or some cause. This type of suicide according to Durkheim may be found in the army, politics and primitive societies. He noted that this type of suicide is common in primitive societies than

in highly developed societies. Here one kills himself because of old age, sickness and death of a loved one. The extreme examples range from the old and sick who kill themselves because they want to relieve the society of themselves to situations where wives and servants kill themselves because they want to follow their husbands and masters into death (Stengel, 1967). Here it seems that one kills himself because social interests are more meaningful to him than his own individual's defined interests. Thus high level of social integration may actually lead to lack of meaning in individual's existence which in turn may lead to suicide. Low social integration also results in the same thing.

The third type of suicide, according to Durkheim, is called anomic suicide. Here one kills himself because the society has failed to control and regulate his behaviour. In normal circumstances, the individual's needs and their means of satisfaction are actually regulated by the society. The common beliefs and practices the individual learns from the society makes the individual develop a kind of collective conscience. But when this is upset, one ends up with anomic suicide. For example, the decline of religion, sudden wealth, loss, excessive relaxation of professional and marital codes and any state that

may cause societal disequilibrium may lead to anomic suicide. Hence whenever, serious readjustments take place in the social order, man's immunity against suicide gets reduced. This then leads one to self-destructive behaviour.

While Durkheim's idea on suicide may appear to be of historical interest, some recent studies have supported his observations by showing that where there are problems due to breakdown of close interpersonal relationships, for example, broken homes, marital disharmony, divorces, losses of any type, the risk of suicide tends to be high (Munro, et.al. 1977; Stengel, 1967). Other social problems of a wider scope, have also been demostrated to have an association with suicide. These could also be indicators of low social cohesion. These according to Munro and others (1977) include: financial problems which at times may indicate a chronic state of impoverishment with consequent loss of morale; employment problems including fears of getting a job, dismissal or redundancy crime and fears of pursuit and prosecution.

The researchers of suicide tend to agree that whatever the individual's social circumstances, the act of suicide has a unique nature and to understand it well one has also to look into psychological explanations of its cause. To this Munro and others have the following to say:

> "Without belittling the significance of long term adverse social factors in precipitation of suicidal behaviour, we must point out that these are usually not sufficient to account entirely for such a severe reaction," (Munro, et.al. 1977).

The psychological explanations of suicidal acts are derived from psychoanalytic and psychodynamic schools of thought. The psychoanalytic viewpoint is mainly based on Freud's concept of the dynamics of depression and his assumption of the existence of a death instinct. The emphasis in this view is on the battle between the unconscious and the conscious part of the mind and suicide is seen as an extreme expression of death instinct directed against self. On the other hand the psychodynamic orientation sees suicide as one of self-destructive behaviour which can be explained by the passive-aggressive hypothesis. This hypothesis, according to Bruno (1980) states that some individuals because of their guilt feelings, have difficulties in expressing their aggressive feelings. Therefore, the aggression they really want to express against others is expressed against themselves. This view considers the experiences the individual goes through as a child. In situations where a child is not allowed either by parents or significant others to freely express his aggression, such individual learns to keep things, especially feelings within himself. Besides in situations where

a child gets blamed for everything he does or any response he makes, the child actually learns to blame himself. Hence as an adult, the individual with such experience may find it difficult to hit back and instead hit himself in terms of suicide. The tendency of turning aggression to self has been actually observed on the suicidal notes the victims leave which often reveal a theme of revenge.

The psychological explanation of suicide also includes traumatic childhood experiences to explain suicide The traumatic childhood experiences may make the individual unstable and liable to breakdown under emotional stress. For example, lack of secure relationship with a parent figure in childhood, may have lasting consequences for a person's ability to establish relationships with others. Such individuals are likely to find themselves socially isolated and suffer loneliness in adulthood. Likewise, feelings of despair, loss of meaning in existence, lack of courage to face one's problems may lead to self-destructive behaviour. For example, a woman who gets married with high ideals, later realizes that her husband is unfaithful, plunges into a state of extreme demoralization and so kills herself because life is not worth living (Munro, et.al. 1977; Bruno, 1980).

The social and psychological theories about suicide as illustrated by Durkheim and Freud share a deterministic view of human behaviour, subjected and subservient to some powerful forces over which the individual has no control. According to Durkheim, these forces are found in the society while Freud allocates the forces in the unconscious part of the mind. Both theories are indeed restrictive as they tend to ignore the participatory nature of man in his environment. They tend to look at man as a totally passive creature incapable of reacting to any situation unless he is stimulated by either internal or external forces. Hence implying that without these forces one would not kill or attempt to kill oneself. Man according to George Kelly quoted by Pervin (1970) is a scientist in a sense that man attempts to predict and to control phenomena. Kelly maintains that man experiences events, perceives similarities and differences among the events., formulates concepts to order phenomena and on the basis of the concepts seeks to anticipate events (Pervin, 1970). From the foregoing statement, one can conclude that man actively interacts with his environment and has the capacity to affect his environment rather than merely respond to it. Hence in situations where one realizes that one can no longer have any effect on

his environment, one may decide to quit the stage. Thus man is really an actor who once realizes that he can no longer attract his audience decides to leave the stage.

There is general agreement among researchers that suicide is still treated with ambivalence in most societies (Stengel, 1967). Although seen as a "cry for help" suicide is still a highly condemned act and its victims apparently get very little support and sympathy from the community. In most cases the survivors and their families are left to their own resources. This punitive attitude to suicide has not deterred people killing or attempting to kill themselves. Durkheim's and Freudian theories have failed to explain why people still kill or attempt to kill themselves irrespective of the nasty consequences they or their relatives experience after the act. The fact that man still attempts to kill himself although he is aware that the society may ostracise him, seems to demonstrate the hedonistic nature of man. According to Carl Rogers quoted by Pervin (1970) man basically seeks to obtain pleasure and to avoid pain. As such an individual may kill or attempt to kill himself not because of his death instinct or inadequate integration and regulation, but because he wants to get rid of those situations making it impossible

for him to obtain pleasure in life by informing others through suicide of the obstacles. Hence suicide becomes the most effective way of communicating with others about situations that may hinder the individual's efforts to realize comfort (Robins, et.al. 1959; Shneidman, et.al. 1961; Sclare,et.al. 1963; Stengel, 1967).

Researchers have observed that the means to suicide depend very much on the familiarity and the accessibility of the devices. Thus in developed countries the use of drugs and other forms of poisons are common as these devices are readily available while in developing countries ropes and substances that are inexpensive and readily available are used. The means used have been observed to be related to the type of suicide where fatal suicide, violent means like guns, tall buildings, dams, knives are used while non violent means like drugs and poisons are used in attempted suicide. While not minimizing the ambiguous nature of suicide, where individuals who intend to kill themselves actually fail in the process and those who only intended to alarm others about their problems end up killing themselves, one can clearly witness the free will of man where he actively chooses whatever means he anticipates would bring about his desired goal. Thus according to Pervin (1970) man chooses that course of behaviour which he believes

offers the greatest opportunity for anticipating future events. The above seems to be at variance with Durkheim's and Freudian theories of suicide. Durkheim sees man to be inactive and can only involve in suicidal acts because of man's relationship with the environment. On the other hand, Freud sees man as irrational, unsocialized and destructive of self and others. According to the above observations man seems to be rational and quite active in selecting the methods and means for suicide, contrary to how man is viewed by both theories.

Researchers of suicide have observed that factors that lead one to suicide are multifactorial (Sclare, et.al. 1965; Stengel, 1967; Munro et.al.1977; Whitlock, et.al. 1967; Shneidman, 1976). These tend to be related to the individual's environment, his mental and physical state. To say that individual an engagesin suicidal acts because he is naturally destructive or that individual is not integrated or regulated by the society is to neglect the fact that man is a unique individual with unique experiences indeed. According to various authors man unlike other objects in the environment is able to think and distinguish between a variety of objects and that man struggles to realize his potentials (Rogers, 1961; Maslow, 1954). Thus man selects and interprets his environment and does not just passively respond to his stimuli. He strives to realize self-fulfillment

and he is capable of experiencing strains or problems when he encounters incongruency between experience and self (Pervin, 1970) For example, a state of relative deprivation may lead to incongruency between experience and self. Therefore, it seems that man out of his own free will chooses suicide as a way of telling people that he has a problem just as another person in a similar situation may choose other forms of behaviour to tell others about their problems. For example, in a situation where there has been loss of a loved one, one person may turn to excessive drinking, while another person may get saved and turn religious while the third person may commit suicide. In all these cases the problem is the same except the individuals are responding to the problem in their own unique ways.

Most preventive work on suicide has been centered on crisis intervention. Countries like Britain have actually claimed some success in the reduction of rates of suicide, that is from 12 to 8 per 100,000 people (Shneidman, 1976; Stengel, 1967). This supports the "appeal" nature of suicide. This means that when there is a response the situation actually improves. Besides it has been observed that suicidal attempts often lead to a change of a person's life situation and that suicidal acts are rarely repeated immediately (Greer, et.al. 1967; 1971) This confirms

the argument that suicide is really a way of looking for help in situations where one experiences problems.

Given the above and considering that man seems to be constantly struggling to obtain pleasure and avoid pain and since man is capable of acting on his own environment except in situations where he is either mentally or physically ill, the major hypothesis of this study is that in Kenya, in situations where one experiences disequilibrium either because he feels relatively deprived or encounters some social problems or experiences failure or loss or difficulties in one's life style, one is likely to use suicide as a cry for help.

Specifically the hypotheses are:

1. Relative differences in status among individuals influence the frequency of suicide.

   The above was measured by:

   (a) using the Likert scale where the respondents were asked to rate themselves on education, employment, place of residence, income and occupation in terms of: very disadvantaged, disadvantaged, moderately disadvantaged;

   versus

   moderately advantaged, advantaged, very advantaged;

(b) in terms of what happened in a situation where one was separated or divorced and a situation where there was poor marital relationship, remarriages, property ownership and custody of children;

2. The incidence of suicide will be related to the current Kenyan major social problems.

The above was measured by using the respondents' background information, mainly using the information from the respondents' personal history and the reasons they gave for committing or attempting suicide.

3. The incidence of suicide among adolescents will increase with the frequency of actual personal crisis.

The above was measured in terms of what had been going on in the personal history of the respondents and the reasons they gave for committing and attempting suicide.

4. That the African lifestyle will influence the occurrence of suicide.

This was measured in terms of background information and personal history of the respondents. It also included reasons respondents gave for committing and attempting suicide.

5. The methods used in suicide will vary with the availability of the means and the type of suicide.

This was measured by the information on the respondents gave on the method and means they used.

6. That the effects of suicide on the family members (relatives) would vary with the type of suicide.

This was measured by asking the respondents about what happened after the incident, how they felt after the incident , whether the situation improved. Questions 6, 13 and 23 of the Instrument III(b) were used.

Definitions

Various concepts and terms have been defined to indicate their specific meaning as reflected in this study.

Successful suicide: This refers to suicidal acts undertaken with conscious self-destructive intent with fatal outcome.

Attempted suicide: Attempted suicide means suicidal acts undertaken with conscious self-destructive intent without fatal outcome

Psychoanalysis: This refers to a scientific theory developed by Sigmud Freud to explain the individual's personality and behaviour. Here the behaviour of individual is seen to be controlled by some forces within the individual. The forces are memories, thoughts and wishes of which the individual may not be consciously aware.

Psychodynamic: A scientific theory which although based on psychoanalytic theory in explaining behaviour of an individual, puts emphasis on the interaction between motivation (wishes, thoughts, memories) and environment (the family, culture, social class and the like). The individual's behaviour is seen as a consequence of the forces within the individual

and everything that goes on in his environment.

Relative differences in status: This refers to situations where an individual perceives self as disadvantaged in terms of education, employment, place of residence, income and occupation. It also refers to situations where an individual enjoys special privileges and opportunities, that is, access to outlets like bars, legal rights especially in relation to marital disputes.

The current Kenyan major social problems: These refer to common problems mentioned now and then such as unemployment, family disorganization, alcohol abuse, low income (poverty) and poor personal relationships.

Adolescent: This refers to youth or young persons of age range between 14 - 20 years.

Personal crisis: This includes situations where an individual has experienced:

(a) loss, that is, where one has been jilted and where one loses a loved one through death;

(b) situations where one has failed a crucial examination, for example, C.P.E., school certificate (O level) and advanced school

certificate (A level).

(c) situations where an individual has failed to achieve his expectations (goals), for example, having to abandon his education because of lack of school fees, failure to obtain places in secondary schools, high schools, university and other colleges, and failure to get employment;

(d) disagreement with parents and teachers. For example, parents refusing him to get married, to associate with people he considers good friends, involving oneself in activities considered by parents to be inappropriate like drinking, smoking, taking drugs and fighting;

The African life style: This refers to some African customs and practices like polygamy and the extended family systems. It also includes the place where the respondent stays and with whom he stays.

The method of suicide: This simply means the ways the respondents killed or tried to kill themselves. This includes hanging, drowning, jumping, shooting, poisoning, stabbing and the like.

The means of suicide: This refers to the tools or devices the respondents use to kill or try to kill themselves. This includes ropes, clothes, dams, buildings, drugs, insecticides, knives, razor blades, guns and the like.

The type of suicide: This means the form of suicide that is, successful suicide and attempted suicide.

Relatives' views: This refers to the way the relatives perceive or look at those who have killed or tried to kill themselves. This will include feelings or sympathy, anger, hate and dislike.

The relatives: This refers to spouses, children, in-laws, uncles, parents, aunts and anybody in the extended family of the respondents.

CHAPTER THREE

"False facts are highly injurious to the progress of science, for they often endure long; but false views, if supported by some evidence, do little harm, for every one takes salutory pleasure in proving their falseness."

(Charles Robert Darwin: Descent of Man, 1809 - 1892)

RESEARCH METHOD

This chapter looked into how the sample of this study was selected. Since in Kenya there is no coroner's office as such and since the study was interested in both successful and attempted cases of suicide including their relatives, the sample for the study was drawn from the newspaper reports, police and hospital records as well as case studies randomly selected and followed up in Nairobi.

Research Design

The Nature and Setting of the Study

The study was done in Nairobi, the capital city of Kenya with a population of over 800,000 people The choice of Nairobi was deliberate not only to control the regional variations, but because of its diversified nature. For example, most urban activities, national facilities and resources are actually concentrated in

Nairobi. Problems such as unemployment, family disorganization, overcrowding, crime and delinquency, rural-urban migration, excessive drinking and many other problems that now face Kenya are best illustrated in Nairobi. Besides Nairobi offers a heterogeneous population that is hard to get in any part of the country. Thus different races, ethnic groups and age groups actually reside in Nairobi.

The study included 173 individuals who had committed or attempted suicide whose names had been either recorded at the 14 police stations selected for the study or those who had attempted suicide and taken to Kenyatta National Hospital's casualty department. The police stations were chosen because suicide in Kenya is still illegal and therefore all cases that come to the attention of the police are taken to police stations and thereafter to the courts and charged. On the other hand Kenyatta National Hospital is the District and Provincial Hospital for Nairobi as well as the national referral hospital where treatment is free. It actually handles over 90 per cent of all emergency cases in Nairobi.

The second group included in the study was a control group consisting of 79 individuals who have been admitted at Kenyatta National Hospital through

casualty department with other physical illnesses during 1975–1979. This group was included mainly to compare some of their characteristics with those characteristics of those who had attempted suicide.

Also the study included 203 individual cases of suicide reported in the newspapers during 1975-1979 period. This was mainly to provide the overall view of the incidence of suicide as reported in Kenya as well as to highlight the major factors that can be associated with suicide in the country.

Finally, the study included 30 family members and relatives of individuals who had committed or attempted suicide mainly to find out their views about suicide and their experiences after the incidence. Together with this there were 30 case studies of individuals who had committed or attempted suicide. This included 25 individuals who attempted suicide and 5 individuals who had succeeded in killing themselves and their relatives were interviewed on their behalf. All the 5 relatives were able to give ample information about their dead relatives and these corresponded with what had/reported in the police / been stations

The period of the study was from 1975-1979. This period was chosen for two major reasons mainly:

1. It covered over ten years since Kenya attained her independence. This period has been characterized by rapid development leading to enormous disequilibrium of social systems It is this period when many Kenyans started migrating to Nairobi mainly to look for education and employment, which means these individuals have to leave part of their families in the rural communities. It is this period that problems like unemployment, school drop outs, divorce, separation and many other problems affecting families like alcohol abuse have been realized.

2. This period also realized the inception and development of the Department of Psychiatry within the Faculty of Medicine and a regular out patient Psychiatric Clinic at Kenyatta National Hospital and one would expect some systematic recording of attempted suicide cases since most of the cases would have been referred for some psychiatric help. Besides the period has also realized the development of other helping professions as social work and psychology and one would expect improved referral systems.

Study Techniques

Purposive or Presenting Sample

1. Most individuals who attempt suicide in Nairobi are usually rushed to Kenyatta National Hospital for resuscitation. As such all the files at Kenyatta National Hospital were perused to determine individuals who had attempted suicide since 1975-1979. All the information obtained in the files were recorded. A total of 138 subjects were identified according to the records that were available to have attempted suicide between 1975-1979 and were treated at Casualty Department of Kenyatta National Hospital.

2. In Kenya suicide is illegal and most suicide cases especially where the attempt has been fatal, often end up in police stations. Besides in Kenya, most individuals who become involved in suicidal acts tend either to hang, stab or drown themselves. Such cases hardly find themselves to Kenyatta National Hospital and are therefore handled by the Police. For the above reasons, the second source of information was the police stations

where the police files on suicide from 1975-1979 were perused and 67 subjects were selected.

Stratified Random Sampling

The police stations were stratified into 7 different divisions. Then internal to each division, simple randon sampling was used where 2 police stations were picked from each division and a total of 14 police stations were selected for the study, mainly Central and Kamkunji in Central Division; Jogoo and Shaurimoyo in Eastern Division; Karen and Langata in Langata Division; Pangani and Muthaiga in Northern Division; Parklands and Kabete in North Western Division; Kilimani and Kileleshwa in Western Division and Buruburu and Industrial Area in Southern Division.

The Case Study

1. It has been observed that suicide cases are often underreported since in most societies suicide is an unwelcomed act. Besides in Kenya, suicide cases may not be reported because suicide is illegal and its victims are liable to punishment according to Kenyan laws. As such a case study was done in Nairobi to determine individuals who might have attempted to kill themselves but never taken to the hospital or reported to the police.

Here 25 individuals who attempted suicide were traced and interviewed while 5 individuals who killed themselves were traced through their relatives and their relatives interviewd The second year social work students and the researcher helped in tracing the subjects through the welfare agencies in Nairobi, namely, the Church Army; Probation Department as some individuals who had attempted suicide were placed under probation in Nairobi; the City Council Family Welfare Offices and Kenyatta National Hospital.

There were also case studies of the relatives who were traced through the social welfare agencies and the letters of invitation sent by the researcher using the addresses left on records at the police stations and Kenyatta National Hospital. A total of 30 relatives were traced in Nairobi.

2. Quite a number of suicide cases are reported in the newspapers. This available information was felt important to the study especially in giving a broader view or perspective of suicide in Kenya. Therefore an analysis was done of the nespaper reports, namely, the Daily Nation, on suicide during 1975-1979 period.

Key Informants

This was the last source of information and individuals with experience and opinion on suicide in Nairobi were interviewed. Different groups and professions were included, that is, counsellors, chiefs, probation officers, priests, magistrates, police, physicians, sociologists, psychologists, nurses, social workers, psychiatrists, wardens of institutions and prison officers. A total of 36 key informants were interviewed. Useful information was got from the practising key informants like psychiatrists and the social workers. For example, one psychiatrist reported seeing 9 patients who had attempted suicide who were referred to him as private patients within a period of less than two weeks in July, 1980. According to him all were depressed and one of them actually ended up killing himself.

Methods of Data Collection

1. A form and three types of structured questionnaire were used. The form was used to fill information on individuals who had killed themselves. The first questionnaire was used for individuals who have attempted suicide and those individuals used/a control group /as for the study. The second questionnaire was used to interview the family members of

those who had killed and those who had attempted to kill themselves. The third questionnaire was used to interview the key informants

2. Twenty-five subjects who attempted to kill themselves were followed and interviewed in their homes in Nairobi using the first questionnaire. The relatives of 5 subjects who killed themselves were interviewed on their behalf.

3. Seventeen relatives of individuals who had killed themselves and 13 relatives of those who had attempted to kill themselves were interviewed.

4. All the information obtained from the patients' and the deceased's files were recorded and used in the study.

5. All the verbal communications with the key informants and relatives were recorded and used in analysing the data.

Methodological Problems Faced in the Study

To carry out this study was suicidal in itself in a sense that one had to go through many obstacles that were indeed discouraging. The first obstacle was the process of research clearance that took about 4 months irrespective of the fact that the researcher had to visit the offices of the President and The National Council for Science and Technology almost everyday. The process is long and tedious and needs serious evaluation Even after having been cleared and letters obtained from Police Headquarters and Ministry of Health, the researcher had to produce other letters from various sections within those organisations in order to be allowed to visit either a police station or a hospital. As that was not enough, the researcher had still to report to section heads who in turn gave her letters of introduction. In the end the researcher concluded that the clearance from the President's office did not help her much but managed to prolong the period of her study.

The study had intended to include private hospitals like Nairobi, Agakhan and others in the sample. To get permission to meet with the authority and discuss about the research was impossible. In one case the researcher was told that she needed

permission from the hospital board before the permission could be granted. But the official was sure the board would not be favourable as patients who go to those types of hospitals do so because they want their problems to be kept confidential. He was sure that I would not be allowed to read patients' files. With this scepticism I researcher had to drop I the the idea of private hospitals and concentrate on Kenyatta National Hospital.

Another problem faced was related to the selection of the police stations. Although the researcher through Stratified Random Sampling, had selected 14 police stations as representatives of the 7 divisions of police stations in Nairobi, some police stations had to be dropped either because they were too small and were not dealing with suicide cases like Buruburu and Industrial Area or the records had been destroyed by some form of calamity. For example when the researcher went to Kamkunji Police Station it was disturbing to learn that torrential rain had destroyed all the files in the station and the station had to start all over again with new records! This situation forced the researcher to alter the approach and after discussing with some police officials, it was decided that in some divisions all the stations had to be included since suicide cases tend to be referred only to some police

stations. Thus all stations in Central, Eastern and Northern divisions were included in the study.

Inadequate information recorded in the files was a major area of problems to the researcher. In general the police files had better information compared to the hospital files. Most hospital files had little information indeed The hospital files were even more confusing in a sense that suicide was actually recorded under 3 titles, that is, suicide attempts, over-doses and parasuicides. The over-dose and parasuicide files tended to have cases of individuals who were aborting. Some were even attempting suicide and in the process had abortion as they were pregnant at the time they were attempting suicide. Hence, it was rather difficult to tell whether the motive for suicide was suicide or abortion. The research became more complicated when the researcher learned after gathering the data at Kenyatta National Hospital that quite a number of those who attempt suicide are protected by the medical personnel and at times discharged with a diagnosis of "Accidental Poisoning". This means that quite a number of suicide cases might not have been included in the study. This ambiguity called for follow-up case studies. The only way the researcher could follow them was through the addresses left in their files in the hospital. Ninety-five files out of one hundred and seventeen

files selected for the study had full addresses. Most of these addresses seemed to have been fictitious because when the researcher sent the letters out only 40 cases responded. Thirty nine letters were returned to the sender because the person was unknown. While not under-estimating the fact that some of the individuals the letters were sent to might have changed their addresses, it was possible that some cases gave wrong addresses mainly to avoid the police since suicide is illegal in Kenya. Besides only 20 cases out of 45 cases who responded gave enough information directing the researcher how to reach them. The rest were actually traced through social welfare agencies using social work students in second year.

The follow-up study was difficult as the researcher had to drive long distances in Nairobi trying to locate the cases. It was actually easier to locate cases where one has killed himself than those who had attempted because the police records suicide were very clear. For example, they had the name of the relative (often next of kin), the estate in Nairobi and the plot number. Sometimes they included a telephone number of the house and office. Where one had been admitted at Kenyatta National Hospital and address give, one had to make several trips before the house was located. In certain cases,

houses had been changed and a neighbour had to be contacted. In some situations, the neighbour had no idea where the family had moved to.

The interviews did not take place all the time at homes. Where the relative had given a name of the employer, telephone calls were made and the relative was asked whether he could be met after work in town. At times the relatives appeared tired and the researcher had to interview them over a cup of tea or soda. The social work students who helped in the research also had a similar experience and the researcher had to give them some money to entertain the relatives while being interviewed in the town. Those interviewed at home could only make it either on Sundays or Saturdays or late in the evening after work. This means that the researcher at times had to stay out very late in order to carry out the interviews.

The individuals who had attempted suicide were not very willing to be interviewed. At first they thought the researcher had been sent by the police to arrest them. Often they asked "How did you know that I was at Kenyatta"? Some even denied having been to Kenyatta National Hospital until the researcher had to reassure them. Some even wanted to know how they would benefit from such interviews.

In situations where there was a relative and the suicide victim, the researcher was unable to interview both of them and had to make another visit as the questionnaires were rather long and could hold the family for too long.

The visit of Pope Paul II in May 1980 was most useful as the researcher used some of the statements he made about the family life to elicit the cooperation of the subjects (Appendix V). The subjects became very interested in the research when they heard that even the Pope was interested in happy living of families and the study was trying to find out how families were living in Nairobi.

The final problem faced was that the researcher managed to trace those subjects who either killed themselves in 1977, 1978 and 1979. Some of the subjects of the earlier years seemed to have either left Nairobi or changed houses.

Methods of Data Analysis:

The study used both descriptive and inferential statistics to analyse the data. The descriptive statistics used included range, means and standard deviations while the inferential statistics included chi-square and t-tests.

Frequencies for all variables as well as cross-tabulations were run for both the total sample as well as sub-groups within the sample.

The analysis of the data included the following categories:

1. Suicide as reflected in newspaper reports and police records. This included the information obtained from the cuttings kept by the Daily Nation papers from 1975-1979; information obtained from the selected police stations in Nairobi specifically this included:

   (a) descriptive data on suicide reported by the newspapers (both successful and attempted suicide);

   (b) descriptive data on suicide recorded at police stations (only successful suicide);

   Here the incidence, the nature and the reasons given for suicide have been discussed and no major attempts were made to compare the sample until Chapter Eight.

2. The second category included descriptive information as reflected in Hospital records. Specifically it included:

(a) descriptive data on attempted suicide;

(b) descriptive data on the control group;

Here the background and general information about the subjects have been presented Means, range, standard deviations, tables and chi-squares and t-tests were used. Again no major comparisons were done until chapter Eight.

3 The third category included the effects of suicide on the relatives. Specifically it discussed what happened to the family members after the incident in terms of the support and sympathy they got from the extended family system and the community in general. It also dealt with the attitude of the family members towards those who had killed or attempted to kill themselves.

4. The fourth category included 14 case studies illustrating suicide. The cases were used to illustrate variables mentioned in the comparison chapter. Thus the subjects in the group were purposively selected

5. The fifth category included comparisons between three groups of subjects, i.e. those subjects who killed themselves as recorded in police records were compared with those subjects who

attempted to kill themselves (as recorded in hospital records). Likewise, subjects who attempted to kill themselves were compared with the general patient group (the control group). The subjects were compared on the basis of age, sex, marital status, education, employment, place of birth, tribal representation, the people with whom subjects stayed, methods subjects used for suicide, reasons for suicide, important events and suicide. All this has been reported in chapter Eight The major statistic used was a chi-square test.

6. The sixth category included discussion on some of social factors associated with suicide. Factors like age, marriage, employment, distance, occupation, sex, method used in suicide, extended family system and changes that occurred in relation to the 6 hypotheses of the study. Multivariate tables and chi-square tests were used.

CHAPTER FOUR

"Your life was given to you
by God and only He can take
it back."

(Magistrate Abdulla, Nation, 1980)

SUICIDE AS REFLECTED BY NEWSPAPER REPORTS AND POLICE RECORDS

Newspaper Reports on Suicide: General View

The information about suicide was obtained from key informants in Nairobi and from suicide files kept by the Daily Nation since 1975-1979. All the key informants interviewed felt that suicide was on increase and attributed this to rapid changes that have been taking place in Kenya. The changes included rural-urban migration; improved medical facilities hence availability of drugs; industrialization with its problem of centralization of industries in urban areas; urbanization with its problems of over-crowding, isolation, family disorganization and marital problems. The following is the analysis of all the information obtained from Daily Nation Newpaper from 1975-1979 by the researcher. All the tables presented are derived from the available information during that period.

According to the Daily Nation newspaper reports 203 people were reported to have either committed or attempted suicide in Kenya between 1975-1979. Among this group, there were 139 (68.5 per cent) Kenyans, 19 residents or tourists (9.3 per cent) and 45 subjects who committed and attempted suicide outside Kenya (22.2 per cent) but were reported in the Kenyan newspaper (Table 1).

Table I: A Summary of Reported Suicide in Kenya, 1975-1979

(Percentage)

Year	Kenyans			Tourists or residents			Cases reported from abroad			%	N
	Male	Female	%	Male	Female	%	Male	Female	%		
1975	4.4	2.5	6.9	1.0	1.0	2.0	1.0	1.0	2.0	10.9	22
1976	6.4	2.0	8.4	1.5	1.5	3.0	1.5	1.5	3.0	14.4	29
1977	6.4	3.4	9.8	1.0	1.0	2.0	3.0	3.5	6.5	18.2	37
1978	10.3	10.3	20.6	0.5	1.5	2.0	4.4	1.5	5.9	28.5	58
1979	16.8	5.9	22.7	0.5	-	0.5	3.9	1.0	4.9	28.1	57
N =	90	49	%	9	19	%	28	17	%	100	203

* Note: All cells in this table are percentages of the total N.

Considering the Kenyan and the residents or tourists samples, 84 subjects (53.2 per cent) succeeded in killing themselves, while 74 subjects (46.8 per cent) attempted suicide (Table 2).

Table 2: A Summary of Types of Suicide Reported (Percentage)

Type of Suicide	Kenyans			Residents or Tourists.			%	N
	Male	Female	%	Male	Female	%		
Successful	35.4	10.8	46.2	3.8	3.2	7.0	53.2	84
Attempted	21.5	20.3	41.8	2.5	2.5	5.0	46.8	74
N =	90	49	%	10	9	%	100	158

All cells in this Table are Percentages of the total N.

Looking at Kenyan sample alone it is evident that successful suicide and attempted suicide has been on the increase. Whereas in 1975 only 14 subjects (10.1 per cent of Kenyan sample only) committed or attempted suicide; in 1979, 46 subjects (33.1 per cent) committed or attempted suicide. The figure doubled in 1978 where 42 subjects (30 per cent) either committed or attempted suicide (Table 3). This figure was even higher among the female subjects (43 per cent of the female sample). The

high representation of female subjects in suicide in 1978 is rather difficult to explain. However, 1978 realised a coffee boom and the death of the First President of Kenya. Although there was a coffee boom and some Kenyans might have enjoyed some increase in their income, this may not have been the case for most women's experience. The same coffee boom might have created problems to some women in Kenya because of the way incomes are at times utilised by the men. It is not uncommon in Kenya to find that in situations where families suddenly get substantial income, men tend either to go in for more wives or take into excessive drinking. Thus the increased incomes are hardly used to improve the living standard of the family. The process often generates alot of problems in the family and can lead women into suicide.

Table 3: A Summary of Suicide Representation Among Kenyans Since 1975-1979 (Percentage)

Year	Successful Suicide			Attempted Suicide			%	N
	Male	Female	%	Male	Female	%		
1975	5.8	1.4	7.2	0.7	2.2	2.9	10.1	14
1976	4.3	1.5	5.8	5.0	1.4	6.4	12.2	17
1977	5.0	-	5.0	4.3	5.1	9.4	14.4	20
1978	7.9	5.0	12.9	7.2	10.1	17.3	30.2	42
1979	17.3	4.3	21.6	7.2	4.3	11.5	33.1	46
N =	56	17	%	34	32	%	100	139

All cells in this Table are Percentages of the Total N.

Table 3 was regrouped according to sex in order to find out whether there was difference in sex as far as the type of suicide was concerned. The subjects were simply divided into male and female in relation to the type of suicide they either attempted or committed (Table 4). When a chi-square test was done the results were significant.

Table 4: Sex and Type of Suicide (Percentage)

Sex	Successful Suicide	Attempted Suicide	%	N
Male	62	38	100	90
Female	35	65	100	49
N =	73	66	%	139

X^2 = 10.2, df = 1, Significance = 0.001

According to Table 4 more men tended to kill themselves than women (62 per cent compared to 35 per cent) while more women were more represented under suicidal attempts (65 per cent compared to 38 per cent). This finding supports other findings in the developed countries where researchers have observed that men tend to kill themselves while more women attempt suicide.

Reasons for Suicide

The study looked into the reasons recorded in the newspapers to have led Kenyan subjects into suicidal acts. According to the results 67 subjects (48 per cent) gave no reason for their suicidal acts. But the other 52 per cent of the Kenyan sample committed suicide either because they had poor relationships with their spouses and parents or they were unemployed and had no proper support or were trying to avoid being imprisoned for various offences (Table 5).

Table 5: A Summary of Reasons for Suicide

(Percentage)

Reasons	Male	Female	%	N
Poor relationship with spouse	4.3	7.2	11.5	16
Poor relationships with parents	8.6	5.2	13.8	19
Unemployment	6.5	-	6.5	9
Avoiding imprisonment	7.9	-	7.9	11
Let down by boyfriend/girlfriend	0.8	3.6	4.4	6
Mental illness	3.6	0.7	4.3	6
Others	2.9	0.7	3.6	5
No response	30.0	18.0	48.0	67
N =	90	49	100	139

According to Table 5, 16 subjects committed suicide because they had poor relationships with their spouses (12 per cent). The poor relationship included infidelity, failure to show love to spouse, constant quarrels and lack of support by spouse.

Nineteen subjects (14 per cent) were reported to have committed suicide because of a poor relationship with their parents. This included lack of understanding by parents, parents not allowing the

victim to marry a person of their choice and parents letting them down.

Nine male subjects committed suicide because of unemployment (7 per cent). None of the female subject was reported to have committed suicide because of unemployment. The male subjects failing to get any job could not support their families as expected by the society This could be a demeaning factor in a situation where one is expected to look after his family as the head of the family. In total failure, the individual may decide to eliminate himself to save his face from the relatives and friends. This can be supported by the fact that only one male subject committed suicide because he was being let down by a girlfriend. This form of a problem may not be appealing to men since the society expects them to be strong when faced with such situations. He can actually show his power by getting another girlfriend. On the other hand, for most women, family support is supposed to come from a man. Hence it makes little difference whether she has a job or not especially in situations where they are married. But she is expected to react in situations where she is let down by a man or not being supported by a husband. Thus it is not surprising that 5 female subjects (3.6 percent) committed suicide because they had been jilted by boyfriends.

Eleven male subjects committed suicide because they were avoiding imprisonment (8 per cent). In this group, 3 subjects were being remanded for theft; 2 subjects killed their neighbours because of land dispute, 1 killed his wife and one was accused of careless driving after he knocked and killed a child in a road accident. No female subject was reported to have committed suicide for avoiding imprisonment. This again is explanatory since the type of crimes the subjects are accused of are hardly expected by the society to be heard among women. Women are expected to be gentle, kind, honest, humble and any positive adjective one may think of. Hence such violent crimes are actually rare among women.

Six subjects had committed suicide because of mental illness (5 male and 1 female subject). Three male subjects and a female subject had been admitted to a mental hospital previously.

Four subjects committed suicide because of various reasons. One subject had lost money, 1 subject had a drinking problem, 1 subject had failed an examination and 1 subject had disagreed with the teachers.

Table 5 was regrouped to find out whether there were differences among both sexes in some of the reasons they gave for suicide, mainly the problem of relationships. The results were insignificant when a chi-square test was done (Table 6).

Table 6: Sex Difference in Relationships with Spouse and Parents (Percentage)

Sex	Poor relations with Spouse	Poor relations with Parents	%	N
Male	33.0	67.0	100	18
Female	59.0	41.0	100	17
N =	16	19	%	35

X^2 = 1.8, df = 1, Significance = .10

Although according to Table 6, male subjects seemed to have poor relationships with their parents and the female subjects with their spouses the results were actually not significant and it seems that there was no significant sex difference.

Methods Reported to have been Used

The common method reported to have been used by those who committed suicide was by hanging. Thus 65 subjects (46 per cent of the Kenyan sample) hanged themselves. Thirty-three subjects (23. 7 per cent) were reported to have poisoned themselves (Table 7).

Table 7: A Summary of Methods Used (Percentage)

Method	Male	Female	%	N
Hanging	37.4	8.6	46.1	64
Poisoning	11.5	12.2	23.7	33
Jumping from tall building	7.2	0.7	7.9	11
Shooting	3.6	0.7	4.3	6
Drowning	-	4.3	4.3	6
Burning	2.9	7.2	10.1	14
Others	2.2	1.4	3.6	5
N =	90	49	100	139

Table 7 was regrouped to find out whether there was difference in the methods used according to subjects' sex. The methods were divided into violent and non-violent methods as Table 7 tended to show that male subjects tended to use rather violent methods. The violent methods included hanging, jumping from tall buildings, shooting, burning, drowning, stabbing and lying on the road to be crushed by a car. The non-violent methods included poisoning and swallowing pieces of ground glass (Table 8) The results were significant when a chi-square was done.

Table 8: Methods Used According to Sex of Subjects (percentage)

Sex	Violent Method	Non-violent Method	%	N
Male	81	19	100	90
Female	61	39	100	49
N =	103	36	%	139

X^2 = 5.87, df = 1, Significance = 0.05

According to Table 8, more male subjects were reported to have used violent methods compared to their female counterparts (81 per cent viz. 61 per cent). On the other hand more female subjects tended to use non-violent methods (39 per cent viz. 19 per cent).

This observation seems to be consistent with the observation that actually more men succeeded in killing themselves compared to women as shown on Table 8 in this chapter. One can also argue that individuals who really want to kill themselves would go for a method that would really finish up the individual, while the individual who only wants to alert others of her difficulties may go in for less violent method.

Means Used to Commit Suicide

Researchers have observed that the methods people use to kill or attempt to kill themselves depend on the means available at that particular time. In Kenya, it was reported that the majority of Kenyans (87.8 per cent) who either killed or attempted to kill themselves either hanged or poisoned or burned or jumped from tall buildings. One can easily understand why these methods were used since their means are readily available. For example, subjects who hanged themselves were reported to have used ropes and pieces of clothes. Sixteen subjects were reported to have poisoned themselves and were reported to have used insecticides, detergents and drugs which in most cases were not specified. Again one can argue that drugs are now readily available and can be easily reached by an individual who intends to kill himself. Fourteen subjects burned themselves using paraffin, another item that can be found in almost every household in Kenya. Eleven subjects jumped from tall buildings in Nairobi. All of them are reported to have occurred in the city centre where tall buildings are actually readily available.

The study chose 4 common means to see the trend of their use in the years when suicide happened.

The four means looked at were ropes and clothes, paraffin and petrol, tall buildings, insecticides and drugs (Table 9).

Table 9: A Summary of Means Used throughout the Years (Percentage)

Means	1975	1976	1977	1978	1979	%	N
Ropes and clothes	17.2	10.9	14.1	23.4	34.3	100	64
Paraffin and petrol	-	14.3	28.6	35.7	21.4	100	14
Tall buildings	9.0	18.2	-	36.4	36.4	100	11
Insecticides and drugs	9.1	6.1	18.2	33.3	33.3	100	33
N =	15	13	19	35	40	%	122

According to Table 9 ropes and clothes remained popular means of committing or attempting suicide throughout the years in Kenya. The use of drugs and insecticides seemed to have increased with years. While in 1976 only 6.1 per cent of subjects used insecticides and drugs in 1978 and 1979, 33.3 per cent of subjects in each year actually were reported to have used insecticides and drugs. The use of tall buildings

also tended to have increased with the years. The frequency of the use of the methods actually tended to increase with suicide patterns. Thus with the increase in suicide the use of certain means also increased (Tables 3 and 9 of this chapter).

Researchers in western world have observed that the type of suicide tends to depend on the means used. For example, it has been observed that subjects who succeed in killing themselves tend to use more violent means. This study attempted to look into the differences of means used and the type of suicide. The means were categorised as violence and non-violence. The violent means included the use of ropes and clothes; guns, petrol and paraffin, throwing oneself into rivers and dams; tall buildings, knives and cars. The non-violent means included insecticides, drugs and pieces of glass (Table 10). A chi-square test was done and results were significant.

Table 10: Means and Type of Suicide (Percentage)

Means	Successful suicide	Attempted suicide	N
Violent	89	58	103
Non-violent	11	42	36
N = 73	100	N = 66 100	139

X^2 = 16.2, df = 1. Significance = 0.001

According to Table 10, subjects who succeeded in killing themselves used violent means more than those subjects who attempted suicide. Those who attempted suicide used non-violent means. This finding tends to confirm what has been observed in developed nations. The only problem with this observation is that those subjects who might not have succeeded in killing themselves while using the non-violent means, might have done so in their ignorance of not knowing the proper dose to take. Due to this, they may take inadequate doses which may lead to their rescue even if they might have intended to succeed. Likewise, those individuals who succeeded might have done so accidentally and hence end up dying because of the violent means available at that time.

Police Records: Successful Suicide

Sixty-seven subjects were traced from the police records and fifty-six subjects were selected for the study. Eleven remaining subjects had either very little information or had been murdered in disguise of suicide. The 56 subjects included 37 male and 20 female subjects (64.3 per cent males and 35.7 per cent females).

Among the 11 subjects not included, there were 5 subjects who although included among those who have committed suicide, were still being investigated as murder cases. Two subjects in this group seemed to have been killed by their relatives and then locked in their rooms hanging as if they had hanged themselves. Three cases involved love relationships where in one case a woman arranged with her lover to kill her husband so that they could get married. The husband was killed, put in a car driven to unknown destination and abandoned in the car with a pistol placed next to him. Postmortem recorded suicide but later the verdict was changed after the relatives of the deceased raised some suspicion. One subject was actually set on fire by her boyfriend. The boyfriend reported suicide but later changed his mind and confessed that he had killed her because she was unfaithful. The last case in this group was of a man who was found in another person's house at night after stories that he used to frequent the man's house in his absence. On this occasion the man had deceived his wife that he had to be away for three weeks. At midnight he came back and found the wife with her usual lover. He

strangled the man and then took him to his house and placed a bottle of insecticides next to him after making him drink some. Post-mortem recorded suicide but a neighbour who heard the commotion reported the matter to the police. All these cases were still being investigated and the matter forwarded to the court. The remaining 6 cases were recorded suicide but investigations were incomplete. This meant that the information needed for the study were inadequate and the cases had to be omitted.

Personal Characteristics and Background of Subjects.

Ages of Subjects

The mean age of the male subjects was 35.5 years with a range of 18-65 years and a standard deviation of 10.9, while that of the female subjects was 34.7 years with a range of 18-49 years and a standard deviation of 9.0. Although, there was difference in age range between male and female subjects, the difference was not significant when the two means were compared ($t = 0.8$, $df = 54$, Sign. $= 0.05$) Table 11 shows a summary of the subjects' ages.

Table 11: A Summary of Subjects' Ages (Percentage)

Years	Male	Female	%	N
18 - 25	12	11	23	13
26 - 33	18	4	22	12
34 - 41	18	9	27	15
42 - 49	9	12	21	12
50 - 57	4	-	4	2
58 - 65	4	-	4	2
N =	36	20	101	56

According to the above table the majority (92 per cent) of the subjects tended to kill themselves between the age range of 18-49 years.

Marital Status of Subjects

According to the results 30 subjects (54 per cent of the total sample) were married while 19 subjects (34 per cent of the total sample) were single. Four subjects were separated and only one subject was divorced (7 per cent and 2 per cent respectively). Two subjects were reported cohabiting (3 per cent of the total population). No subject

was widowed. Among the married subjects, 11 subjects (37 per cent of the married subjects).

Table 12: A Summary of Subjects' Marital Status (Percentage)

Marital Status	Male	Female	%	N
Single	20	14	34	19
Married (mono)	25	9	34	19
Married (poly)	11	9	20	11
Separated	5	2	7	4
Divorced	-	2	2	1
Cohabiting	4	-	4	2
N =	36	20	101	56

Education of Subjects

Thirty subjects (54 per cent of the total sample) had no formal education while 14 subjects (25 per cent of the total sample) had primary education. Therefore, the majority of the subjects seemed either to have no education at all or primary education (Table 13).

Table 13: A Summary of Education Distribution Among Subjects. (Percentage)

Type of Education	Male	Female	%	N
No education	36	18	54	30
Primary	14	11	25	14
Secondary	9	7	16	9
Higher	4	-	·4	2
University	2	-	2	1
N =	36	20	101	56

According to Table 13 the majority of subjects had either no education or primary education. No female subject had studied beyond secondary type of education.

The low education among the subjects seemed to support the observationsthat have been made about education in Kenya where the majority of the Kenyan adult population tends to have little education (see Appendices A and B). This also reinforces the observation made in this study that the majority of the subjects who succeeded in killing themselves were actually older since it is this older group that had been observed to have little education in Kenya.

The statistics in Kenya tend to show that in each age group the proportion of males with schooling was always higher than that of females (Bigsten, 1975:74; Smock, 1977:28; Economic Survey Report, 1981:30). This difference demonstrates the traditional influence relating to the allocation of scarce resources. In Kenya, traditionally, male children were often sent to school more than female children in situations where the family was poor. This situation still prevails in Kenya and even in 1979 census, a higher proportion of males still benefitted from higher education compared to the females (Appendix A). As such it is not surprising that no female subject had higher or university education among the individuals who killed themselves.

Occupation of Subjects

The majority of the female subjects were housewives (40 per cent of the female sample) while the majority of male subjects were casual labourers (33 per cent of the male sample). Table 14 shows the occupation of subjects.

Table 14: A Summary of Subjects' Occupation (Percentage)

Occupations	Male	Female	%	N
Casual labourer	21	-	21	12
Housewife	-	14	14	8
Driver/Mechanic/ Builder	7	-	7	4
Salesman/Business-man	9	4	13	7
Students	4	7	11	6
Clerical Worker/ Secretary	9	2	11	6
Teacher	2	4	6	3
Nurse	-	2	2	1
Messenger	9	-	9	5
Administrator	4	-	4	2
Prostitute/ Barmaid	-	4	4	2
N =	36	20	102	56

According to Table 14, the majority of the subjects were either casual labourers (21 per cent of the total sample) or housewives (14 per cent of the total sample). This was followed with salesman/businessman, clerical work and students (13 per cent, 11 per cent and 11 per cent respectively).

When the occupation of subjects was divided into manual and non-manual work, the majority of the subjects were manual workers (52 per cent of the total sample). Manual work included casual labour, housework, driving, mechanical work, building and messenger).

Subjects Place of Birth

According to the results subjects came from 6 provinces in Kenya with Central and Eastern Provinces having the highest representation (Table 15).

Table 15: A Summary of Subjects' Place of Birth. (Percentage)

Provinces	Male	Female	%	N
Central	29	17	46	26
Eastern	13	5	18	10
Nyanza	5	5	10	6
Western	5	2	7	4
Nairobi	4	4	8	4
Others	9	2	11	6
N =	36	20	100	56

According to Table 15, 46 per cent of the total sample came from Central Province and 18 per cent of the total sample came from Eastern Province. The majority of the subjects reported to have been born in the rural areas while only 4 subjects reported to have been born in Nairobi. The high representation of Central and Eastern Provinces here is understandable as both are the closest provinces to Nairobi and movement into the city to look for jobs and work would be higher compared to other provinces.

Subjects Place of Residence

It was difficult to order the subjects according to residential areas in Nairobi since there is no organized system one can readily use. As such the study grouped the residential areas according to the economic status associated with the estates. The estates were categorised as low, medium and high. Those estates categorised as low income group were: Bahati, Muthurwa, Makadara, Maringo, Pumwani, Ziwani, Mathare Valley, Uhuru, Umoja, Kariobangi, Kijabe and Kirinyaga roads, Dagoretti and Kawangware. Those categorized as middle income group were Harambee, Kimathi, Buruburu, Eastleigh, Pangani, Parklands, Nairobi West and Nairobi South C. While those categorized as high income group were Ruaraka, Ridgeways, Milimani, Woodley, Bernard Estate, Westlands, Lower Kabete and Red-Hill (Table 16).

Table 16: Subjects' Place of Residence and Sex (Percentage)

Residence	Male	Female	%	N
Low income	46	15	61	34
Medium income	7	14	21	12
High income	11	7	18	10
N =	36	20	100	56

X^2 = 7.13, df = 2, Significance = 0.05

The majority of the subjects (61 per cent of the total sample) lived in those estates in Nairobi that can be considered low income. Within this group, Pumwani had the highest representation. For example, out of 11 subjects in the 3 estates (that is, Pumwani, Ziwani and Mathare Valley), Pumwani had 8 subjects who killed themselves.

The study tried to determine whether more male subjects stayed in the low income estates than female subjects. A chi-square test was constituted and the results were significant. According to these findings more male subjects stayed in low income estates.

Tribal Representation of Subjects

Six tribes were represented with the Kikuyu tribe having the highest representation in the sample (48 per cent of the total sample). This was followed by Kambas (13 per cent of the total sample), Baluhyias and Luos (11 and 10 per cent respectively), (Table 17) shows tribal representation.

Table 17: A Summary of Tribal Representation (Percentage)

Tribes	Male	Female	%	A
Kikuyu	29	20	49	27
Kamba	9	4	13	7
Baluhyia	7	4	11	6
Luo	5	5	10	6
Meru	4	-	4	2
Asian	2	2	4	2
Others (Tanzanian/ German/Ugandan/ Italian)	9	2	11	6
N =	36	20	102	56

The high presentation of the Kikuyu tribe is understandable since Nairobi where the study was done is quite near to those areas where Kikuyus reside. This observation has been supported by Table 32 in Chapter five where the tribe was more represented Again the same tribe was more represented among the general patient group (control group) where 48 per cent of the total sample was admitted to the hospital with general illness (Chapter Five, Page 195)

Subjects' Nationality

The study had 48 Kenyans (86 per cent of the total sample), 2 Europeans (4 per cent of the total sample), 2 Ugandans (4 per cent of the total sample), 1 Asian and 1 Tanzanian (2 per cent each).

General Information about Subjects

Employment Situation of the Subjects

The study tried to find out the working situation of the subjects. This was related to their marital status and sex. The working situation was categorised as 'employed' and 'not employed'. The employed subjects included those who were in salaried jobs and those self employed. Those subjects not working included students and individuals not involved in any form of employment. The marital status was divided into 2 broad categories. This included 'single' where the subjects were not married at all, separated or divorced and 'married' where the subjects were either monogamously or polygamously married and those cohabiting (Table 18).

Table 18: Employment, Marital Status and Sex (Percentage)

Marital	Employed			Not Employed			%	
	Male	Female	%	Male	Female	%		N
Single	21	7	28	4	10	14	42	24
Married	28	10	38	13	7	20	58	32
N =	27	10	66	9	10	34	100	56

Thirty-seven subjects (66 per cent of the total sample) were employed while 19 subjects (34 per cent of the total sample) were unemployed. Twelve subjects (31 per cent of the employed sample) were casual labourers while 6 subjects (32 per cent of the unemployed sample) were students.

The Persons Subjects Lived with

Sixteen subjects (29 per cent) stayed with their spouse while 12 subjects (21 per cent) reported to have been staying alone (Table 19).

Table 19: A Summary of Persons Subjects Stayed with (Percentage)

Relations	Male	Female	%	%
Husband/Wife/Children	18	12	30	39
Parents	4	5	9	8
Sister/Brother	4	2	6	3
Uncle/Nephew/Step-father/Cousin	5	2	7	6
Daughter/Son	11	2	13	7
Alone	14	7	21	18
In-Laws/Co-Wives & Husband or Wife	2	4	6	3
Boyfriend or Girlfriend/ Other Friends	7	2	9	9
N =	36	20	100	96

According to Table 19 the majority of subjects stayed with their spouses and children (30 per cent) while 21 per cent of subjects stayed alone.

Table 19 was regrouped to find out whether there was difference between those who stayed alone and those who stayed with their relatives in relation to successful suicide. The table was divided into three categories, mainly those who stayed with

spouse and children; those who stayed with relatives and friends and those who stayed alone (Table 20).

Table 20: Persons Subjects Stayed With and Suicide (Percentage)

Persons Stayed with	Male	Female	%	N
Spouse and Children	18	13	31	17
Relatives/Friends	32	16	48	27
Alone	14	7	21	12
N =	36	20	100	56

X^2 = 0.42, df = 2, Significance = 0.05

According to Table 20, there was no significant difference between sexes and the persons they stayed with and the majority in both sexes stayed with their relatives.

Years Suicide was Committed

According to the findings suicide tended to be higher in 1979 and 1975 and was low in 1976 to 1978 (Table 21).

Table 21: A Summary of Years Suicide was Committed (Percentage)

Years of Suicide	Male (%)	Female (%)	%	N
1975	13	12	25	14
1976	5	9	14	8
1977	9	2	11	6
1978	9	5	14	8
1979	29	7	36	20
N =	36	20	100	56

According to Table 21, the majority of subjects (36 per cent of the total sample) committed suicide in 1979. This was followed by 1975 where 14 subjects (25 per cent of the total sample) committed suicide. According to the results few people committed suicide in 1977 (11 per cent of the total sample). The high rate of suicide in 1979 and the low rate in 1977 is hard to explain. One obvious explanation could be explained in terms of recording system that is available. The recording system used in most police stations is indeed inadequate

and keeping records seems to depend very much on the officer-in-charge rather than the overall expectation of the police system. In some police stations, although they could make files in a given year available, this was not possible in other years. Therefore, although they had recorded suicide for all the year, the files were not available to support the records. In other files vital information was missing and things like years or dates the suicide was committed were missing.

Nonetheless, it is interesting to note that the suicide rates tend to coincide with 'coffee boom' in Kenya. For example, illicit coffee trading was at its peak in 1977 and really declined by 1979 leading to drop in agriculture and service sectors as indicated in 1980 Statistical Abstract. It is possible that this downward trend affected some individuals.

More male subjects tended to commit suicide in 1979 (29 per cent of the total sample) and only 4 female subjects (7 per cent of the total sample) committed suicide in the same year. Female subjects tended to have committed suicide in 1975 and 1976 (21 per cent of the total sample). One would expect

that during the "coffee boom" employment opportunities could be created for the unemployed individuals. Hence more men would actually be able to get jobs, but with the decline of the "coffee boom" the same men were more likely to lose these jobs compared to women.

Suicide According to Months of the Year

The study looked into months suicide was committed and the months were grouped into 4 categories as shown on Table 22.

Table 22: A Summary of Months Suicide was Committed (Percentage)

Months	Male	Female	%	N
January-March	14	7	21	12
April-June	23	17	40	22
July-September	9	5	14	8
October-December	18	7	25	14
N =	36	20	100	56

According to Table 22, 22 subjects (40 per cent of the total sample) committed suicide between April and June. Suicide tended to be low between July and September (14 per cent of the total sample).

None of the subjects committed suicide in January and only 3 subjects were reported to have committed suicide in February. Then there is sudden increase in suicide cases from March reaching its peak in May (6 subjects in March; 7 subjects in April and 10 subjects in May). Thus between March and June 28 subjects (50 per cent of the total sample) committed suicide. Subjects tended to commit suicide less in September (only 1 subject was reported) while 4 subjects had been reported to have committed suicide in July and October (2 subjects in each month). But there is a sharp increase in suicide cases in November as shown on Graph of Table 63 in Chapter Eight.

Although it is difficult to relate suicidal peaks in April, May and June to any event in Kenya, it is perhaps worth noting that these same months tend to be associated with shortages in the country especially on food crops. This is when the majority of people are ploughing, planting and weeding their crops. This is the time people need food after exhausting their previous harvest. Also this is the time most parents have seen their children going through major examinations mainly O and A levels and have either to settle them in schools or look for jobs for them. With the limited resources we have in the

country, this process can be quite stressful to parents in terms of getting schools, school fees, uniforms, books and jobs for their children as well as supporting the family.

The sudden increase of suicide cases in November can also be explained in terms of the activities that come after that month. For example, in November, most families prepare for the celebrations that come in December and January where there are Jamhuri, Christmas and New Year celebrations. It is likely that where the individual feels left out or disadvantaged in terms of resources, such an individual may decide to kill himself.

Place Where Suicide was Committed

Thirty-six male subjects (64 per cent of the total sample) were reported to have killed themselves away from their residential homes (houses). All of them went into hiding before killing themselves. Fifteen out of the 36 male subjects (27 per cent of the total sample) jumped from tall buildings in the city centre while 11 male subjects (20 per cent of the total sample) hanged themselves in the forest around Nairobi. The rest of the male subjects either

drowned in Nairobi dam, set themselves on fire in industrial area or cut their throats while hiding in some bushes around Nairobi. There was one subject (foreigner) who ran away from his residential area and shot himself in a nearby bush.

The buildings the subjects used for committing suicide were Kenyatta Conference Centre (3 subjects), Electricity House (3 subjects), National Bank of Kenya (2 subjects), Uchumi-Agakhan Walk (2 subjects), Development House (2 subjects), International Life House (2 subjects), and Ambassador Hotel (1 subject).

Only one female subject killed herself outside the home. The remaining women (34 per cent of the total sample) killed themselves in their houses.

Table 23: Means of Suicide

(Percentage)

Means	Male	Female	%	N
Rope/Cloth	20	16	36	20
Poisons (Insecticides, Diazonon, Gametox, Chloroquine)	9	11	20	11
Jumping from tall buildings	26	2	28	16
Drowning	2	-	2	1
Gun/knife	4	-	4	2
Paraffin	4	6	10	6
N =	36	20	100	56

The majority of the subjects according to Table 23 used ropes and cloths (lesso wrappers) to kill themselves (36 per cent of the total sample). This was followed by jumping from tall buildings (28 per cent of the total sample). More male subjects (26 per cent of the total sample) killed themselves by jumping from tall buildings. More women used paraffin to kill themselves (6 per cent

of the total sample compared to men where only 4 per cent of the total sample did so. No female subject used either the gun or the knife or drowning to commit suicide.

Methods Used in Suicide by Subjects

The majority of the subjects either hanged themselves or jumped from tall buildings in the city centre (36 per cent and 27 per cent respectively). A high proportion of the subjects (11 per cent of the total sample) poisoned themselves.

The method used by the subjects were categorised as 'violent' and 'non-violent'. The violent method included hanging, jumping from tall buildings, shooting, cutting throat, drowning and burning. The non-violent method included poisoning (Table 24).

Table 24: Method Used According to Sex (Percentage)

Method	Male	Female	%	N
Violent	55	25	80	45
Non-violent	9	11	20	11
N =	36	20	100	56

X^2 = 2.15, df = 1, Significance = 0.05

According to Table 24, 45 subjects used violent methods (80 per cent of the total sample). More male subjects (55 per cent of the total sample) used violent method compared to female subjects where only 25 per cent of the total sample used the same method.

Although the male subjects tended to use violent methods, the findings were not significant when a chi-square test was done. Thus both sexes tended to use violent method in killing themselves.

Method of Suicide and Age

The study tried to look into the method the subjects used and their ages. The methods were categorised as violent and non-violent. The violent method included hanging, jumping from tall buildings, shooting, cutting throat, drowning and burning while the non-violent method included poisoning (Table 25).

Table 25: Method Used and Age (Percentage)

Method	Young (18-35 years)	Middle (36-65 years)	%	N
Violent	37	43	80	45
Non-violent	11	9	20	11
N =	27	29	100	56

X^2 = 0.15, df = 1, Significance = 0.05

Forty-three per cent of the older subjects used violent methods while 38 per cent of the young subjects used the non-violent method. When a chi-square test was done to determine whether there was difference in the method used among the two age categories, the results were insignificant. Thus all the subjects irrespective of their age groups tended to go in for violent methods.

Thirty-six subjects (64 per cent of the total sample) either jumped from tall buildings or hanged themselves (Table 23). Sixteen older subjects (29 per cent of the total sample) hanged themselves while only 4 younger subjects (7 per cent of the total sample) used the same method.

Ten younger subjects (18 per cent of the total sample) jumped from tall building while only 6 older subjects used the same method (11 per cent of the total sample). According to the findings older subjects tended to hang themselves while younger subjects jumped from tall buildings.

Reasons for Suicide

Most subjects were recorded as saying "life was miserable and like hell and there was no need living" (63 per cent of the total sample). The major reasons given for the above feeling were related to poor relationships, unemployment and some form of mental illness. Within the poor relationships' group there were subjects who had problems with their spouses, children, parents and friends. Within the unemployment group, there were subjects who felt that they had no proper employment and those who had no employment at all. Those in the mental illness group were subjects who seemed to have either had some depressive illness or were paranoid (Table 26).

Table 26: A Summary of Reasons Subjects Gave for Suicide (Percentage)

Reasons	Male	Female	%	N
Poor relationships	38	23	61	34
No proper employment	17	11	28	16
Others	9	2	11	6
N =	36	20	100	56

According to Table 26, 21 male subjects (38 per cent of the total sample) had poor relationships. Fourteen subjects (25 per cent of the total sample) in this group had poor relationships with their wives. Nine subjects out of the 14 subjects felt that their wives were not treating them well and considered them nothing. Seven subjects in this group reported their wives running around with other men. Five subjects out of the 14 subjects with poor relationships among the male subjects reported their wives mistreating them and their children. For example, statements like "I cannot

stand seeing you mistreating my children in the presence of my eyes. Even if you hated me, it never occurred to me that you could hate your own children - your blood; you have mistreated us so much, please never attend our funeral" were common in the suicidal notes left by the deceased. Three male subjects (5 per cent of the total sample) had poor relationships with their parents. They mainly blamed the parents for having made life difficult for them and wished the parents a peaceful life after their departure. Three male subjects (5 per cent of the total sample) had been jilted by their girlfriends and suicide was a protest for the rejection. For example statements like, 'I am now out of your life and you can do what you want; I hope you will now get your person" were left on the suicidal notes. One subject among the male subjects with poor relationships committed suicide because his son had neglected him. He made his point quite clear in the suicidal note, "I troubled educating you and this was a sacrifice on my side and your mother. We had hoped that you would look after us. But as things are you do not bother. I hope in my absence you will look after your mother". (This was a direct translation from Luo).

Thirteen female subjects (23 per cent of the total sample) had poor relationships. Nine subjects (16 per cent of the total sample) had poor relationships with their husbands. Eight subjects in this group (8 out of 9 female subjects) reported their husbands being unsupportive, moving about with other women, coming home late, being cruel and beating her frequently and keeping mistresses. One subject in this group killed herself because her husband had had some love affairs with her daughter (incestuous relationship with the daughter) and had the following to say, "I cannot stand what you are doing. I do not know what it is and what you are up to. But after I have gone I hope God will help you" (direct translation from Kikuyu language). Two female subjects had poor relationships with their parents. One subject was raped by her stepfather, got pregnant and later killed herself with this note, "I cannot face the world, you are my father although not by blood". The remaining subject in this group killed herself because her mother has been abusing her and had this to tell the mother in the suicidal note, "I have thanked God to have given me this opportunity to write to you this short letter. The main point I want to tell you is that: you have been abusing me as stupid and I roam about deceiving you to be polite but tough-headed.

Therefore, you told me that you can do without me. We will meet, we will meet. But do not cry much. . . Your dead daughter". Two female subjects were jilted by their boyfriends. Six female subjects reported having no employment (11 per cent of the total sample). There were other reasons given for suicide. For example, there were 2 subjects who had drinking problem, two subjects a with mental problems(depression and paranoia), one subject with prolonged physical illness and one subject who was accused of misusing 40,000 shillings. This subject shot himself because he had no way of getting money to refund whatever he had misappropriated.

Previous Suicide Attempts

The study attempted to find out whether subjects had attempted suicide before killing themselves. Eight subjects (14 per cent of the total sample) had previous suicidal attempts. Five male subjects (9 per cent of the total sample) and 3 female subjects (5 per cent of the total sample) had previous attempts.

Three female and one male subjects had attempted suicide twice. Two male subjects had attempted suicide 6 times while 2 male subjects had made 3 attempts before the fatal attempt.

Suicidal Notes

The study looked into whether the subjects had left any suicidal notes. The results showed that 17 subjects (30 per cent of the total sample) left suicidal notes (9 male and 8 female subjects). Most suicidal notes were either revengeful, punitive or depressive. Female subjects tended to leave quiet depressive notes as illustrated by the following:

1. "Sister, you have helped me so much but I could no longer go on. Please look after my two children".

2. "Life is unbearable. I can't stand any more of it".

3. "I cannot face the world, I am sorry to my mother".

4. "I have made peace with God and I have known where I will go and to that I am full of a

wonderful faith in future. Dear, I have a great need for love and the presence of an understanding in our life and I have quietly decided that there could be no real satisfaction for me floating around uselessly and unattached and so I have to look for a sound and a happy home".

Most male subjects tended to leave very revengeful and punitive notes. For example:

1. "I just came to confirm what I hear and if it is true then we have to say goodbye in this odd way. Best wishes with your new man".

2. "I hope God will give me a proper wife in my next life. You should not claim any of my death benefits, but throughout your life you must keep the 3 educational files of our children. Bury our bodies at Langata Cemetry in one single grave. No cementing of the grave, no coffins and no burial ceremonies. Have as many condolences from your friends as you can and let them and you call me anything you wish, but remember these people have lost nothing, yet they

are the people you heard more than your husband. They will forget but you will take time to forget". (This was the longest suicidal note and what is reported here is half of what the subject had written. He killed himself and 3 of his children).

3. "Since you are free, you can do what you want in life. I would not stand sharing you with another man. I cannot leave my children behind to suffer. You are free as I found you. Do not bother to attend our funeral service". (The subject also killed his 3 children and later killed himself).

According to the findings quite a high number of subjects had behaved or even told their relatives that they would kill themselves. Eleven female subjects (20 per cent of the total sample) had told their relatives that they would harm themselves while 15 male subjects (27 per cent of total sample) had behaved and informed their relatives of their act. In all cases, the subjects were not taken seriously. For example 7 female and 9 male subjects were seen unhappy and at times

used threats of killing themselves. The remaining subjects actually said that they were thinking of killing themselves, for example, the following statements were used: "If I die do not cry; give my mother and sister these photographs and keep one for yourself as you won't see me again, you will never see this drunkard again, whatever it is I have to disappear, I feel like leaving the world". Thus according to these observations at least 29 subjects (46 per cent of the total sample) had given a clue to the relatives that something was disturbing them and they were thinking of killing themselves. Six subjects in this group had had previous attempts This might have affected the relatives' attitudes and assumed the warnings to be the usual threats.

CHAPTER FIVE

"I find by experience that the mind and the body are more than married. For they are most intimately united. And when the one suffers, the other sympathizes."

Lord Chesterfield (Philip T. Stanhope) 1694-1773.

THE SUICIDE PROBLEM AS REFLECTED IN HOSPITAL RECORDS.

Attempted Suicide

One hundred and thirty eight subjects were reported to have attempted suicide at Kenyatta National Hospital between the years 1975-1979. Only 117 subjects were selected for the study. Ten cases were excluded from the study because they had very little information and their records showed that they were unconscious and no proper information was got. The remaining 11 cases were recorded as having taken overdose mainly to secure an abortion. All 11 subjects were found to be pregnant at the time they took the overdose and their major motive for the overdose was abortion.

Personal Characteristics and Background of the Subjects

Age of Subjects

The mean age of the subjects was 24.2 years with a standard deviation of 7.3 and a range of 13-50 years. Unlike the subjects who committed suicide, the majority of subjects who attempted suicide were young. For example 79 per cent of the total sample of those who attempted suicide was between 13-28 years, while 21 per cent was between 29-50 years (Table 27).

Table 27: Age, Sex and Suicide
(Percentage)

Years	Male	Female	%	N
13 - 20	7	28	35	41
21 - 28	14	31	44	52
29 - 36	6	6	12	14
37 - 44	6	1	7	8
45 - 50	-	2	2	2
N =	38	79	100	117

t = 6.96, df = 171, Significance = 0.05

Studies done in developed countries have shown that younger people tend to attempt suicide while older people succeed in killing themselves. The means of the subjects who have attempted suicide and those who have committed suicide were compared and the results were significant. Thus individuals who attempted suicide were younger than those who succeeded in suicide. Therefore, the observations made by other researchers in developed countries was confirmed in this study. One of the reasons for the high suicide rate among the old people in western world has been related to the long life expectancy enjoyed in these countries. In most of these countries the majority of the people live over 60 years, compared to developing countries where the life expectancy is shorter. A study done in Nigeria by Asuni (1962) found no significant difference among the age groups. Asuni concluded that in Africa, the old people still enjoy the respect from the community and are highly protected by the extended family system. Asuni's observation however, was not confirmed in this study and based on the same argument it seems that the African old folks may no longer be respected and are not really protected by the extended family system.

The explanation of life expectancy does not fit this study since compared to western samples, the subjects in this study were actually younger and subjects in age bracket of 35 years and above tended to kill themselves more than other groups. In Africa, Kenya included, an individual above 30 years old is regarded as an old enough individual with full responsibilities in the society. Therefore, in situations where one feels that he has not lived to the societal expectations, he may consider himself a failure and decide to kill himself.

Sex of Subjects

According to the findings more female subjects (68 per cent of the total sample) attempted suicide than the male subjects (32 per cent of the total sample). This observation was different among the subjects who committed suicide where male subjects who committed suicide (64 per cent actually killed themselves more than the female subjects (Table 12). This observation has been made by other researchers in developed nations. Different explanations have been given by different researchers, but one explanation that fits this study is that offered by Durkheim where he observes that men in most societies tend to enjoy more or are more privileged in most relationships. Hence

when faced with problems in these relationships they may suffer more compared to women who in most cases have little to lose. In Africa, Kenya included, if one looks into marriage relationships, the man comes out better placed in traditional society. As the head of the family in most cases he is supposed to be looked after. Besides, the man tends to have more outlets in times of crisis compared to the woman. For example, if frustrated in life, he can easily take refuge in drinking or enjoy other forms of relationships while the woman is very much left to her own resources. For example, she is castigated by the society if seen in drinking places or involved in illicit relationships. Above all the African woman is very much needed at home and by children a factor which may stop her killing herself and in times of crisis she can only use threats like suicidal attempts to make people aware of her problems. Thus it may not be surprising in Kenya to find that more women attempt suicide.

Marital Status of Subjects

Fifty-nine subjects (50 per cent of the total sample) were married while 54 (46 per cent of the total sample) were single. Only two married subjects came from polygamous marriages. Three

subjects (3 per cent of the total sample) were separated - all of them were male subjects. One female subject was cohabiting. No subject was recorded as divorced or widowed (Table 28).

Table 28: Marital Status, Sex and Suicide (Percentage)

Marital status	Male	Female	%	N
Single	15	31	46	54
Married (mono)	15	34	46	54
Married (poly)	2	3	4	5
Separated	3	-	3	3
Cohabiting	-	1	1	1
N =	38	79	100	117

X^2 = 0.16, df = 1, Significance = 0.10

In developed countries, suicide has been observed to be more common among single individuals not married, separated, divorced or widowed. It has been observed that marriage can prevent suicide.

The study attempted to find out the difference among the sexes in relation to their marital status. Table 28 was regrouped into 2 categories consisting of single and married. Single group included individuals who were separated and the married group included individuals cohabiting. The results were insignificant when a chi-square test was done. Thus the subjects did not differ as far as their sex composition was concerned.

Occupation of Subjects

The occupation of the subjects was analysed in relation to the subjects' sex, since the two groups seemed to differ on what they were reported to be doing.

Occupation of Female Subjects

The majority of female subjects were housewives (51 per cent of the female sample: 40 females). Twenty female subjects (25 per cent) were students. Nine subjects (11 per cent) were reported to be housemaids while 4 subjects (5 per cent of the female sample) were reported as being receptionists and typists. There were three barmaids (4 per

cent), 1 laboratory technician, 1 enrolled nurse and 1 shopkeeper.

Overall 60 subjects were not engaged in any form of economic activities like business and the like (76 per cent of the female sample). This shows that most female subjects were actually dependent on other individuals for their livelihood. Again in Kenya, this observation may be misleading since a housewife who is doing her business at home like selling vegetables or making dresses may consider herself as unemployed and unless probing questions are asked, she may still go on record as a housewife.

Occupation of Male Subjects

Twenty-seven male subjects were reported to be manual labourers (71 per cent of the male sample). Twenty-one subjects in this group were either casual labourers or unemployed, while 4 subjects were shamba boys and 2 were recorded as houseboys.

There were 2 businessmen, 2 mechanics, 2 messengers and 2 students. There were also 1 laboratory assistant, 1 policeman and 1 tailor.

The Employment of Subjects

According to the results only 33 subjects (28 per cent of the total sample) were employed. Among this group 3 subjects were self-employed. The majority of subjects were unemployed (53 per cent of the total sample). Twenty-two subjects were students (19 per cent of the total sample). Twenty subjects (17 per cent of the total sample) were female students. Thus a large number of subjects were not economically productive (72 per cent of the total sample).

Education of Subjects

Fifty-seven subjects had primary education (49 per cent of the total sample) while 39 subjects had secondary education (33 per cent of the total sample). See Table 29.

Table 29: A Summary of Subjects' Education (Percentage)

Standard Reached	Male	Female	%	N
No education	3	12	15	17
Lower Primary (2-4 years)	7	8	15	17
Upper primary (5-7 years)	10	24	34	40
Secondary(form 1-4)	13	20	33	39
Higher (form 5-6)	-	2	2	2
University	-	2	2	2
N =	38	79	101	117

According to Table 29, no male subject with A level and university education was reported to have attempted suicide, while 4 female subjects with this form of education were reported to have attempted suicide.

Although the above observation could be as a result of documentation problems, where the male

counterparts of such education level may end up in private hospitals in Nairobi, one can still argue that women for the most part experience situations that lead one to suicidal acts compared to men. For example, 2 of the women with higher education were followed in the case study and the situations that led them to suicidal attempts were highly provocative. In one case, a man had married one of the university graduates with full promise that he had divorced his first wife. Immediately after marriage, the husband started to sneak out to his first wife. This lady went through spells of depression and eventually tried to kill herself mainly to punish the husband who had deceived her. This lady is still very bitter as she feels that the man has in fact ruined her life.

The second case was of a lady who was jilted by her lover after actually having his twins. This lady was still a student and her support systems were indeed limited. She also went through spells of depression and later attempted suicide. The rest of the 2 cases were also situations of abandonment by a lover, especially when he is mostly needed. Situations as described above often are

women's worries and hardly bother men. It is not surprising that even women with higher education can still participate in suicidal acts.

Subjects' Place of Birth

The majority of subjects came from Central, Nyanza and Western Provinces. Thirty-five subjects (30 per cent of the total sample) came from Central Province. Twenty-nine subjects (25 per cent of the total sample) came from Nyanza Province. Twenty-eight subjects (24 per cent of the total sample) came from Western Province (Table 30).

Table 30: A Summary of Subjects' Place of Birth (Percentage)

Provinces	Male	Female	%	N
Central	9	21	30	35
Nyanza	7	18	25	29
Western	9	15	24	28
Eastern	3	5	8	10
Rift Valley	3	2	5	6
Others (Coast, Nairobi, North Eastern, Uganda)	1	7	8	9
N =	38	79	100	117

Subjects' Place of Residence

This was not easy to determine as most subjects were recorded as coming from Nairobi without specifying a particular location within Nairobi (65 per cent of the total sample). Thirty-three subjects were recorded as if they had just come to Nairobi to visit or look for a job (28 per cent of the total sample). Two subjects came from Kibera while 2 subjects were living in Madaraka. The remaining 6 subjects were reported to be living in Eastlands.

Subjects' Tribal Representation

The majority of subjects came from 3 tribes mainly Kikuyu, Baluhyia and Luo tribes (79 per cent of the total sample). There were 38 Kikuyus (32 per cent of the total sample, 28 Baluhyias (24 per cent of the total sample) and 27 Luos (23 per cent of the total sample). Twenty-one per cent of the total sample included 10 Kambas, 5 Kisiis, 2 Taitas and 7 subjects came from Somalia, Ugandan,Kipsigis, Masai, Duruma, Meru and Indian/ (Table 31). /groups

Table 31: Tribal Representation

(Percentage)

Tribes	Male	Female	%	N
Kikuyu	10	22	32	38
Baluhyia	9	15	24	28
Luo	7	16	23	27
Kamba	3	5	8	10
Kisii	2	3	5	5
Taita	-	2	2	2
Others	2	4	6	7
N =	38	79	100	117

X^2 = 1.08, df = 3, Significance = 0.05

Four major tribes, that is the Kikuyus, Baluhyias, Luos and Kambas, were chosen to find out whether there was any difference among them in terms of sex representation. A chi-square test was done and the results were insignificant and there was no difference in sex among the 4 tribes' representation.

General Information About Subjects

According to the findings there were 115 Kenyans (38 male and 77 female subjects) an Asian and a Ugandan. All were living in Kenya when they attempted suicide.

The Person with whom the Subjects Stayed.

The majority of subjects stayed with either their spouses and children or parents or relatives or friends or employers. Only 10 subjects (9 per cent) stayed alone (Table 32).

Table 32: A Summary of Persons the Subjects Stayed With (Percentage)

	Male	Female	%	N
Spouse and children	9	34	43	51
Brother/Sister/ Brother-in-law	7	8	15	17
Parents/family	6	7	13	15
Father or mother alone	1	7	8	10
Alone	6	3	9	10
Uncle/Aunt/Cousin	2	3	5	5
Friend/Employer	2	3	5	7
Stepfather/Stepmother	-	2	2	2
N =	38	79	100	117

According to Table 32, 43 per cent of subjects stayed in a family, that is, a husband, a wife and children. Thirteen per cent of the subjects stayed with their parents, again in a family form and 9 per cent of the subjects either stayed with their fathers or mothers. Thus according to these findings 65 per cent of the total sample stayed with what one would call a family.

This study attempted to find out differences between the sexes in relation to the people they stayed with. Table 32 was regrouped into 3 categories. The 3 categories were those subjects who stayed with their spouses and parents, those subjects who stayed with their relatives and friends and individuals who stayed alone. The results were significant when a chi-square test was constituted (Table 33).

Table 33: Persons Subjects Stayed with and Sex (Percentage).

Persons Subjects Stayed with	Male	Female	N
Spouse and children/parents	50	72	76
Relatives	32	24	31
Alone	18	4	10
% =	100	100	
N =	38	79	117

X^2 = 10.32, df = 2, Significance = 0.05

According to the above table more male subjects stayed alone while the majority of female subjects stayed with their spouses or parents. Again more male subjects tended to stay with their relatives compared to the female subjects.

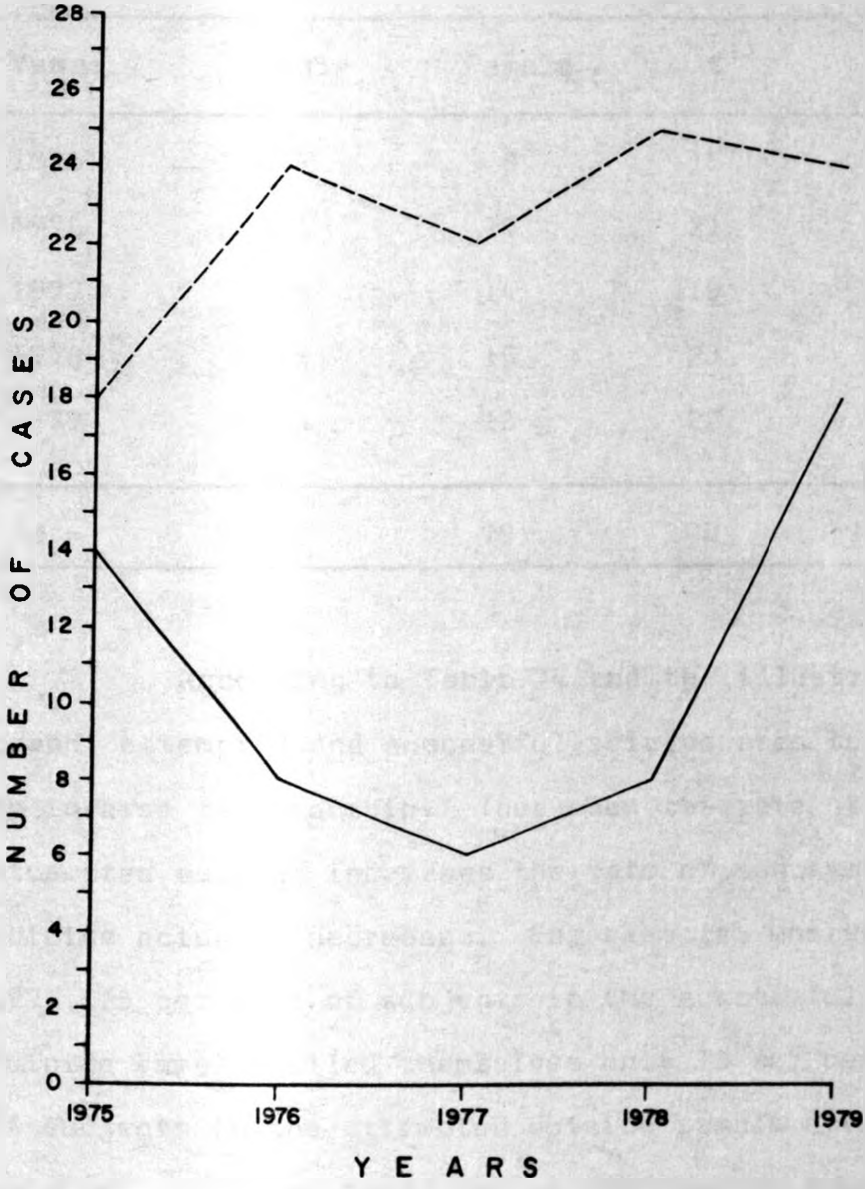
The fact that more female subjects should stay with either their spouses or parents may be related to the fact that in Africa, Kenya included, women are supposed to be protected especially when they are in new environments.

Thus a woman in town is expected either to stay with her husband or her parents or relatives. Those who stay alone are not readily accepted and at times are considered to be mischievous. On the other hand their male counterparts are often expected to be independent especially when employed.

Suicide Attempts According to Years.

Unlike successful suicide, fewer people attempted suicide in 1975 (15 per cent of the total sample of the attempters). According to the findings more subjects attempted suicide between 1976-1978 (62 per cent of the total sample) than those subjects who succeeded in suicide (39 per cent of the successful sample) during the same period (Table 34).

An illustrative Graph of Successful and Attempted Suicide according to Years



KEY

_____ Successful suicide

_ _ _ _ _ _ _ _ _ Attempted suicide

This graph was drawn from Tables 21 and 34.

Table 34: A Summary of Suicide Attempts According to Years (Percentage)

Years	Male	Female	%	N
1975	7	8	15	18
1976	6	15	21	24
1977	5	14	19	22
1978	8	15	23	27
1979	6	16	22	26
N =	38	79	100	117

According to Table 34 and the illustrative graph, attempted and successful suicide seem to be in an inverse relationship. Thus when the rate of attempted suicide increases the rate of successful suicide actually decreases. For example, whereas in 1975, 25 per cent of subjects in the successful suicide sample killed themselves only 15 per cent of subjects in the attempted suicide sample attempted suicide. The same trend can be observed in subsequent years (Tables 21 and 34).

This negative relationship can be explained in terms of the trend of suicide. It is possible

that individuals who attempt suicide and those who kill themselves come from the same population sample. Hence those who attempt suicide end up killing themselves at a later date, reducing the number of individuals who may attempt suicide.

Nonetheless, the high rates of suicide in 1975 and 1979 as illustrated by the graph on page 171 can be related to the events that took place at that time. For example 1975 was one of the years of famine in Kenya and 1979 witnessed sudden drop of incomes in agricultural and service sectors (Statistical Abstract, 1980:101). It is possible that individuals who faced hardships during the period might have seen no meaning in life and decided to kill themselves. According to some studies done in developed countries, suicide rate tends to decline in periods of prosperity and full employment and increases if the reverse is true (Dublin, 1963; Farber, 1968; Henry, 1954; Sainsbury, 1955). Thus Durkheim observed in his early days that the number of suicides immediately rose in Vienna when a financial crisis occurred in 1873-1874 (Durkheim, 1951). Therefore, with a fall in agriculture, the major occupation of the majority of Kenyans, it is possible that some individuals most

affected with these unanticipated events may kill themselves leading to the increase in the rates of successful suicide.

Suicide Attempts According to Months

The months were grouped into 4 categories, that is, January to March, April to June, July to September and October to December. According to the results the subjects tended to attempt suicide between January to March and October to December (44 per cent of the total sample). Few subjects attempted suicide between April to June (10 per cent of the total sample). See Table 35.

Table 35: A Summary of Suicide Attempts According to Months (Percentage)

Months	Male	Female	%	N
January - March	10	25	35	41
April - June	7	10	17	20
July - September	8	13	21	25
October-December	8	19	27	31
N =	38	79	100	117

Suicide attempts also increased sharply in August almost to the same level of March. (Also see the illustrative graph of Table 64 in Chapter Eight).

Although researchers in some countries like Great Britain have observed that individuals tend to commit suicide during early months of summer, such observations were hard to make in this study. Nonetheless, quite a large proportion of the subjects attempted suicide during the months that some parts of Kenya like Western Kenya experience shortages in terms of food and water. Besides during those months most families in Kenya incur rather high expenses in terms of school fees, Christmas and New Year celebrations. It is possible that in the process of planning for these festivities, some families and individuals may find themselves in difficulties leading to quarrels and feelings of one being disadvantaged in situations where one is unemployed. Besides it is during these months when major examinations affecting youths throughout the country take place and their results are also announced. All this could lead individuals and families to some form of instability and hence suicide (the section

has been discussed more in Chapter Eight).

Reasons for Attempting Suicide

The reasons subjects gave for attempting suicide were so varied that they had to be considered in terms of subjects' sex.

Reasons Male Subjects have for Committing Suicide

Eleven subjects (30 per cent of the male total sample) attempted suicide because they had disagreed with either their parents or brothers or sisters (Eight subjects disagreed with their parents, two subjects with brothers, and one subject with her sister). Those who disagreed with their parents did so because the parents were too strict. Subsequently, they either decided to run away or were told to leave their homes. For example, among some of the case studies followed the following statements were recorded:

> "My parents did not like my friends, so they asked me to leave their home; when I got a girl pregnant my sister told me to go away; I had no where to go when they sent me away and I decided to get rid of myself".

Seven male subjects attempted suicide because they were unemployed and life was unbearable (18 per cent of the male sample). For example among the cases followed:

> "I had many children but no income; I could not stand my children not attending school; if I cannot get a job I better quit".

were some of the statements given.

Six subjects (16 per cent of the male sample) attempted suicide, because of domestic problems. These included their wives running away and leaving them with many children they could not support. They too had no proper support and some in the case study had the following to say:

> "I could not stand my wife leaving me with children; life was unbearable with children and no mother; I was the mother and father with no job and life became too much".

Most of these subjects still appeared to be bitter and one feels that they may end up killing themselves.

Five subjects (13 per cent of the male male sample) attempted suicide because they experienced some forms of depression. For example some were recorded as, "patient reported to be fed up with life; patient said that life was unbearable.

patient could not sleep and was fed up". It is possible that these subjects were also experiencing some domestic problems as well as unemployment which might have precipitated their depression. Four subjects in this group were unemployed.

Five subjects (13 per cent of the male sample) attempted suicide because of abusing alcohol. Four subjects in this group were reported to have actually blamed their drinking while habit one subject was reported to have acted on alcohol hallucinosis. Again it is possible that these subjects were abusing alcohol because of the problems mentioned above that led other subjects to attempt suicide. All of the subjects were married and only 2 were employed.

Three subjects attempted suicide because they had disagreed with their employers and they feared to lose their jobs. Although it has been observed in Africa that some African men commit suicide because of impotence only one subject was recorded to have attempted suicide because of impotence. This could be so because of underreporting of the problem due to inadequate record keeping at the hospital where the study was done. Besides,

unless the interview was being done by either a psychiatrist or a social worker it was impossible for a general practitioner to ask the patients questions that might have given some information on the patients' sexual life. In most cases the reasons for suicide attempts were briefly recorded and summarised as follows: "fed up with life; life unbearable; gross marital problem; disagreement with partner; dispute with parents; alcohol; etc.". The records did not probe into reasons behind domestic problems or alcohol. The only impotent case was revealed after the patient had been to a psychiatric clinic and even then the notes were extremely brief.

Reasons Female Subjects gave for Attempting Suicide

Forty subjects (51 per cent of the female sample) attempted suicide because of poor relationships with their husbands. Sixteen subjects in this group attempted suicide because their husbands were unfaithful, slept outside their homes and did not support them. Nine subjects in the poor relationship attempted suicide because they could not give birth and so their husbands wanted to chase them away in order to marry other 'productive' wives.

For example the records reported some as saying:

> "Husband infected her and now claims that she cannot produce; Patient says that she is not God who gives children and felt bad when husband wanted to chase her to her parents. Patient decided to kill herself because she cannot have children and she has no parents".

Six subjects in the poor relationship group attempted suicide because their husbands felt that they were unfaithful. For example the following statements were recorded:

> "Husband abuses patient claiming that she is unfaithful; patient was chased to her parents because husband felt she had affairs outside; husband brought another wife home because the patient was alleged to be unfaithful; Husband accused her of infidelity".

Four subjects in the poor relationship group attempted suicide because their husbands brutally beat them and even allowed their brothers-in-law to abuse them, hence felt unsupported. Three subjects in this group committed suicide because their husbands abused them all the time and claimed that they did not like their relatives.

Two subjects in the poor relationship group committed suicide because they belonged to

different ethnic groups from that of their husbands and the relatives of their husbands did not accept them but their husbands did not care. For example the records of one subject read:

> "Patient belongs to another ethnic group. This has caused her a lot of torture from the husband's relatives; She has never been accepted, but the husband colludes with the relatives."

Another reason that made the female subjects attempt suicide in this study was the disagreement either with parents or sisters or brothers (24 per cent of the female sample). Eight subjects in this group disagreed with their parents or relatives because they got pregnant. For example, the records read:

> "Victim felt that parents consider her a failure; parents felt that patient ashamed them and chased her away; patient's sister and her husband felt that patient may teach their children bad behaviour and sent her away; patient felt nobody wanted to see her face; getting pregnant was hell to the patient as parents reacted as if she had murdered someone".

Six subjects in this group attempted suicide because their parents and relatives disliked their boy friends and other friends. Some were recorded as having said:

> "Patient's boyfriend was sent away and she felt humiliated; patient had been warned many times not to see the boyfriend any more".

Five subjects in the disagreement group attempted suicide because their mothers often got drunk and abused them. One subject in this group was even instructed to call her mother 'sister' so that the mother could not lose her second husband. The records stated:

> "Patient's mother abuses her when she is drunk. Patient feels that sometimes it is her mistake. Her mother calls her sister because the mother does not want her present husband to know she has a big daughter. Sometimes her mother tells visitors to the house that she is her maid. Imagine your mother calling you a maid! Patient resorted."

The common statements recorded as subjects said were:

> "Patient was fed up of being insulted by a drunkard mother; patient reported that her mother becomes unreasonable when drunk; patient felt that her mother embarrasses her".

The third reason that made some female subjects to attempt suicide was because they had

been jilted by boyfriends (11 female subjects). Most of them felt deceived and let down. For example:

> "Patient could not face friends after being deceived; patient was disgusted with herself after being used; patient's time was wasted, patient reported that she loved the boyfriend and life was no longer meaningful".

Two subjects attempted suicide because they had failed their certificate of primary education examinations. Three subjects committed suicide because their families were too poor to support them. Although prolonged illness has been observed in developed nations to be one of the factors associated with suicide, only one female subject attempted suicide because of this factor.

Loss in terms of death or property has been observed to be one of the reasons that may cause one to commit suicide. In this study only 2 female subjects attempted suicide because of loss. One subject in this group has lost 600 shillings while the other subject had lost her boyfriend through death and she wanted to be united with her boyfriend. The boyfriend died and left her pregnant.

Although polygamous marriages are common in Africa, Kenya included and one would expect frictions within such marriages leading to suicidal attempts, only one subject was reported to have attempted suicide because of disagreement with her husband's second wife. Although/recording system/the at the hospital might not have been useful in eliciting this phenomenon, it is also possible that polygamy having been widely practised in Kenya, women may no longer bother about it and see it as a normal practice which one has to learn to live with.

Thus according to this study it seems that most people attempt suicide because of poor relationships and unemployment. Factors like loneliness, prolonged illness and the like did not feature as major factors in suicide in the study.

Methods Used in Suicide

Studies done in the western world have shown that individuals who attempt suicide tend to poison themselves. According to this study, the majority of subjects (89 per cent of the total sample) poisoned themselves (Table 36).

Table 36: A Summary of Methods Used (Percentage)

Method	Male	Female	%	N
Poisoning	27	62	89	104
Burning	2	3	5	5
Cutting throat	3	-	3	4
Drinking broken glass	-	2	2	2
Hanging	-	1	1	1
Stabbing	1	-	1	1
N =	38	79	101	117

According to Table 36, subjects who attempted suicide were more likely to poison themselves compared to those subjects who succeeded in suicide (89 and 20 per cent respectively).

Studies in suicide have shown that individuals who attempt suicide tend to use non-violent methods and females tend to use non-violent methods compared to males. To test this observation the methods used were categorised as non-violent and

violent methods. The non-violent methods included poisoning and drinking broken glass while the violent methods included hanging, stabbing, cutting throat, burning and jumping from tall buildings. A chi-square test was done and the results were significant (Table 37).

Table 37: Methods Used by those who Attempted Suicide and Sex (Percentage)

Methods	Male	Female	N
Violent	18	5	11
Non-violent	82	95	106
N = 38	100	100 N=79	117

$X^2 = 4.07$, df = 1, Significance = 0.05

According to the above table female subjects tended to use non-violent methods while the male subjects tended to use more violent methods than their female counterparts.

Although suicide attempts have been considered to be a "cry for help" for those individuals involved, it is possible that more women in Kenya may actually use suicide to alert other people of

the problems facing them or influence other peoples' opinions. Hence women may not actually have the intention of killing themselves and resort to less violent methods like poisoning. On the other hand men having really failed to utilize the facilities that exist in the society to help them get rid of their frustrations, may actually be quite deliberate in their attempts and use those methods that are violent intending to succeed.

Most subjects (89 per cent of the total sample) used poisons and drugs. The poisons used included Diazinon, Kerosene, Iodine, D.D.T., clear-tone, organophosphate and sulphur acid (63 per cent of the total sample). The drugs used were asprin, chloroquine, piriton, lagactil, valium and barbiturates (26 per cent of the total sample). Five subjects (one female and 4 male subjects) used knives to cut and stab themselves, while 2 female subjects used broken glasses. One female subject used electric cord to hang herself. This subject had had 2 other suicide attempts.

Previous Suicide Attempts

Six male (16 per cent of the male sample) and 12 female subjects (15 per cent of the female sample) have previous suicide attempts. One male

and 4 female subjects had attempted suicide twice. Two male and 5 female subjects had attempted suicide 3 times and 3 male and 2 female subjects had attempted suicide 4 times. There was one female subject who had attempted suicide 5 times.

The reasons for the subsequent suicide attempts varied. Five male subjects who had had other suicide attempts were recorded as depressed. For example, one subject in this group was recorded as wanting to kill himself in order to save hiself from the sinful world. One male subject with 3 other attempts wanted to kill himself because he had problems with his parents and relatives.

Four female subjects who had other attempts did so because of problems they had with their husbands. While 6 female subjects with other attempts did so because of problems with their parents. One female subject thought that she was pregnant and could not face her parents (this same subject attempted suicide after being chased away by her sister because she was pregnant). One female subject had attempted suicide because she had failed her Certificate of Primary Education (C.P.E.) examination.

According to this study most subjects tended to reattempt suicide because of a poor relationship with parents (39 per cent of the reattempters); depression (28 per cent of the reattempters) and poor relationship with husband (22 per cent of the reattempters). Thus the relationship and mental state of an individual seem to be significant in situations where suicide attempts have to be repeated.

What Happens to Individuals Who Attempt Suicide.

The study looked into what happens to individuals who attempt suicide.

According to the findings 22 male subjects (59 per cent of the male sample) and 42 female subjects (54 per cent of the female sample) were referred to Psychiatric Clinic at Kenyatta National Hospital. Thus only 64 subjects (55 per cent of the total sample) were recorded as to have been referred to the Psychiatric Clinic. Among this group 7 subjects (3 male and 4 female subjects) were referred to Mathare Mental Hospital for treatment which was not specified. All that was recorded was "patient still suicidal - refer to Mathare".

Sixteen male subjects and 37 female subjects although recommended to attend the Psychiatric Clinic at Kenyatta National Hospital actually never appeared at the Clinic. At least they were not recorded as they had attended the clinic.

The majority of those subjects who actually attended the clinic only did so once (13 male subjects and 29 female subjects). Only 6 male and 13 female subjects attended the clinic regularly. For most of these subjects the attendance range was 2-7 visits.

This study confirms the observations that have been made in other studies that individuals who attempted suicide in most cases find it difficult to accept the services offered to them and have the tendency to disappear into thin air after hospitalization for the attempts. The disappearance of those who attempt suicide from the services offered is not accidental since in Kenya suicide is actually illegal and anybody found doing so is liable to punishment under the legal system of Kenya. Besides suicide is stigmatized in most societies although is a "cry for help" that things are not well. Although one may attempt suicide to show others that he has a problem, the same

individual may not have the intention of exposing his family or personal problems to the public unnecessarily and he may hope that what he has done may warn the person responsible for his predicament. This warning is often hoped would change the behaviour and the individual may not see the need of going to the hospital to attend the clinic. It is also possible that the conflicts might be resolved in due course.

In Africa, suicide is not really considered to be an illness that may need a doctor's prolonged attention and not knowing the role of a psychiatrist, the individuals who have attempted suicide may not see the importance of attending above all, a psychiatric clinic. Besides, problems of relationships and unemployment at least are those problems that no one would think can be solved in the hospital. Therefore, it is not surprising that even those who agree to attend the clinic only appear once. Another factor that can influence the clinic attendance is whether one has money for transport. Since most of the subjects studied were unemployed, it is possible these individuals had no money to use for travelling to the hospital. Some subjects after

realizing that the type of lives they were living was rather difficult, may actually leave Nairobi to their rural homes again making it difficult to attend the clinic.

In Kenya, suicide is still illegal and an individual attempting suicide is not only risking his life, but is also risking the possibility of being imprisoned. Thus in this study there were 2 subjects recorded as having been to court. One subject was recorded as having been put on probation for 2 years and one subject had actually been imprisoned for 6 months. This subject had absconded from prison and made another suicide attempt.

General Patient Group (Control Group)

Background Information

A hundred and nine subjects were randomly selected at Kenyatta National Hospital among patients who had been admitted at the hospital through casualty department between 1975-1979. Thirty subjects had to be dropped in the analysis for various reasons. Nineteen subjects were children and babies of the age range of 10 years to 4 months. Eleven subjects had very little information recorded in their files and hence were not considered useful for the analysis of this study. Thus only 79 subjects were chosen for the analysis in this group.

Age of Subjects

The ages of 17 subjects were not recorded in their files and only 62 subjects of the total sample had their ages recorded. The mean age of the subjects was 27.4 years with a standard deviation of 9.9 years and a range of 13-60 years. Like the subjects who attempted suicide, the majority of the subjects were young and 66 per cent of the subjects were between 13-28 years while only 34 per cent of the subjects were between 29-60 years (Table 38).

Table 38: A Summary of Subjects' Ages (Percentage)

Age (years)	Subjects		Total	N
	Male	Female	(%)	(%)
13 - 20	5.0	14.0	19	15
21 - 28	5.0	28.0	33	26
29 - 36	5.0	11.0	16	13
37 - 44	1.5	1.5	3	2
45 - 52	2.5	2.5	5	4
53 - 60	3.0	-	3	2
No response	11.0	10.0	21	17
N =	26	53	100	79

Sex of Subjects

According to table 39 more female subjects (67 per cent of the total sample) were admitted through casualty department. Like the subjects who have attempted suicide only 26 male subjects (33 per cent of the total sample) were admitted through casualty department.

Marital Status of Subjects

The majority of subjects were married (54 per cent of the total sample). This included 16 male and 27 female subjects in the study. Eight male and 24 female subjects were single (41 per cent of the total sample). Only one female subject (2 per cent of the total sample) was widowed. Two subjects (3 per cent of total the sample) were not recorded as married.

Occupation of Subjects

Forty-two female subjects were housewives (53 per cent of the total sample). Thirteen male subjects (16 per cent of the total sample) were peasant farmers. Thirteen percent of the total sample (5 male and 5 female subjects) were students. Four male subjects (5 per cent of the total sample) were mechanics. There were 2 female hawkers, 2 female teachers, 2 male drivers, one male clerk, one male doctor, one female messenger and one female business woman (13 per cent of the total sample).

Employment of Subjects

The majority of subjects were unemployed (70 per cent of the total sample). This included

13 male subjects (50 per cent of the male sample) and 42 female subjects (53 per cent of the female sample). Fourteen subjects (18 per cent of the total sample) were employed. This included 8 male subjects (31 per cent of the male sample) and 6 female subjects (11 per cent of the female sample). The employment situation of the subjects seemed not to be different from the subjects who attempted suicide and in both cases the majority of subjects were unemployed.

Education of Subjects

The majority of subjects had no education (44 per cent of the total sample). Table 40 shows the education of subjects.

Table 39: A Summary of Subjects' Education (Percentage)

Standard Reached	Male	Female	%	N
No education	13	32	45	35
Lower primary (2-4 years)	4	9	13	10
Upper primary (5-7 years)	6	4	10	8
Secondary (Form 1-4)	3	5	8	6
University	1	-	1	1
No response	6	18	24	19
N =	26	53	101	79

Subjects' Place of Residence

Like the subjects who committed and attempted suicide, the majority of the subjects in this group came from Central Province (38 per cent of the total sample). Nyanza and Western Provinces had 15 subjects each (38 per cent of the total sample). Nairobi, Eastern and Rift Valley Provinces had 6 subjects each (23 per cent of the total sample). Only one subject came from the Coast Province.

Place of Subjects' Residence

All subjects were staying in Nairobi at the time of admission at the Casualty Department. Unlike those subjects who attempted suicide, the subjects in this group had actually indicated where they were staying (Table 40). The subjects place of residence was categorized as shown in Table Chapter Four.

Table 40: A Summary of Subjects' Place of Residence.

Residence	Percentage	Subjects
Low	69	55
Medium	14	11
High	17	13
N =	100	79

While not trying to compare the control group and the successful suicide group as the 2 samples were quite different, it is worth noting, nonetheless, that the majority of subjects who went to hospital also tended to come from low residential areas just like those who killed themselves. Thus the early observations made by other researchers that suicide rates tend to be higher in high density and poorer and in lower-income residential areas (Dublin, 1963; Henry, 1954; Meer, 1976) may not be applicable in Kenya as this study tends to show that both individuals who killed themselves and those who went to hospital to get treatment for other diseases actually tended to live in low income residential areas in Nairobi.

The fact that all subjects were recorded as staying in locations in Nairobi could be as a result of subjects' length of stay in the hospital. Most of the subjects in this group stayed longer in the hospital (Mean of 1.1 months). It is also possible that these subjects revealed where they were staying because they had nothing to hide from the authority. Since suicide attempt is illegal in Kenya, the subjects who attempted suicide may not say where they reside mainly to avoid being followed by the police in case they had to appear in court for the offence. Thus it was logical for them to avoid leaving proper records in the hospital.

Tribal Representation of Subjects

Thirty-seven subjects were Kikuyus (48 per cent of the total sample). Twelve subjects were Kambas (15 per cent of the total sample). Eleven subjects were Baluhyias (14 per cent of the total sample). Nine subjects were Luos (11 per cent of the total sample). Ten subjects came from various tribes mainly Kisii, Kalenjin, Masai and Meru (13 per cent of the total sample).

The Persons Subjects Stayed With

Twenty-six subjects (33 per cent of the total sample) lived with their spouses in Nairobi. Thirteen subjects (16 per cent of the total sample) stayed with either their brothers or sisters. Nine subjects (11 per cent of the total sample) stayed with both their parents while 7 subjects (9 per cent of the total sample) stayed with one of the parents. Five subjects stayed with their friends (7 per cent of the total sample). Only 4 subjects were reported to be staying alone. Fifteen subjects (19 per cent of the total sample) were not recorded as staying with anybody.

Religion of the Subjects

The majority of subjects were either Catholics or Protestants (Table 41).

Table 41: A Summary of Subjects' Religion

Religion	Subjects	%
Catholics	28	35
Protestants	26	33
Moslems	5	6
No religion	9	11
No response	11	14
N =	79	99

Unlike the subjects who attempted suicide, the majority of subjects had their religion recorded in their files. This again could be related to the fact that these subjects stayed longer in the hospital, a situation that may make the staff to get more information from them.

General Information About Subjects

Year Subjects Were Admitted to the Hospital

Eighteen subjects were admitted to the hospital in 1976 while 17 subjects were admitted in 1979 (Table 42).

Table 42: A Summary of the Number of Subjects who were Admitted to the Hospital in 1975 - 1979.

Year	Subjects	%
1975	14	18
1976	18	23
1977	16	20
1978	14	18
1979	17	22
N =	79	101

Also like / subjects who attempted suicide fewer / the people were admitted through the Casualty Department in 1975. But in 1978 more subjects seemed to have been admitted through casualty department with attempts of suicide than the subjects in the control group (23 per cent in the suicide attempt group and 18 per cent in the control group). But in 1979 the rate of admission at the casualty department seemed to be the same for both groups (22 per cent in each group was actually admitted through casualty department in 1979).

Months Subjects were Admitted to the Hospital

As in attempted suicide sample, the months were grouped into 4 categories, that is, January to March; April to June; July to September and October to December (Table 43).

Table 43: A Summary of the Months Subjects were Admitted

Months	Subjects	%
January-March	24	30
April - June	14	18
July - September	24	30
October - December	17	22
N =	79	100

According to table 43, most subjects in the control group were admitted through casualty department in January-March, and July-September, unlike subjects in attempted suicide group where most of them tended to attempt suicide in January to March and October to December.

Reasons for Subjects' Admission to the Hospital.

Most subjects in the control group were admitted at the hospital for organic reasons (97 per cent of the total sample). Only 2 subjects were admitted with non-organic complaint (hysteria). According to the diagnosis recorded 23 subjects had infections (29 per cent of the total sample). Fifteen subjects in this group had urinary infections and syphilis while 8 subjects in the group had tuberclosis (Table 44).

Table 44: A Summary of Reasons for Admissions (Percentage)

Reasons for Subjects Admission	Subjects	%
Infections (T.B.,Urinary, Syphilis)	23	29
Abortions	22	28
Injuries (accidents)	13	17
Anaemia	9	11
Pheumonia, Diabetes, Armernorhea	7	8
Peptic ulcer	3	4
Hysteria	2	3
N =	79	100

According to Table 44, the majority of subjects in the control group tended to be admitted to the hospital through casualty department because of infections and abortions.

Fifty-seven subjects (72 per cent of the total sample) had had previous admissions with organic problems, mainly infections, abortions and accidents. Seventeen subjects in this group had previous admissions with abortions. Only 5 subjects had previous admissions with hysteria.

Subjects' Personal Habits

Only 10 subjects were recorded as drinking (13 per cent of the total sample) and 9 subjects (11 per cent of the total sample) were smoking.

Subjects' Recorded Problems

Only 15 subjects were recorded to have problems that perhaps needed someone to attend to (19 per cent of the total sample). One subject had lost money while 4 subjects had lost their relatives. Ten subjects in this group were reported to have family problems which were not specified.

Nine of them were female subjects and all had abortions. Only one male subject was reported to have a family problem and he had had an accident.

Eighteen subjects (23 per cent of the total sample) were reported to have other illnesses apart from the illnesses that led to their admissions.

CHAPTER SIX

THE EFFECTS OF SUICIDE ON RELATIVES

This section includes a case study of 30 relatives of individuals who had committed and attempted suicide in Nairobi since 1975-1979. Although 95 relatives of those who had attempted to kill themselves and 30 relatives of those who had succeeded in killing themselves were written to through the addresses they had left at the police stations and Kenyatta National Hospital only 25 relatives responded to the letters. Five more subjects were identified through social work agencies and a total of 30 relatives were eventually interviewed. This included 17 relatives of individuals who had succeeded in killing themselves and 13 relatives of those who had attempted suicide.

Reasons Relatives Gave for Suicide

The relatives were asked in general what they thought made people kill themselves. Nine subjects said that, people kill themselves because of social problems. Six subjects felt that people kill themselves because of frustrations in life.

Five subjects felt that people kill themselves because of anger. Seven subjects felt that people kill themselves because of devils and witchcraft while 2 subjects felt that people kill themselves because of parental abuse. Only one subject said that people kill themselves to avoid suffering.

When the relatives were specifically asked about what happened in their own situation, the majority of them gave reasons that are related to the reasons they had given above, mainly frustrations, social problems, devils and witchcraft.

Twenty subjects (67 per cent of the total sample) reported to have been away either at work or in the garden or at school or in another house when the relative/committed or attempted suicide. /either Only 5 subjects (17 per cent of the total sample) reported to have been at home at the time the relative committed suicide and witnessed the act. The majority of the relatives had to be informed about the act.

How the Relatives Felt about what had Happened

The subjects were asked whether they felt or thought what had happened was fair to their families. Only 3 subjects felt that what happened

was fair, mainly to the victims. One subject in this group was a young girl whose mother had had a psychiatric illness for a long time and had really changed in behaviour and the young girl did not like seeing her mother suffering. The other subject in this group had a father who had been physically ill for a very long time and the father decided in their absence to kill himself. The third subject was in a family where the victim was considered a threat to the family. For example, he drank excessively and sometimes stole family property and sold for drinks. He fought other people and the family really suffered because of the victim's behaviour.

The majority of the relatives(90 per cent) felt that the act was unfair to their families. When they were asked why they felt the act was unfair to their families, the following responses were obtained as shown in Table 45.

Table 45: Reasons Subjects gave as to why they felt the Act was Unfair.

Reasons	%	N
Left us with a lot of sorrow	37.0	10
Created a lot of problems to us	18.5	5
It is wrong to kill oneself	18.5	5
We were made responsible	15.0	4
Had children to look after	11.0	3
Total =	100	27

According to Table 45, a large proportion of the relatives felt that the act left them with lots of problems and sorrow. Fifteen per cent of the relatives actually disliked the act because they were held responsible and this might have left them with a lot of guilt feelings.

The subjects were asked how things were after the suicidal acts. The question was categorized as "alright, terrible and very terrible". Twenty subjects felt that the situation was terrible (67 per cent of the total sample). This

included 8 subjects whose relatives had succeeded in killing themselves and 12 subjects whose relatives had attempted suicide. Eight subjects whose relatives had succeeded in killing themselves felt that things were very terrible (27 per cent of the total sample). Only one subject whose relative succeeded in killing himself felt that things were alright (the relative had had a prolonged illness and his death seemed a relief to the family). One subject whose relative attempted suicide also felt things were alright as the family considered the boy to be a difficult person who was out to manipulate family relationship. The family seemed to be least sympathetic to the victim. For example, when the researcher asked whether they had thought that the boy would one day actually succeed in killing himself since this was his third attempt, the mother replied:

> "There are many people in Kenya. If he wants to kill himself, he can do so. We have had enough of his manipulations".

Subjects were also asked whether they felt the act would have been avoided. Twenty-three subjects (77 per cent of the total sample) felt that the act would have been avoided while 7 subjects (23 per cent of the total sample) felt that there was no way to avoid the act.

When the subjects were asked about their reasons of feeling as they did, 23 subjects felt that suicide would have been avoided if for example:

- Parents were understanding (30 per cent of subjects);
- Spouse was understanding (44 per cent of subjects); and if
- the victim was not left alone (6 per cent of subjects).

Those subjects who felt that suicide could not have been avoided include 2 subjects whose relatives had physical and mental prolonged illness. Two subjects had relatives who killed themselves because of incestuous relationships. Three subjects had relatives who killed themselves because of prolonged severe marital problems.

Burial Process

Subjects whose relatives succeeded in killing themselves were asked about the burial processes of their relatives. The experience was categorized as "easy, very easy, difficult, very difficult". Nine subjects felt that the burial was actually difficult while eight subjects felt that

the burial process was very difficult. Thus all 17 subjects whose relatives succeeded in killing themselves admitted experiencing some difficulties in burying their relatives. They experienced difficulties because of the reasons in Table 46.

Table 46: The Burial Experience of the Relatives

Experiences	%	N
Painful and terrifying as few people were willing to help	35	6
Everybody blamed us/daddy/mummy	29	5
Financial problems to take the body home	12	2
Police and post-mortem took too long	18	3
Few church people came	6	1
Total =	100	17

The above responses tend to support what has been observed by other researchers that the relatives of individuals who kill themselves often do not get the support often accorded to individuals who have lost their relatives through other sources of death (Bohannan, 1960; Douglas, 1967;

Orley, 1970), relatives, friends, neighbours, including police and the church. Even the 2 subjects whose relatives committed suicide because of prolonged illness also reported lack of support and understanding from the people.

All subjects were asked what type of death would be easier to deal with. Twenty-five subjects (83 per cent of the total sample) felt that it was easier to deal with natural death than suicide. Only 5 subjects felt that there was no difference. All 5 subjects had relatives who attempted suicide and it is possible that they lacked the experience while all 17 subjects whose relatives succeeded in killing themselves actually felt that suicide was difficult to deal with.

The subjects felt that suicide was difficult to deal with during the burial because of the reasons in Table 47.

Table 47: Reasons that made the Burial of those who Committed Suicide Difficult.

Reasons	%	N
People tend to talk about you	52	13
People are not sympathetic and willing to help	20	5
Government wants to know the cause of death	12	5
Relatives always worry about what happened	12	3
One feels ashamed as it would have been prevented	4	1
Total =	100	27

The subjects whose relatives succeeded in killing themselves were specifically asked whether they got help when their relatives died and who actually participated in giving help. Thirteen subjects (76 per cent of the successful suicide) reported that help was not forthcoming. Only 4 subjects (24 per cent of the successful suicide group) reported some help being given. Seventeen

subjects in the successful suicide group reported that only close relatives actually participated in the funeral arrangement. Two subjects reported friends and neighbours participating in the funeral arrangement. According to these findings, it seems that only close relatives of individuals who have killed themselves tend to participate in the burial arrangements. Hence suicidal deaths seem to be a family affair and the friends and neighbours seem to keep their distance. Nonetheless it was not possible to ascertain how much these relatives contributed to the treatment they received, especially their response to stigma attached to suicide.

What Happens to the Property of Individuals who have Committed Suicide.

Although researchers have observed that in some parts of Africa the property of the individuals who have killed themselves is often burnt, this study has not shown the same results. Although the sample is rather small, 6 subjects reported that in their case, the property of the deceased was given to his relatives and friends while 5 subjects

reported that the property was given to the spouse. Three subjects reported that their relatives had given their property away before they committed suicide. Three subjects even reported that their relatives had no property as they were young.

Orley (1970) observed that the property of individuals who killed themselves among the Baganda in Uganda were burnt and no relative was prepared to inherit from them. Orley's observation was actually supported by the key informants who reported that in most cases relatives are not willing to take the property of the individual who has killed himself. But the results in this study, according to the relatives, no problem was faced with the property showed of the relatives. However, the results have to be treated with caution as the subjects might have said what they might have wanted the researcher to hear in fear that they would appear too cruel and neglecting to their dead relatives if they had revealed the truth.

Family Change After Suicide

All subjects reported changes in their families after the incident. These changes varies according to the type of suicide. The subjects whose relatives succeeded in killing themselves reported loneliness.

Eleven subjects in this group reported that they lost their friends after the incident. These subjects felt that their relatives and friends held them responsible for what had happened. Thus a large proportion (65 per cent of relatives of successful suicide sample) observed some change in their relationship and reported loneliness. The following remarks were common:

> "things will never be the same; life will never be the same; everybody seems to blame daddy/father and brother for the death, they feel guilty and isolate themselves; it was not our mistake but we now pay the price, etc.".

Three subjects whose relatives succeeded in killing themselves reported that other family members broke down and had to be admitted to a mental hospital. Two subjects reported improvement in relationship. One female subject reported her daddy to have stopped drinking after her mother's death, while one male subject just observed life to be now peaceful. This was a case of a family where the victim had been misusing family resources and was considered to be disruptive to the family.

Twelve subjects whose relatives attempted suicide also reported some changes in their family's

relationships for example, the following remarks were common:

> "since this happened, people are not free with us; we were made to appear awful; we were made to appear too cruel; we have never been free with each other since it happened".

Two subjects in this group were reported to have attempted suicide since the incident.

The subjects in this group felt that the incidence may spoil their names and hence relationship with others in favour of the relative responsible. Thus although, the number of subjects who were involved was rather small, still one can conclude that the relatives of individuals who involved in suicidal acts do experience problems in their families not only before the act but much more after the act.

How the Relatives felt about Individuals who Committed Suicide

Subjects were asked whether they thought that individuals who either kill or attempt to kill themselves were sick. Twenty-one subjects (70 per cent of the relatives sample) felt that individuals are actually sick. These subjects felt that individuals who either kill or try to kill themselves had

some sort of mental problem. Twelve subjects (48 per cent) felt that people who kill themselves or try to kill themselves must be weak in mind or had been bewitched. Only 2 subjects (8 per cent) felt that suicide was infectious.

Ninety-three per cent of the subjects reported that people tend to fear bodies of people who have killed themselves. The following statements were common:

> "the bodies are often considered untouchable; their bodies are supposed to be unclean and should not be seen".

The subjects were asked what help and advice they would give to the relatives of those who have killed themselves. The majority of the subjects (77 per cent) felt that the relatives of individuals who have killed themselves should be prayed for. Three subjects (10 per cent) felt that the relatives should be given material help while 4 subjects (13 per cent) felt that the relatives needed friendship and understanding.

Subjects were also asked why people fail in their suicidal attempts and the following responses were recorded in Table 48.

Table 48: Reasons for Failing in Suicide

Reasons	%	N
God saves them	30	9
Change of mind after second thought	20	6
They want to tell others about their problems	17	5
It may not be the right time	13	4
The dose may be inadequate	7	2
They may be rescued	7	2
If there is no witchcraft	7	2
Total =	101	30

Thus the majority of subjects felt that the individuals who attempt suicide may not succeed in their attempt because God may save them or they may change their minds after a second thought (15 per cent). Five subjects (17 per cent) felt that suicide attempts may fail because the individuals concerned may only want to alert others or their problems while 4 subjects felt that suicide attempts fail because it may not be the right time for those concerned to succeed (13 per cent).

Subjects were asked whether individuals who have attempted suicide should be punished. Fifteen subjects felt that individuals who have attempted suicide should be punished (50 per cent). Ten subjects in the group felt that suicide is a crime or a sin and those who involved in it should be punished (33 per cent). Three subjects in this group felt that the punishment would teach others a lesson and hence deter others from doing so. This view was also held by non-professional key informants, that is, some priests and chiefs who said that those who try to kill themselves should be severely punished to discourage other people who may be contemplating suicide. Some policemen felt the same. Some of the key informants and the relatives felt that those who attempt suicide should be punished because they also punish others. The view of punishing those who attempt to kill themselves support the observation that has been made by other researchers of the punitive attitude of the society towards those who either kill themselves or attempt to kill themselves (Stengel, 1967).

Fifteen subjects (50 per cent) felt that the individuals who attempt suicide should not be punished. Eight subjects in this group felt that the

individuals who attempt to kill themselves do so because of problems that lead them to do so. This view was consistent with the professional view among the key informants where those key informants who were involved in some form of counselling felt that people who attempt suicide needed professional help. Five relatives felt that individuals who attempt suicide do so because they are either sick or weak and therefore need more help than punishment. Two relatives felt that those who attempt to kill themselves have been punished enough by God and so do not need any more punishment.

The majority of subjects whose relatives succeeded in killing themselves felt that those who attempted suicide should be punished (11 subjects out of 15 subjects who preferred punishment). The punitive attitude of individuals whose relatives have killed themselves is not accidental. These individuals having experienced the traumas of suicide in their families may not be tolerant of those individuals who attempt to kill themselves. Thus any suicidal attempt would remind these individuals of their own situation.

CHAPTER SEVEN

CASE STUDIES

Fourteen cases illustrating some points that have been observed in this study have been discussed in this chapter. The 14 cases reported here have been purposively selected from the 25 subjects who attempted suicide and were followed by the researcher and interviewed. They also include some of the subjects who had killed themselves and their relatives were traced and interviewed. Whatever they left in the suicide notes were also included to verify the information given by the relatives.

Cases 1, 7 and 9 show the dynamics of African life styles that can lead one to suicide, mainly the extended family system, polygamy and the value of children. Cases 2 and 6 show situations where because of changes in the family's economic systems the family gets adversely affected, that is, the economic loss of a husband and economic gain of a wife led to total loss of a wife. This in turn led to fatal suicide. Cases 3, 11, 10 and 14 show types of conflicts that exist between children and their parents and how these conflicts can lead to suicide.

Case 4 specifically illustrates the status of women irrespective of their education. It also shows the African perception of polygamy whatever their status in the society. Case 5 illustrates how resource utilization in the family can actually lead to suicide. Case 8 illustrates how difficult it is for an African in Kenya to accept or tolerate incestuous relationships. Case 12 illustrates the consequences of suicide on the family members while case 13 shows the Kenyan law stand on suicide. All these cases illustrate the appeal nature of suicide and how man struggles to seek some pleasure in life.

These cases have been distorted a little to avoid revealing the identity of the victims since providing the full details would have enabled some Kenyans to recognize the families. Hence unnecessary torture to the families that already have just had enough as shown in this study.

Case Number One

In Kenya, the extended family system is not only limited to the rural communities. The practice actually extends to urban areas. Thus when one looks for jobs or education in the towns he often stays with his relatives, whether distant or not.

Often the family is supposed to welcome the individual or individuals once the head of the family (often a father) decides. Depending on the size of the family, the family members may have to sacrifice a lot to accommodate the new person into the family. Given the economic situation of most Africans living in the towns, especially Nairobi, the family often faces a lot of problems. In this situation, the head of the family that is, the father and the husband tends to be irrelevant and frequently participates in outside activities like drinking and football games rather than face the situation. He may only come home to sleep as illustrated by this case. The wife finding herself being left to her own resources sometimes gets involved in suicidal acts mainly to show her husband that she has some difficulties at home.

Mrs. P. is a mother of 5 children. She came to Nairobi 4 years ago. Her husband works as a salesman in one of the Asian shops. The family stays in one of the slum areas in Nairobi in a two roomed semi-permanent house. According to Mrs. P., there was no time she has been in Nairobi without having stayed with some relatives from her husband's home. Being the first born, her husband often has to look after

his younger brothers especially when they have to look for work. Besides at times he has to accommodate his cousins who at times come to look for jobs. His house sometimes operates as a rest house especially when his relatives who work in Mombasa travel to Western Kenya for holidays and also when they return to Mombasa. Mrs. P. hardly goes to the rural home because she has no proper house and her husband has failed to build her a house according to her report. Besides, Mrs. P. had been having some illness which was recorded in the hospital as hysteria. To Mr. P. his wife had epilepsy which could not be treated by modern medicine.

The most interesting part of Mrs. P.'s illness is that she always lost strength, followed by loss of consciousness, whenever there was a relative staying with them. But often after fainting she could recount all that happened when she was supposed to be unconscious. Mrs. P. actually feels that some of the relatives are responsible for her illness as one of the relatives is very envious of her children. For example she had this to say:

> "I do not think my husband's people are happy with me because I was able to give Mr. P. these children".

Actually Mrs. P. is very proud that she has 5 children and yet she is only 23 years old.

Mr. P. on the other hand feels that Mrs. P.'s illness must have come from her home because of the stories he had heard of her uncle who does not actually like Mrs. P.'s family. In most cases Mr. P. does not arrive home until 11 P.M. He says that after work he meets his friends to discuss important current issues. His favourite bar is at Kaloleni where he meets people from his rural home who work in Nairobi. He works on Saturdays and spends his Sundays watching football at the City Stadium. He enjoys football although he does not play. This means that it is Mrs. P. who spends her time with the children and the relatives. When asked whether he takes his children also to see football, Mr. P. responded:

> "In Africa, the children of my children's age are looked after by their mother. If I take them what would their mother be doing".

Mr. P.'s first born is 7 years old and the last born is 8 months.

In most cases Mr. P.'s family lives on a two meals per day as he cannot afford lunch. Mrs. P. prepares porridge in the morning and then supper

in the evening. The meals are often far from what one may call a balanced diet. Tea with milk is often taken during public holidays. Meat is also eaten during special occasions and these are often national holidays.

On the day Mrs.P. attempted suicide her husband actually had just returned from wat-ching football. This time he arrived quite early according to him and he was shocked to discover that after his wife had given him food and went back to sleep he heard her breathe differently. First he thought that the wife was having one of her fits, but he realised that the wife was groaning. He woke the relative who was sleeping in one of the rooms with the children and when they checked on her she was sweating. They rushed her to the hospital and she was saved. It was in the hospital where they were told that his wife had taken some tablets. He thought and still thinks that the wife was crazy. He admitted having spent some nights outside his home and on those occasions the wife did not attempt suicide. He wondered why the wife decided to kill herself on the day he actually came home earlier than other times.

Mrs. P. reported that she attempted to kill herself because her husband wanted to marry another wife as she had epilepsy. She thought her husband was trying to get rid of her as she heard her husband tell the relative that she would be sent home to stay there for sometime. Prior to the suicide attempt the relative and Mrs. P. had disagreed as the relative sometimes used to bring his friends to the house and at times he had helped himself with Mrs. P.'s food in her absence. In the process of the disagreement, the relative told her that she was a lazy woman and he repeated what her husband had said that she would be sent home. Mr. P. felt that Mrs. P. should actually go home to be treated traditionally. Although Mrs. P. was referred to the Psychiatric Clinic, she could not attend because she had no money as the husband could not afford bus fare.

Case Number Two

Unemployment, as one of the factors associated with suicide, may not only lead one to suicide because a person can no longer support his family but it can create losses that can lead one to fatal death as illustrated by the following case.

Mr. F., 35 years old came from Eastern Kenya and was living in Nairobi with his wife and 5 children. He lived in Ziwani, one of the slum areas of Nairobi.

Mr. F. lost his job with the Railways because he was abusing alcohol. Later according to his sister he got saved and got a job with a private firm in Nairobi as a messenger. The firm closed down because of financial problems and Mr. F. lost his job once more. He became dependent on the wife who was a vegetable hawker and the sister (the informant) who was brewing alcohol to support herself. The sister also owned some mud houses, one of which she had given to her brother.

For one year the family lived on this meagre income. Mr. F. also tried to do some manual work (casual) to help subsidize the family income. During this time of unemployment Mr. F. noticed some change in his wife, a thing he discussed with his sister. The sister tried to talk to the wife, but the wife never heeded. He also talked with the man he thought was confusing the wife, but the man never stopped. In the end the wife eloped with this rich man leaving Mr. F. with his 5 children. He became very unhappy when he learned that his wife was actually

pregnant. Friends tried to talk him out of suicide but he could not stand it and eventually he jumped from one of the tall buildings in the city. According to the sister, the building was facing the office where the rich man, who took his wife, was working. His suicide note reads:

> "Although even after my death you will never come tobelieve this, when I wrote the letter you read I meant no harm. I wanted to post it to you. Also I wanted you hurt but anyway let us forget that.
>
> Believe it or not I could never in this world have ever hurt any soul, but God is the judge. Before I end my life I would like to let you know that I loved you till the last minute I was on this earth. I also love my children. Don't be sorry for me or my children. We deserve it. Bye.
>
> I will prepare a home for you wherever I will be. I feel deep down inside me that God will once bring you back to me".

Case Number Three

The interpersonal conflicts between children and their parents were observed to be one of the major factors that can be associated with suicide in this study. The following case illustrates a situation where a girl actually committed suicide because she felt her mother was embarrassing her.

Miss Y was 18 years at the time she killed herself. She was living with her mother and 2 sisters in one of the estates in Nairobi. She was the second born and did not know her father. One of her sisters and her mother were working in Nairobi at the time she killed herself. According to her sister Miss Y. was not a regular school attender, a situation that made her very unpopular with her mother.

Miss Y. had had a very prolonged conflict with her mother who was reported to be very harsh after drinking. The mother was reported to have involved herself with some boyfriends that Miss Y. did not like very much. Miss Y.'s elder sister had to run away from home and went to stay in a hostel because of the mother's bad behaviour. This situation was only described by Miss Y.'s sister, "Mum drinks badly and does not realize that we are now big." Because of constant abuses when Miss Y.'s mother came from drinking, Miss Y. hardly brought any visitors home. According to Miss Y.'s sister, sometimes they could not even introduce their mother to their friends. She says Miss Y. was actually weak and instead of killing herself she would have just left home as she did. The suicide note Miss Y

left to her mother reads:

> "I have thanked God to have given me this opportunity to write you this short letter. The main point I want to tell you is that you have been cruel and abusing me as stupid and that I roam about. You too have been drunk and roaming around. I have been pretending to be polite but tough headed. Therefore, you have told me that you can do without me. But I can no longer stand your abuses and behaviour. We will meet, we will meet. Do not regret, do not regret. But do not cry so much. Your dead daughter".

Before the suicide, the mother had come home with a friend and found Miss Y, with a man friend. She started abusing Miss Y and both the mother and the boyfriend chased Miss Y.'s man friend from the house saying that he was a thief. Miss Y. committed suicide on the following day in the morning after her mother had gone to work.

Case Number Four

The African woman whether educated or not still falls the victim of men's polygamous nature. Faced with the societal expectation of what is a good wife, the African woman can still be considered disadvantaged in terms of marital status.

This case illustrates the point.

Mr. and Mrs. K. are both educated and are in high positions in their places of employment. They have been blessed with 5 children. Mr. K. travels quite a lot because of the nature of his job. The problem started when Mr. K. met a lady, also holding a very responsible job in the city, in his process of travelling. The executive lady had been actually separated from her husband. Friendship developed and after one year Mrs. K. discovered that her husband who had been highly religious was actually engaged in some love affair. Mrs. K. strongly protested and she managed to rally the husband's relatives' support and they united against the executive. The executive realizing what was happening, started giving gifts in terms of money to the relatives. According to Mrs. K., she literally bought them with her money. Soon the relatives turned against Mrs. K. after the bribes and Mr. K. was persuaded to marry the executive. Mrs. K. witnessed her husband packing his things and going to stay with the executive. Being left with 6 children and constant provocations from the executive Mrs. K. attempted suicide. Mrs. K. reported that the executive told her that Mrs. K. should keep her wedding ring while the executive keeps the

husband, that is, "keep your ring and I keep the husband". Mrs. K. has actually attempted suicide several times and is still very bitter about the way she was robbed of her husband. The husband's relatives cannot understand why she feels bitter about Mr. K.'s marriage since in Africa that is expected. Besides her own parents feel that since she now has some children she is supposed to be appeased by her children and nothing more.

Case Number Five

For the Kenyan working woman the way the money she earns is used can lead one to suicide. Because of the changing role of women, the husband's authority seems to be threatened. To maintain the status quo, the man has a tendency to employ tactics that may be detrimental to the wife's life as illustrated by the following case.

After having been married for 6 years and blessed with 4 children (2 daughters and 2 sons), Mrs. J. decided to look for a job since she felt that whatever the husband was earning could not support herself and the children, let alone her family and the husband's family. According to

Mrs. J. life was good when they were poor, but after her step-brother helped her to get a job and she started "making money" things changed.

Since she had some basic education she managed to get reasonable pay and they could afford those things they could not afford before she began working. She brought a 13 year old girl from her rural home to look after her young child when she went to work. During this time she also managed to get one of the City Council houses, a three-roomed house. During this period her husband also got a job of a messenger in the same firm and also got some good pay.

After 2 years of living reasonably well, her husband declared that he was married to the maid. He brought the maid from where she was sleeping into the main bedroom and demanded that Mrs. J. leaves them the bed. At this time the maid was only 15 years old. Mrs. J. left and went to sleep in the sitting room with her 2 daughters as the 2 sons and 2 nephews were occupying the second bedroom. After 2 years of marriage, the second child of the maid died. It was this time that Mr. J. decided to send Mrs. J. home because it was alleged that she was responsible for the

death of the maid's child. Mrs. J. got very disappointed and decided to kill herself. For 3 years of the maid's marriage, life was like hell according to Mrs. J. The husband not only demanded that she cook for the maid, but that she also look after the maid's children when they happened to be out together. Things were even worse after she refused to go home.

Mrs. J. was staying under the most demeaning conditions the researcher has ever witnessed in her time of clinical work. The rooms were quite small and there was hardly any space for 2 wives. The maid's children slept under the main bed with a cot for the baby next to the bed. Mrs. J. had moved herself from the sitting room and put her small bed in the main bedroom. It was hard to imagine how the 2 wives actually had any relationship with their husband without the other wife being provoked. It was even more difficult to imagine all that goes on in the house with 4 grown up children with no privacy whatsoever.

Mr. J. had developed a taste for alcohol and at the end of the month he was known for making trouble and taking all the money Mrs. J. earned. He had declared that Mrs. J. can only stay in the

house so long as she surrenders her money. So when she tried to kill herself, she had faced many problems as regards her salary, her maid who became her co-wife and occasional beatings and threats from her husband. When being interviewed she was still very sad although not suicidal as she now sets her hope on her children who apparentlly were getting on well at school.

Case Number Six

It is not only women who at times face difficulties from men. Hence sometimes men too face terrible experiences that may rightly lead them to suicide. The following case illustrates the point.

Mr. W., 36 years old was married and had 3 children. When he got married his wife had no training. Later he took her for some secretarial training and later she got a well paying job with a private firm in Nairobi. Later the wife seemed to have gotten a boyfriend and actually left her job in Nairobi and went to work in another town where one of the sisters was working. Mr. W. got very dissappointed and wrote many letters to her with no response. He later wrote her the following note (see page 237) and then poisoned his three children

and himself. After the children died he placed their photos above each child showing the dates of death and birth. He wrote letters to his friends and relatives about the cause of his death. He wrote other letters to settle his bills and how his property should be managed. He finally placed his wedding photo on his head and drank poison. He placed a Bible on his side and opened Matthew chapter 19 verse 2-6. This was the most tragic death recorded in the police station.

Mrs. W. after running away decided to legally seek maintenance from her husband. Although Mr. W. had the custody of the children, it seems that the court decided that he should maintain his wife. This actually led him to kill his children and himself as he did not really see any reason for supporting a wife in exile! The court's decision seemed to have not been very much based on the real situation of what happened. According to the relative, Mrs. W. got a rich government official, she was having an affair with. This top man in the government could not be mentioned in court. The man being married could not marry Mrs. W. as his wife promised to kill either the official or Mrs.W.

if they got married. In order to get money from her husband she asked for separation with maintenance which she was granted by the court.

II

Address:
Across the bridge where there are no sorrows. There you'll meet M,N,B and G.

Dear W,

I have nothing to tell you in this last letter you 'll ever read from your first husband throughout your life. All that I needed to tell you had already told you in my previous letters which you did not answer. However, all I need is to wish you happy second marriage to your boyfriend the big high ranking officer Mr. G.

I know my decision is not the best but I'm more happier dead than alive. Whatever shameful deeds of prostitution which you'll be doing after my death, is just what you have been doing when I was alive. But what has made my heart to sink so much below a point of no return is to see how you neglected our children so much and inhumanly with no feelings of any maternal love. You considered your blood with your sisters to be much thicker than to your own children. So, have a good party with your most beloved sister M and your fiancee G to celebrate our death to give you the opportunity you longed for. Let M. be your best-maid.

In the letter dated 30th August 1977 which M. wrote to G., I noted with regret how your all sisters will not live as wives of a man. It's a pity because when I married you I thought you were a marrying kind woman but poor M. never knew of your

resolution not to live as wives. I hope God will give me a proper wife in my next life, and for these children, may God give them a proper loving mother on or in heaven as I believe we will come back to life again and enjoy the family life we expected to enjoy with you. All your prostitution, sweating looking for the money your sister M. promised you, no doubt you 'll spend it to bring up M. children as she has already killed her husband to achieve your declaration of not living as wives. If you 'll need to be called a mother again, . . . believe me, it will take you years to bring them up to where N. B. and G were. Maybe by then you 'll have learnt the art of motherly love to her children which you are missing with our three children. For us we shall be waiting you at the gate of death when your inevitable turn comes, but our spirits shall continue to haunt for you here on earth demanding your explanation for the benefit you have gained by wrecking our family. I would have liked to live longer but the suffering of our children and the dark future that lies ahead of them has taken away my life. I have already witnessed such sufferings right from the day you left them. I had tried all I could to save our home but all in vain. The devil using M.'s body has penetrated into your mind so much that you could not see the Light, but, believe me after our departure, a day will come for you to see the Light and you will remember my words that 'Had I known, always comes last'.

So W., as you made your final decision to wreck our family may what comes, where for 8 years you did not become the rich woman you expected to be so the same, I have made up my final decision to accomplish the FULFILMENT of my marriage vow 'For worse for good . . . till death depart us'.

By the time you will be reading this letter

you will no more be Mrs. M. neither will you be Mama N., B, and G. You 'll just be W. - a no man's woman and that's what you have been longing for.

However, this is what you MUST DO:

(1) YOU MUST COME and witness your victory to wreck our family against my will and the will of our children. That is you must come and see our bodies.

(2) YOU MUST NOT CLAIM for anything of my death benefits; Be satisfied with G.'s property. But throughout your life, keep the three educational files for our children which are in the court. You can take photographs but NOTHING ELSE in my household effects.

(3) YOU MUST BURY OUR BODIES at Langata Cementry in ONE SINGLE GRAVE four of us because that is how we have been living ever since the day you left us. NO cementing of the grave and NO ... coffins - let the'SOIL RETURN BACK TO THE SOIL'.

(4) NO BURIAL ceremony or speech or V.o.K. announcement but whoever wishes to put us in the newspaper can do so. Above ALL people M. MUST NOT attend our burial. Let her be busy at making a feast at her PALACE FOR ALL HER BELOVED SISTERS TO CELEBRATE.

(5) For M.'s evil deeds which have cost this family so much, I leave vengence to the Lord God. Tondu wathi-ino urihagiruo thi-ino. I pity G. for the inconvenience he is presently getting with his wife M. because of M. but that's how you are all of you. I am very sorry W. because I could not afford to give maintenance to a prostitute. What I needed is a woman

to build a family home and since you failed to make either a wife or a mother, things must come to an end. Whoever told you that M. will maintain you, was not in the church on 11 November 1964 to witness and hear what I said. So, get your richness from men and no doubt men do see that prostitutes earn their money properly. That is, what your sister means by saying that her beloved sisters will not live as wives.

Have as many condolences from your friends as you can and let them and you call me anything you wish, but remember these people have lost nothing yet they are the people you heard more than your husband. They will forget but you will take time to forget.

For our children and I, the Bible says, 'Happy are the dead ones but more happier are those who have never been born'. Let M. join G. and give the wise daughters of M. opportunity to enjoy life. Yet if people are led by a blind person, all of them fall in a pit and that is how and what is happening in M.'s family who follow their blind leader M.

Case Number Seven

In Africa, infertility has been observed to lead women to suicide. This case illustrates this.

Mrs. D. got married and stayed for 10 years without any children. Her husband held

responsible positions in the city. Although Mrs. D. had no child her husband had not cooperated to take her for any medical check-up. A teacher by profession Mrs. D. stayed with her husband with no problem for 2 years. On the third year the husband's parents, especially the mother started complaining to her husband. Since they were Catholics, Mrs. D. thought that her husband would not marry a second wife and so she suggested that they should adopt a child. This was highly rejected by both her husband and the family members.

One time her husband left her in Nairobi for some holidays in his rural community. When he came from the holiday, he brought a second wife with him. The wife had a child from other places. Later she started having her own children, but Mrs. D.'s husband insisted that she looks after her co-wife's children. She was supposed to washand feed them. According to Mrs. D., her husband made her appear like she was a maid. She got very depressed and she made suicidal attempts several times. She saw no point of living especially the way the husband was treating her.

Case Number Eight

In Kenya, there are certain types of behaviour that are not expected from parents, especially those of an incestuous nature. In situations where it happens the family remains damaged as often friends and relatives gossip a lot about the events. The guilt and shame often permeate the family and some members may either end up breaking down or attempting suicide as the following case illustrates.

Mrs. E. killed herself after discovering that her husband Mr. E. was actually having some incestuous sexual relationships with their daughter who was by then 18 years old.. She left a note telling her husband that she could not believe what she had heard people say, but when she physically caught her husband with the daughter, she could no longer face life and she hoped God would forgive both her husband and the daughter. Mr. E. was actually having sexual affairs with his second born daughter. Several months after the incident, Mr. E.'s elder daughter experiencing spells of depression and had to be/a psychiatric /admitted to hospital several times.

Mr. E. is supposed to be having some mental problems and he also abuses alcohol. The incestuous daughter, according to the aunt was pulled out of the "terrible relationship" with her father by her relatives, especially the aunts. She eventually managed to get married outside the tribe. Although one can see that there is some form of mental problem in the family, the aunt still feels that what her brother-in-law did ruined her sister's children and she sees no future for the 6 children her sister had.

Case Number Nine.

The African extended family system has been seen by early researchers to be highly generous. For a long time the African gates and doors have been widely opened for relatives and strangers. The English words like, "What can I do for you?" when a visitor comes into the house never existed in the African vocabulary. In Africa, a visitor was welcomed and offered food before he was asked where he came from. The individual was then allowed to stay as long as he wished. Such individuals could readily participate in the family activities without even being asked. The assimilation process was indeed

facilitated by the cordial and friendly atmosphere that existed between the family members and the relatives or visitors for that matter.

Nonetheless, situations have been changing in Kenya and the simple life in the rural communities no longer exists. Individual families have now to migrate to towns in order to fend for themselves. While in the towns, the families have to heavily rely on money which may not be enough considering the high cost of living and familial demands in towns. Yet in Kenya, most individuals who come to look for jobs in the towns still expect to put up with their relatives until such a time as they are able to live by themselves. The process of looking for jobs and shelter is not an easy exercise as illustrated by the following case.

Mr. O., a 29 years old came to Nairobi to look for employment. He had 6 years of education and he had problems of getting what he wanted. According to Mr. O.'s cousin, he wanted an office job and whenever the relatives got him brick-laying jobs he was not keen to take up the offer. This situation led to Mr. O. being in and off Nairobi, a situation that irritated the relatives who were supporting

him. At the time he was looking for jobs he was married and had 2 children. The wife and his children stayed with his parents in the rural community.

Prior to committing suicide, Mr. O. had virtually lived with every relative he had in Nairobi according to his uncle (the brother to his father's third wife). This uncle admitted that he just came to stay with Mr. O. because none of his close relatives could any longer welcome him. Mr. O.'s uncle saw him as somebody who enjoyed others' work and could not do so himself. He reported that Mr. O. was very choosy as far as jobs were concerned and was rather insensitive about the type of education he had. The uncle reported that Mr. O.'s relatives felt that he enjoyed being served. He even revealed how his wife felt about Mr. O. who sat in the house doing nothing and expected to be served. He demanded his clothes be washed and ironed and if you refused he left the house to the next relative. Nonetheless, they got surprised when the police informed them that Mr O threw himself from electricity house and died. The uncle remarked:

> "He was a gentleman and had no quarrels with anybody. He just hung around and you get fed up with him, but he would not utter any bad words".

Mr O left a note indicating that he could no longer bear life in Nairobi.

> "Life here is not bearable. I saw no need alive Goodbye my children and Mama K".

The impression one gets from Mr O.'s uncle is that Mr. O. did very little in the families he was staying with. He enjoyed being waited on and all the time behaved as a visitor who had just arrived in the house. Although he never answered back, it seems that in the process of all that he got depressed and eventually decided to kill himself, realizing that he had failed to get what he wanted and perhaps that the relatives were also fed up with him.

Case Number Ten

Education to many Kenyans means a lot and an individual aims at helping his children to get education so that they can get jobs. Those parents who work in Nairobi prefer their children to have education there even if the conditions under which they live may not be conducive to learning. The following case illustrates the point.

Miss X. was 13½ years when she attempted suicide. At that time she was living with her father and step-mother. There were her 2 brothers and a sister also staying with the family in Nairobi. Her step-mother had 3 small children ranging from 4 years to 2 months.

Miss X. and her family were staying in one of the flats of the Railways as her father was a carpenter with the firm. The flat was one roomed with a small kitchen. The room size was 10' x 10' and actually there was no space for such a large family. The father had tried to get a bigger flat from the firm, but he was not granted one because he was not in the rank for bigger houses. Miss X.'s mother was at the time of suicide staying in the rural home in Western Kenya with other 4 children who were young and so could not come to learn in Nairobi.

Miss X. and her 2 brothers and a sister were brought to Nairobi because of education. Both her parents felt that they can only get good education if they come to Nairobi. So Miss X. was to stay with her father and step-mother in a very small room indeed. Miss X. and her siblings slept in the small kitchen while the father and the step-mother

slept in the sitting room-cum-bedroom with a sheet put across the room as curtain to divide the room into 2 sections. Her step-sisters were sleeping under the bed while the baby was sleeping with the mother and the father in the bed.

When Mr. X. was asked why he could not send his children to the rural home to say with their mother while they are getting an education, he strongly objected to the idea and said:

> "Both me and their mother had no education and I would not like my children not to get good education. Tell me who is who without education in Kenya now? They have to learn".

Actually Mr. X. was extremely emotional when describing the education he would like his children to have.

According to Miss X. she attempted suicide because her father was very strict and does not allow them to mix with other children in the estate. Besides her step-mother was very cruel and always bullied her even if she was tired from school. Actually the step-mother expected her to take over house duties as soon as Miss X. arrived from school. Miss X. and her brothers and sister

always walked to school in the morning and evening. The school was quite far from the estate. Besides he did not trust the estate school because the children were not passing the C.P.E. well. Miss X. and the brothers and sister went to school barefooted as the father could not afford shoes. It was even hard for Mr. X. to provide his children with school uniforms and there was a time when Miss X. stayed for a term without going to school because she had no uniform.

Miss X. reportedly admitted being very tired every time she arrived at school and home in the evening. Often they hardly have any lunch and have to contend with the black tea they have for breakfast until at night when they eat supper.

Mr. X. was very unhappy because his children were not doing well in school. He was particularly sad about Miss X.'s performance who by then was in standard six. Miss X.'s report had shown that she always appeared tired and hardly participated in class. Her performance was very poor. Although Mr. X. wanted his children to have a good education he did not see how the small

living space and too much work could affect a child's performance in school. He felt that his daughter was being influenced by other girl friends in the estate. He admitted that often he had to quarrel with her daughter because of friends.

On the day Miss X. attempted suicide, she had a disagreement with her step-mother. That day she did not go to school as she was not feeling well, but her step-mother told her that she was pretending. This made her very disappointed and she went to a neighbour's house and borrowed insecticide for bed-bugs. Later when the neighbour came to visit the step-mother, she noticed that Miss X. was looking strange. She told the step-mother who went to call her father from work. Although Miss X. wanted to go to her mother and attend school there, her father could not allow it and she had to have her education under stark poverty in Nairobi.

Case Number Eleven

The interpersonal conflicts among parents and children can be so grave that the parents may actually get relieved after the death of the person they thought created problems for the family as illustrated by the following case.

Mr. B. killed himself when he was 20 years because of constant conflicts he had with his parents. He was described by the parents to have been different from other children in the family. According to his maternal uncle, Mr. B. was a trouble-maker who never heed any warning. This difficult behaviour started when he was in primary school where he could steal money from home and buy samosas to share with his friends. Later on he passed his C.P.E. and had to go to another province for his secondary school. Here he was expelled when he was in Form II after spending a night outside the boarding school he was attending. Before that, he was involved in several fights and his parents were warned about this.

After the expulsion his uncle got him a school in Nairobi. Here again he disturbed everybody. He stole money from his uncle's shop. He never went to school regularly and attempted suicide 4 times and made many threats. In the process his father died and he became depressed and attempted suicide again but was saved. The teachers got fed up with his many absences from school without proper explanations and eventually wrote him a letter copied to his uncle to explain why he felt he should

not be discontinued. At this time the uncle was fed up and never responded. The night before he jumped from Kenyatta Conference Centre, his uncle had chased his friends and himself away from the house because they were making too much noise for him. Mr. B. often played music until small hours in the morning and then spent his time sleeping the whole day. This disappointed his mother and relatives very much. Mr. B. did not leave any suicide note, but his uncle says that after the burial the family felt relieved. He also reported that Mr. B.'s mother was more well compared to the time Mr. B. was alive. According to him nobody could understand B. and it is good that he died to go and rest somewhere. The uncle said the following:

> "B was not meant for this world he made life difficult for his parents and everybody. At least his mother can now relax".

Mr. B.'s mother apparently used to be too thin when she thought of what B was doing. He got involved in every bad activity one could think of according to the uncle. The parents had to work hard to educate them but B never appreciated their sacrifice.

Case Number Twelve

Suicide has been observed to bring about changes in interpersonal relations as well as influencing decisions. The same suicide can cause untold suffering to the relatives of the victim as shown by the following case.

Miss T. attempted suicide after her sister had killed herself several weeks back. The problem originally started when T.'s mother killed herself because of the poor relationship that existed between her and her husband. It was T.'s sister who killed herself after finding their mother hanging in one of the rooms at their home. T.'s sister came from attending her classes at a Secretarial College. This seemed to have created problems in the family as it was the first time according to T. that other people realized that her father and mother were unhappy. T. and her 3 sisters were terribly hurt to learn that their father had caused a lot of problems to their mother.

A year later almost the same time T.'s elder sister 22 years old also killed herself in the house their father had rented for them to stay.

Her father at that time was cohabiting with another woman and living in the other part of the town. T. the third born had also to be called from a class in one of the Secretarial Colleges in the town, to be told that her sister was found dead. On arrival she also attempted to cut herself with a knife, but was saved by the relatives who were present. According to T, since her mother's death they lived like orphans as not many people visited them. Those who did had to do so because they were very close relatives and were concerned of what was happening. Their father, in particular, had very little to do with them and although he paid house rents, hardly came to vist them. They also were very resentful towards their father because of his behaviour as they realized that they could not even get boyfriends from their tribe. T. admitted the fact that they too isolated themselves because they were not sure what other people thought of them. After the second death an aunt came to live with them.

Case Number Thirteen

In Kenya, individuals who try to kill themselves are punished by the law if found since suicide is still considered illegal. The law apparently seems to be so insensitive to the problems

one may be facing and hence which made him kill himself. In certain situations the subjects needed real protection because they were attempting suicide because of severe mental problems as illustrated by the following case.

Mr. N. was 25 years at the time he attempted suicide. He was working and living alone in Nairobi. He started slashing himself with a panga because he wanted to kill himself. He was saved, but several days later he was at the Kenya Air Force looking for a gun to shoot himself. According to the records he wanted to kill himself because he was totally fed up with the world. He wanted to kill himself before the K.A.F. people got him and butchered him at the Ngong hills. He believed his father had been killed in order to be saved from the Air Force people.

The records read:

> "The accused seemed heavily drugged or confused when he arrived at K.A.F. with bleeding arms and asked either for two rounds of ammunations or to be taken to Ngong hills to be shot dead. He begged them to help him die and leave the world".

Mr. N. was taken to the hospital for two weeks and later appeared in court. He was put on probation for two years and he promised not to induce anybody to kill him! The patient was referred to the psychiatric clinic which he only attended once after he had been put on probation.

It is possible that Mr. N. was either suffering from alcohol problem or had a depressive illness which might have been better handled by a psychiatrist rather than a probation officer who might have not really understood what was happening to this young man.

Case Number Fourteen

Although disagreement between parents and their children are common phenomenon in Kenya, the majority of parents still try to play the role of parents. Occasionally the parents may use threats of disowning a difficult child mainly to discipline him and make him conform to the other members. It is indeed hard to find a mother calling her daughter, "sister", let alone introducing her as a "sister".

The following case illustration shows some of the problems that have been emerging in present Kenya.

Miss H was 18 years when she attempted suicide. She was living with her mother, sister and a step-father. Before this she was living with her maternal grandmother who later died and Miss H had to come and live with her mother who had just found a young husband from Uganda. At the time she attempted suicide she was selling things in her mother's shop.

Miss H did not know who her father was as nobody told her. After the grandmother's death in 1976 she came to live with her mother. Before, she reached the house her mother told her the position and requested that they should call each other 'sister' to save her marriage. She accepted this. But when she reached the house her mother started treating her as a maid and even told her friends that she was a maid. She got disappointed and left for Nakuru. Here she got involved in drinking as she worked in a bar. She had actually stolen her mother's clothes and sold them in Nakuru. The mother went for her after hearing of her behaviour of drinking and moving around with many men. Nonetheless when she came, there was no improvement

as she still remained her mother's "sister". The mother always warned her not to tell anybody that she was her daughter.

Because of constant conflicts and staying with a mother one calls "sister", Miss H. got disgusted and attempted to kill herself. She preferred death to her present life. H. could not face the life she was leading.

The multifactorial nature of the factors leading to suicide has been demonstrated by the 14 cases presented. Even within an individual case, one still gets several factors that might have led the individual to suicidal acts.

However, the two theories that have been looked into in the study, that is Durkheim's and Freudian theories tend to look at those who engage in suicidal acts as doing so because of some powerful forces. According to Durkheim, these forces are located in the society while Freud sees them originating from within the individual. Thus one can only commit suicide if he is not integrated into the society or family life and or when one turns

aggression against self. The fourteen cases presented seem not to fit into the integration and regulation continuum. Besides they have failed to show aggression being turned against self, and actually some cases have demonstrated aggression being turned against others. For example cases 2, 3, 6, 8 and 10 demonstrate situations where suicide was committed to punish the aggressor. But even with the above, other factors like loss, rejection, poverty, illegitimacy, overcrowding, prolonged poor relationships and abuse of alcohol were other factors which might have led these people to suicide.

Suicide has been seen by Freud and his followers as resulting from man's need to destroy himself and man's traumatic childhood experiences. All this is supposed to lead one to turn aggression against oneself. The above statement supported by the cases presented leaves one with many questions to ask. For example what have the self-destructive needs and childhood experiences to do with a true life situation where a man spends his time out and one is bogged down with relatives and no support whatsoever from a husband (Case number one); where one uses his resources to train a wife, only to be slapped on

the face by her disappearing from marriage and claiming maintenance (Case Number Six); where a husband, supposedly educated, abandons his wife and marries another wife less educated than his first wife (Case Number Four); where one loses a job and the wife leaves him for greener pastures (Case Number Two); where a husband marries your maid and takes all that money you earn (Case Number Five); and where a wife fails to have children and is punished even before the medical world proved her guilty (Case Number Seven). All these cases clearly show that suicide seems really to be as a result of many factors and its victims tend to use it as an effective means of communicating their problems.

The limitation of looking at very few casual factors can also be seen in terms of Durkheim's discussion of marriage. Durkheim had noted the importance of marriage and hence family life in the prevention of suicide. Suicide rates were seen to be higher where individuals were single or widowed or divorced. Cases 1, 2, 4, 5, 6 and 10 actually tend to refute Durkheim's work. Individuals who were involved in suicidal acts were married and had large families and the conflicts

within marriage and the family systems led them to suicide. For example, in case number 4 Mrs. K got disappointed when her husband abandoned her and married another wife leaving her with quite a large family to look after. In case number 6 Mr. W. got very disappointed when he realised that his wife, whom he spent his money educating, actually took off with another man leaving him with children to look after and finally Mr. F. in case number 2 killed himself after he had been abandoned by his wife after he had lost his job. The three cases clearly demonstrate that it is not the family life that may prevent one from suicidal acts, but the quality of that family life. What this implies is that marriage in itself does not explain much about suicide.

As well Durkheim dealt with three types of suicide based on the integration and regulation continuum and resulting from the type of relationship a man has with his society. In egoistic suicide one kills himself because one is isolated and left very much to his resources. However, the problem with interpreting isolation is that the factors that may lead one to the state of

isolation can lead one to suicide before the state of isolation is actually reached. For example, in Case number 14, many variables led Miss H to her final isolation. Miss H. attempted suicide for many reasons. Firstly, she is an illegitimate child who was brought up by her grandmother. She lost her grandmother through death and she had to join her mother who calls her a 'sister' for her own practical reasons. She involved herself in drinking and ran away from her mother who later fetched her from where she had taken refuge. Back with her mother, she still remained a 'sister' to the mother's husband and a 'servant' to her mother's friends. All this is indeed provocative and demeaning to Miss H. and cannot be seen as purely a problem of isolation. Again looking at Case number 11 Mr. B. before killing himself, had gone through a series of problems before he was isolated. All along his life was characterised by failing, running away from home, drinking and being blamed by his family. His behaviour made it difficult for the family to accept him. All the conflicts Mr. B. had with his family were enough to lead him to suicidal activities irrespective of isolation.

The altruisic suicide has been observed by Durkheim to be related to situations where one is over integrated into the society. He observed this type of suicide to be common in primitive societies. One kills himself because he values the society more than himself. So servants are supposed to kill themselves to follow their masters and the wives may kill themselves to follow their dead husbands. This type of suicide seems not to have occurred in any of the 14 cases presented here. The majority of the cases engaged in suicidal acts because of conflicts in their families. For example in Case number 8 Mrs. E. killed herself because her husband had had an incestuous relationship with her daughter and she could no longer face the world as that had created shame to the family. Her husband on the other hand had been experiencing some mental problems which led him to abuse alcohol. All this caused the relationship between him and his wife to be poor. In case number 12 Mrs. T. killed herself because of poor relationship she had with her husband and this led to subsequent suicidal acts in the family. Here one gets shame, and vengence as major reasons, for suicide rather than obligations one has towards issues or the society.

Durkheim has called the other form of suicide Anomic suicide. This is supposed to come about when one's behaviour is not regulated because the norms are no longer acceptable to the individuals. Without norms the individual may feel as if nothing matters because there are no norms to which one adhers and regulates his behaviour. The 14 cases have not demonstrated a case where one kills himself because of the state described above. Although one could observe some elements of anomie in cases numbers 1, 2, 4 and 5, the individuals who might have been going through this process were not the victims but the aggressors. For example in case number one, although men are allowed to marry several women in Kenyan society, he is not expected to spend nights outside his homestead, unless the situation is unavoidable. But Mr. P. easily slept outside his house because he was in the city where his behaviour is not really controlled by anybody. He is supposed to control his own behaviour but with no rules and regulations as to when he should do it. In case number 2 Mrs. F. disappears with another man because her husband has no job, a thing she would never do in her rural

community because of the rules and regulations that still exist in those communities. But in the city where no one really watches her behaviour she decides to do what makes her happy. In the two cases one can clearly see situations where behaviour is not regulated or controlled, but the state has not reached the level of suicide as described by Durkheim. In fact the individuals who involved themselves in suicidal acts tended to show protests against situations where they were supposed to practice the cultural values and norms on their own while their partners were free to do whatever they felt fitted them. For example in Case 4 Mr. K., although highly educated decided to acquire a second wife knowing very well that this practice although traditionally acceptable, would be very humiliating to his wife who was also highly educated. Because of this humiliation Mrs. K. decides to kill herself mainly to protest against the practice. In Case number one, Mr. P. decides to practice the African hospitality, by inviting all his relatives to his house in the city. The door of the house remaining open for any relative and friends, but he is hardly at home to welcome them. He does not even provide enough food to feed them. He

spends his nights outside the home expecting his wife to manage the family including his relatives with no problem. This state provokes Mrs. P. to attempt to kill herself, mainly to protest at a traditional practice which may have little relevance to her present situation.

In conclusion, the 14 cases have clearly demonstrated that no one factor leads to suicide and any one theory which may limit itself to one causal factor may be limiting indeed.

CHAPTER EIGHT

COMPARISONS AND CONTRASTS BETWEEN SAMPLES

Successful Suicide and Attempted Suicide

Age Comparison

The ages of the subjects who committed and attempted suicide were compared using the two means. The results were significant and individuals who succeeded to kill themselves tended to be older than those individuals who attempted suicide (Table 49).

Table 49: Age and Type of Suicide

	Successful Suicide	Attempted Suicide	N
Mean	35.5	24.2	
S.D.	10.9	7.3	
N =	56	117	173

t = 6.96, df = 171, Significance = 0.05

The difference in age of those who participate in suicidal acts has been observed in most researches done in developed countries. In these countries more younger people tend to make suicidal attempts than successful suicides (Henry, 1954; Kessel, 1965; Kreitman, 1973; Stengel, 1967). Although what is considered to be old in this study might be seen as young in the developed countries, still the individuals that can be considered old according to Kenyan life expectancy, tended to succeed more in suicidal attempts compared to individuals who would be considered as young in Kenya. Kenyan life expectancy is about 50 years while life expectancy in the developed world is about 70 years. Thus old age then becomes relative to national life expectancy.

In Kenya those considered old persons may commit suicide for various reasons. Apart from the usual argument that older people are no longer supported and recognised by the modern society as was the case in traditional society, it is also a fact that older persons in Kenya are expected to be highly independent and look after

their affairs well. Individuals who are 30 years and above are expected to have been married and should be looking after their children and old parents and any other relatives that may exist within the extended family systems. Failure to shoulder such responsibilities, the individual is seen as a failure. Shouldering responsibilities was an easy exercise in the traditional society where individuals cultivated and grew all that they consumed. The animals were available. An individual could feed his family and other relatives with ease. With the onset of education and cash economy one has to face stiff competition and in situations where unemployment is rampant the individual is left with very few alternatives indeed. An individual who cannot shoulder responsibilities not only perceives himself as a failure as he cannot meet the obligations, but his family members and any other person who depends on him, see him as a failure because he cannot support them.

The above statement can be supported by the reasons individuals who killed themselves gave for doing so and those given by those individuals who attempted suicide. In this study 16 subjects who succeeded in killing themselves left notes clearly indicating that they killed

themselves because they were unemployed and could no longer face life (Table 26). Although the majority of the subjects who attempted suicide were unemployed (70 per cent of the attempted suicide sample), only 10 male subjects (7 per cent of the attempted suicide sample) said that they attempted to kill themselves because they were unemployed. This made them not to support their families who actually expected them to do so.

Sex Comparison

Studies done in the developed world have indicated that the type of suicide depends on the sex of the individuals. Thus male individuals tend to kill themselves more than the female subjects. This study attempted to look into this observation and sex of subjects was matched according to the type of suicide. When a chi-square test was done the results were significant and more female subjects attempted suicide while more male subjects succeeded in killing themselves (Table 50).

Table 50: Sex and Type of Suicide

	Successful Suicide	Attempted Suicide	%	N
Male	49	51	100	74
Female	20	80	100	99
N =	56	117	%	173

X^2 = 15.5, df = 1, Significance = 0.001

Whitlock et.al. (1967) had made early observations as to the reasons that may lead women into suicidal acts more readily than men. According to these authors, neurotic illnesses tend to be common among women and hence women are more likely to dramatize their difficulties. Besides they felt that women are often more lonely and isolated than men who have opportunities outside to work out their frustrations and anxieties.

Other studies have made similar observations that even in Africa more women tend to participate more in suicidal acts (Bohannan, 1960; Meer, 1976; Harrington, 1959; Yap, 1958; Stengel, 1977). Most of these studies seem to indicate that women are

rather restricted in terms of out lets compared to men. But the studies also are rather vague and are not explicit as to whether they are referring to either suicide in general or different types of suicide. This study has actually observed that more male subjects tended to be over represented in successful suicide while more female subjects tended to be over represented in attempted suicide.

The high presentation of women in attempted suicide in Kenya may be related to many factors. If suicide is seen as a cry for help, then it is possible that most Kenyan women having/denied the /been opportunities their menfolk have, decide to yell for help through suicide. For example, in Kenya women both married and single are not encouraged by the society to go out and drink to forget their problems in the bars, a thing a man can easily do. In Kenya, men have very many opportunities to work out the tension from their systems in situations that frustrate them. For example, if frustrated in relationships either in marriage, work or any other situation, a man can marry another wife, he can enjoy illicit sexual relations outside

the marriage and he can join his friends in a drinking place and drown his problems through discussions with friends and/in alcohol. In terms of responsibility, the Kenyan man tends to be freer when it comes to the care of children and the home in general. So long as he provides material support he is not obliged to stay at home and look after the children. Hence the usual tension that exists in the process of bringing up the children and looking after the other family members within the extended family systems, are not often equally shared. At times the emotional support that is needed when one is carrying out the societal obligations bringing up the children is hardly forthcoming from the men. The woman left alone with her burden is actually likely to attempt suicide, mainly to sensitize the people about problems she is facing and not to really kill herself (see case illustration number one).

On the other hand it is logical that men should be more presented in successful suicide. With all the opportunities or outlets available to the men, it is possible that a man who decides to commit suicide must have tried all the available

means to get rid of his frustrations and failed. Eventually he decides to kill himself because he finds no meaning in life.

Marital Status Comparison

The study attempted to look into the marital status of individuals who committed and attempted suicide. The marital status was categorised as single (those individuals who were either widowed, divorced, separated and never married) and married (those individuals who were married and those cohabiting). Cohabition was considered marriage because in Kenya quite a number of couples live together as husband and wife under the customary marriage which in western view may be called cohabition but in African view is called marriage. A chi-square test was done comparing those who attempted and those who committed suicide and the results were not significant (Table 51).

Table 51: Marital Status and Type of Suicide

Marital Status	Successful Suicide	Attempted Suicide	%	N
Single	34	66	100	89
Married	31	69	100	84
N =	56	117	%	173

X^2 = 0.11, df = 1, Significance = 0.05

According to Table 51 this study has not shown much difference among individuals who succed in suicide and those who attempt suicide. But it has, however, shown that individuals who are single succeeded in killing themselves 3 per cent more than the married individuals. This observation was reversed where individuals attempt suicide. Here these single individuals attempted suicide 3 per cent less than the married individuals.

In general suicide has been observed to be common among the single people, that is, unmarried, widowed, separated and divorced individuals. Most of these studies do not explicitly indicate whether they are referring to successful suicide or attempted suicide. In this study the observations made by these researchers tend to be supported by successful suicide figures where more single subjects actually killed themselves. But in attempted suicide married people tended to excel. This observation tends to be consistent with the general marriage situation in Kenya. In Kenya, although no systematic study has been done on marital problems, it has been observed that marital instability especially in the towns has become common. Thus divorce rates

and other forms of problem marriages have been on increase (Atieno 1976; Otieno, 1981). It has also been observed that there is quite a lot of family disorganisation in Kenya mainly related to rural - urban migration. Most Kenyans of working age have to leave their families, wives included in to towns in search of employment. Often new relations are established and marriage bonds end up being violated. When the families get united a lot of problems are encountered that can lead to suicidal attempts.

Education Comparison

The study attempted to compare the level of education of individuals who have killed themselves and those who have attempted suicide. Education was divided into 4 levels, that is no education, primary education (Std. 1 - 7), Secondary education (Form 1 - 4) and higher (Form V and above). A chi-square test was done and the results were significant (Table 52).

Table 52: Education of Subjects and Type of Suicide.

Education	Successful Suicide	Attempted Suicide	%	N
No Education	64	36	100	47
Primary	20	80	100	71
Secondary	19	81	100	48
Higher	43	57	100	7
N =	56	117	%	173

X^2 = 31.5, df = 3, Significance = 0.001

According to the above table, education has some influence on suicide and those who succeeded in suicide tended to have less education compared to the individuals who attempted suicide. The majority of individuals who attempted suicide were young and considering that education facilities have improved tremendously in Kenya, it is possible that more younger people would have had the opportunity for education. Since individuals who succeeded in killing themselves appeared to be older, similar

opportunities for education might have not been available and hence/end up not educated. Accor- /they ding to the Integrated Rural Survey (Yrs. 1974/ 1975), the national percentage of the population in rural Kenya in age group 15 and above reported to be literate is approximately 46 per cent (social Perspectives 1977). This report also shows great disparities in education not only between the sexes, but between age groups as well. Thus the majority of individuals who are literate are actually young (65 per cent of the total literacy is in young age group, while 20 per cent is in old age group). The above observation is well illustrated by Appendix C.

Not having proper education may mean less chances of getting proper employment and lack of education might have been a contributing factor in successful suicide where these individuals might have found themselves without one of the major requirements for proper employment in Kenya, that is education. This factor is reflected in what the subjects said were doing. For example, although 53 per cent of those who succeeded in suicide were employed, 52 per cent of the working group were manual labourers.

Employment Comparison of Subjects

The study looked into the employment situation to determine whether employment has some influence on suicide types. Employment was divided into 3 categories, mainly, employed; unemployed and students. A chi-square test was done and the results were significant (Table 53).

Table 53: Employment of Subjects and Type of Suicide

Employment	Successful Suicide	Attempted Suicide	%	N
Employed	53	47	100	70
Unemployed	17	83	100	77
Students	23	77	100	26
N =	56	117	%	173

X^2 = 23.5, df = 2, Significance = 0.001

According to Table 53, the majority of individuals who succeeded in killing themselves were employed while the majority of those who attempted suicide were unemployed. Thus individuals who are

employed tend to kill themselves while those unemployed tend to attempt suicide.

The above observation tends to differ from those observations made by early researchers. According to these researchers suicide rates increase during periods of business depression, unemployment and general misery (Dublin, 1963; Farber, 1968; Henry, 1954; Sainsbury, 1955). These researchers observed that employment can actually prevent suicide and individuals employed may be immune to suicidal acts. Apparently, according to this study, employment per se may not prevent suicide and factors like the nature and type of the employment one is engaged on, have to be considered before conclusions are made.

In Kenya, the fact that individuals who are employed may actually still end up killing themselves may not be surprising since individuals who work as manual labourers are often lowly paid. With the rising cost of living in Nairobi it is likely that the individuals who are working earning little money may find life frustrating and face problems in their relationships more often than say a person who is not working. This individual

if often expected to share his meagre salary with a large group of relatives within the extended family system. The sharing creates a lot of conflict within the individual concerned and among the family members. These conflicts and the demeaning salaries may actually drive one to successful suicide.

In Kenya, the process of looking for a job if one is unemployed is indeed demeaning. To begin with the jobs are not available and there is a very high level of competition for the few jobs that are available. As such one still has to have connections, often relatives or friends with some influence inorder to be employed. As this is not enough, one has at time still to buy the job either by money or in kind. Above all, one still has to migrate into towns, Nairobi included, where the jobs are available. The individual after arriving in the city, has to live with some of his relatives who may be close or distant. In most cases these relatives do not have enough to share with the individual and have to contend with the imposition of the job seeker. Although the African is supposed to be generous and his door is often

opened (Asuni, 1962) such generosity has been gradually disappearing in Nairobi because of economic realities. As such the individual is often seen as a burden. These feelings are in most cases communicated to the individual in most indirect ways. As jobs are not easy to get in the end, the feelings get exploded and the relationships become really sour. Such individual often move from one relative to another, but as the time goes on he is often made to know that he is a burden. With all this, his family in the rural community often impatiently wait for his help and keep on siphoning letters to him, informing him of the helpless situation at home. In such situations, it is therefore, not surprising to find out that actually individuals who attempt suicide are often unemployed and hence might be in the process of seeking jobs.

Place of Birth Comparison

The study compared the individuals who killed themselves and those who attempted suicide, in terms of where they were born. The subjects were compared in terms of provinces and 4 major provinces

mainly Central, Eastern, Nyanza and Western were chosen since they had the highest representation. A chi-square test was done and the results were significant (Table 54).

Table 54: Place of Birth and Type of Suicide

Provinces	Successful Suicide	Attempted Suicide	%	N
Central	43	57	100	61
Eastern	50	50	100	20
Nyanza	17	83	100	35
Western	13	87	100	32
N =	46	102	%	158

X^2 = 16, df = 3, Significance = 0.001

According to Table 54, subjects from Western and Nyanza Provinces tended to attempt suicide more than other individuals from other Provinces. The subjects from Eastern and Central Proncinces actually succeeded in killing themselves.

The observation that individuals from Western and Nyanza Provinces tended to attempt suicide more than those provinces closer to Nairobi may be related to the fact that the majority of individuals who come from the 2 provinces to Nairobi do so to look for jobs. While in Nairobi they have to stay with either relatives or friends. As already observed in the section on employment comparison, living with relatives can actually lead to a lot of frictions leading to frustration and hence a cry for help (suicidal acts). The individuals from short-distance migration as those coming from Central and Eastern Provinces are actually advantaged in terms of distance. These individuals manage to travel to their rural homes more frequentlly and visit their families. Besides they can readily pick any manual job found around in Nairobi. In times of frustrations such an individual can seek help from his immediate family as the distance is not really far. On the other hand those individuals from long distance - migration like Western and Nyanza provinces may be disadvantaged in a sense that once they have managed to come to Nairobi they may find it hard to regularly go to their rural homes because of the distance and the

cost of transport involved. Hence they have to rely more on their town relatives than their immediate families. They may also be more likely to be involved in other relationships in the towns compared to those individuals who come closer their homes. If working, individuals who travel long distances to Nairobi are likely to be visited by their wives and children compared to those whose homes are close. All this may create problems that may lead to suicide.

Tribal Representation Comparison

The study attempted to compare suicidal acts among major tribes in Kenya mainly Kikuyu, Baluhyia, Luo and Kamba. A Chi-square test was done and the results were significant (Table 55).

Table 55: Tribal Representation and Type of Suicide.

Tribes	Successful Suicide	Attempted Suicide	%	N
Kikuyu	42	58	100	65
Luo	18	82	100	33
Baluhyia	18	82	100	34
Kamba	41	59	100	17
N =	46	103	%	149

X^2 = 10.4, df = 3, Significance = 0.01

As shown on Table 55, Kikuyus and Kambas tend to be more represented in the successful suicide while the Luos and the Baluhyias are more represented in the attempted suicide. According to these findings it seems that the closer the individual is to the city centre, the more likely that the individual would actually succeed in killing himself. The Kikuyus and Kambas tend to stay nearer to Nairobi compared to Luos and

Baluhyias who have to travel over two hundred miles to come to Nairobi. The long distance-migration can be associated with many disadvantages as already been indicated. However, the individual who comes from long distance into Nairobi may have to go through a lot of adjustments which the individual who comes from homes closer to Nairobi may not experience. The individual coming to settle in Nairobi may be doing so for the first time in his life and hence gets exposed to many changes. For example he may realise that there are quite a lot of exciting things in Nairobi compared to his rural home. He may realise that there are plenty of entertainments but he may be limited to these activities because he is unemployed. After obtaining employment he may spend all his earnings on the exciting things he had not seen in life. Back in his rural home he may have relatives anxiously waiting for help, but with no help forthcoming the relatives may decide to follow him in Nairobi. Overburdened the individual may take to drinking and other activities which may create poor relationships in his family. The constant problems may lead to suicide.

On the other hand an individual coming from a home closer to Nairobi is advantaged because

in times of crisis he may turn to his family members for help. Besides such an individual may accept any manual job that is available as he can still perceive Nairobi as his home. The individual from far may consider such a job humiliating considering the distance he has travelled. Besides he may not even know that such jobs are available and he may indefinitely remain unemployed in Nairobi. The individual coming from homes closer to Nairobi may even reduce their expenses by growing his own food and not only eat it, but sell the surplus to subsidise whatever he earns, while the individual from far may pay for everything he gets in Nairobi.

The individuals closer to Nairobi may be disadvantaged in a sense that their lives may be too restricted by their relatives who keep close watch on them and at the same time may demand too much from them, compared to their counterparts who come from far and may have the freedom of doing what they wish and may actually abscond from responsibilities. Thus the former may actually kill himself when he feels life is unbearable while the latter may attempt suicide to alert people that he is having some problems.

Comparison of the Persons with whom the Subjects Stayed.

The study looked into the persons the subjects stayed with and whether this was related to the type of suicide. A Chi-square test was done and the results were significant (Table 56).

Table 56: Persons the Subjects Stayed with and Type of Suicide.

	Successful Suicide	Attempted Suicide	%	N
Spouse and Children	24	76	100	67
Parents	19	81	100	31
Relatives	41	59	100	41
Alone	55	45	100	12
Friends	42	58	100	22
N =	56	117	%	173

X^2 = 12.3, df = 4, Significance = 0.05

As can be seen from Table 56, individuals who stayed alone or with friends actually succeed in killing themselves. On the other hand those individuals who stayed with either their parents or spouse and children tended to attempt suicide more frequently.

Durkheim in his early studies of suicide observed that individuals who are not well integrated into the societal systems tend to commit suicide. Also those whose behaviour is not well regulated may also suffer from the same problems (Durkheim, 1951). Since Durkheim studied successful suicide, that is, individuals who had killed themselves, this study has supported his observations especially among the successful suicide group.

In Kenya the individual who lives alone especially in the towns may be quite isolated if such individual does not welcome his relatives to stay with him. In most cases individuals who work in the town live with some sort of relatives. Therefore, in situations where one says he is staying alone, it is possible that such an individual had already faced the problem of living with

others and hence decided to live alone or such individual might have been isolated from his rural community and came to town as an escape from his general miseries. To such an individual the town life provides anonymity but becomes rather fragile in times of crisis as he has no one to turn to except himself. Such an extreme case of anomie may lead one to self-destruction.

To live with friends, especially in a city like Nairobi, may mean that the individual does not really have relatives working in the city. It may also mean that the individual does not have close ties with his family members. This state is also dangerous especially in situations where one gets into conflict with his friends and hence fails to get their support in times of crisis. Again this has been reflected in situations where one stays with relatives and not parents and spouse. The relatives may not be supportive especially, when they feel that the individual's presence has antagonised them. Besides while in the city they might have adopted certain values which might be inconflict with the individual's values. Thus in situations where there might be ambivalences and frustrations of the individual's presence in the

family, it is likely that the individual may not be adequately integrated into the family or relative systems. Hence the individual is left to his own resources and in times of problems the individual feels unsupported, unwanted and may end up killing himself.

It is not surprising that those individuals who stay with their parents and spouses tend to attempt suicide more than those who stay with other people. As can be seen from the reasons the subjects gave for attempting suicide, most of the reasons are centered on the conflicts that arise within the family. This included disagreement with parents and poor relationships, mainly conflicts with the spouse.

The disagreement between children and parents is universal and often the young generation attempts suicide mainly to influence the adults' decisions. Often the adults do not accept the fact that the young people can choose their own friends, marry whoever they feel like and have babies before marriage. In Kenya, the parents still control whatever goes on in the lives of their young people. For example, parents are anxious that their children

should complete their education successfully and hence they are not allowed to bring anybody home of whom parents do not approve. They are not allowed to have friends from those homes wherein the children are considered to have been spoilt by parents. In short because of the competitive nature of the education system in Kenya, most parents especially in Nairobi are indeed apprehensive about what their children should do and not do. This in turn has created a lot of problems between parents and their children leading to frequent conflicts within the family (Case Illustration Number 10). Hence it is not surprising that more younger people attempt suicide. In certain situations the adults have not helped the children to realize their obligations in life without contradicting themselves. For example, in certain situations the children have been warned that certain behaviour like drinking, smoking, dancing, dating and the like are bad and dangerous indeed, but the same parents have gone ahead and done what they are condemning. Some parents have shown such bad behaviour in front of their families that some young persons have been driven to suicide attempts because of what they

consider shameful behaviour of the parents (Case illustration number 3).

The interpersonal conflicts between spouses has been observed in much research work done in developed countries as the major course of suicide. In Kenya the interpersonal conflicts between couples have been on increase although no systematic study has been done. The problem is even worse in towns, Nairobi included. The conflicts between the spouses are mostly centered on infidelity, alcohol abuse and infertility.

Most spouses in Nairobi, have experienced situations where the family resources have been squandered on other women and alcohol and the family has often been left unsupported. In extreme cases, men have spent endless nights away from their families and only came back to their families to change their dirty clothes. In this process men have managed to marry other wives, a situation that has driven their first wives to suicide attempts (see case illustration number 4).

In Africa, early researchers have observed that infertility was one of the causes of suicide (Bohannan, 1960; Asuni, 1962). Children have been and are still highly valued in Africa and an individual who does not have children is disregarded

in the society. This attitude is pronounced in Kenya and children are valued. Individuals who marry are expected to have children and if they do not, the husband is expected to marry another wife to produce children. In certain cultures, the wife can also marry another woman to produce children on her behalf. In traditional society this was amicably done and there was mutual agreement between the spouses. In modern Kenya such a mutual agreement no longer exists and the husband unilaterally makes his decision and marries another wife. Often the husband does not even bother to take advantage of the available medical facilities and marries a second wife without even taking his first wife for treatment. This creates a lot of friction and the first wife often makes threats and ends up attempting suicide. In certain cases several suicide attempts are made as the husband often sends his first wife away (case illustration number 7).

The spouses' conflicts have been made worse because the roles of women have been changing. In Nairobi, it is now common to find women actively involved in activities that in most cases subsidize the family income. As such more women are now working outside their homes and earning

salaries. Others are now engaged in business, again earning enough money to support their families. This has adverse effects on the relationship among the spouses. In certain situations, some women have realized that they can be quite independent and manage their own affairs and even have their own men friends if they so wished. This situation has driven somemen to actually kill themselves and others to attempt suicide (case illustration number 6). On the other hand some men have driven their wives to suicide attempts because of either taking all the money the wife earns and squanders or leaving the entire responsibility in the wife's hands because she too is working and earning a salary (case illustration number 5).

The study attempted to compare individuals who stayed with their relatives in general and those who stayed alone and with friends. The relatives here included spouses, parents, brothers, sisters, cousins, uncles, aunts and others. A chi-square test was done and the results were significant (Table 57).

Table 57: Suicide when one Stays with Relatives, Friends or Alone.

	Successful Suicide	Attempted Suicide	%	N
Relatives	28	72	100	139
Friends	42	58	100	12
Alone	55	45	100	22
N =	56	117	%	173

x^2 = 6.9, df = 2, Significance = 0.05

According to Table 57, the observations made in earlier sections are still valid and individuals who stayed alone tended to kill themselves more than those staying with other people. Besides those staying with relatives attempted suicide more compared to other groups.

The attempt was also made to compare the subjects who stayed alone and those who stayed with people and the relative group was emerged with the friendship group. A chi-square test was done and the results were once more significant (Table 58).

Table 58: Suicide and When one Stayed Alone or with Others

	Successful Suicide	Attempted Suicide	%	N
Staying with People	29	71	100	151
Staying Alone	55	45	100	22
N =	56	171	%	173

X^2 = 6.1, df = 1, Significance = 0.05

Again the above Table 58, confirms the observations made in Tables 53 and 54. It seems that individuals staying alone in Nairobi may have the tendency of killing themselves as already been discussed.

Comparison of the Methods the Subjects Used

Table 59 shows a summary of the methods the subjects used.

Table 59: A Summary of Methods Used

Method	Successful Suicide	Attempted Suicide	%	N
Hanging	95	5	100	21
Poisoning/ Overdose	9	91	100	117
Jumping from tall building	100	-	100	16
Burning	55	45	100	11
Drowning/Shooting/Stabbing	38	62	100	8
N =	56	117	%	173

As can be seen from the above table those subjects who succeeded in killing themselves either jumped from tall buildings or hanged themselves

while those who attempted suicide either poisoned themselves or drowned and cut their throats. Because of these observations and other observations made by other researchers that individuals who kill themselves tend to use violent methods while those who attempt suicide use nonviolent methods. The study attempted to find out whether the methods used depended on the type of suicide. Therefore, the methods were grouped as indicated in Table 60 and a chi-square test was done. The results showed significant difference and individuals who kill themselves actually opted for violent methods while those who attempt suicide tended to use the non-violent methods (Table 60).

Table 60: Method Used and Suicide

Method	Successful Suicide	Attempted Suicide	%	N
Violent	80	20	100	56
Nonviolent	9	91	100	117
N =	56	117	%	173

x^2 = 87.5, df = 1, Significance = 0.001

In Kenya the means for both violent and nonviolent methods are available and it seems individuals who really intend to kill themselves tend to go in for the violent methods like hanging jumping from tall building, drowning, burning shooting and stabbing while individuals who only wish to tell the world that they have problems and perhaps needed some help tend to go in for less lethal means like poisons and drugs. Although the poisons and drugs can be as lethal as the violent methods, they are easy to control and their lethality depends very much on the dosage one takes. Besides if taken closer to other people and the victim is immediately discovered, the victim can be saved if rushed to the hospital on time. Such a thing may not be possible where one jumps from the sixth or tenth floor of a building or where one has hidden to hang himself.

Comparisons of Reasons given for Suicide

The study attempted to find out whether there was difference among the suicide groups with regards to the reasons given for suicide. The

reasons were grouped into 5 broad categories as shown on Table 61. When a chi-square test was done the results were significant. These results showed that the two suicide groups differed in reasons they said led them to suicidal acts.

Table 61: Reasons for Suicide and the Type of Suicide.

Reasons for Suicide	Successful Suicide	Attempted Suicide	%	N
Poor relationship with spouse	37	63	100	63
Disagreement with parents/employer children/co-wife	17	83	100	41
Unemployment i.e. poverty	50	50	100	32
Loss i.e. jilted/ death/money/failing	25	75	100	20
Mental & Physical problems i.e. depression, alcohol abuse, impotence, prolonged illness.	29	71	100	17
N =	56	117	%	173

x^2 = 10.5, df = 4, Significance = 0.05

According to Table 61, the subjects who attempted suicide did so either because they experienced some disagreement or had had some loss or had some mental or physical problem or had poor relationship with their spouses. Those who succeeded in suicide had killed themselves either because they were unemployed or had poor relationship with their spouse. Thus reasons like disagreement, loss and mental and physical problems did not feature much in successful suicide as reflected in the findings. Unemployment and poor relationship with spouse tend actually to feature more in both groups. Again this is consistent with the current problems experienced in Kenya, mainly unemployment and marital problems.

These observations tend to confirm studies that have been done in developed countries where interpersonal conflicts within families and lack of employment and loss tend to drive people to acts of suicide.

Important Events and Suicide

Since the period of this study included the period when Kenyans experienced a coffee boom,

an attempt was made to find out whether the boom had any influence on suicide. The period was divided into 3 categories, mainly 'prior to the boom' (1975-1976), 'the Boom period' (1977-1978) and 'after the boom' (1979). A chi-square test was done and the results were not significant (Table 62).

Table 62: Important Events and Suicide: Coffee Boom and Suicide.

	Successful Suicide	Attempted Suicide	%	N
Prior to Boom	34	66	100	64
Boom Period	22	78	100	63
After Boom	43	57	100	46
N =	56	117	%	173

$X^2 = 5.2$, df = 2, Significance = 0.05

Although during the coffee boom period there was a decrease on individuals who succeeded in suicide, the number of those who attempt suicide increased. On the other the number of those who attempted suicide dropped drastically after the boom but there was tremendous increase in the number of those who killed themselves. From this observation one can conclude that although the coffee boom did not influence suicide as might have been expected, it showed a trend of more attempted suicides in a boom period compared to non-boom periods.

Months in which Suicide was Committed

The study also attempted to look into months suicide was committed and compared them with the types of suicide. The months were divided into 4 categories as shown on Tables 22 of Chapter Four and 35 of Chapter Five. The results were significant when a chi-square test was done (Table 63).

Table 63: Months and the Type of Suicide

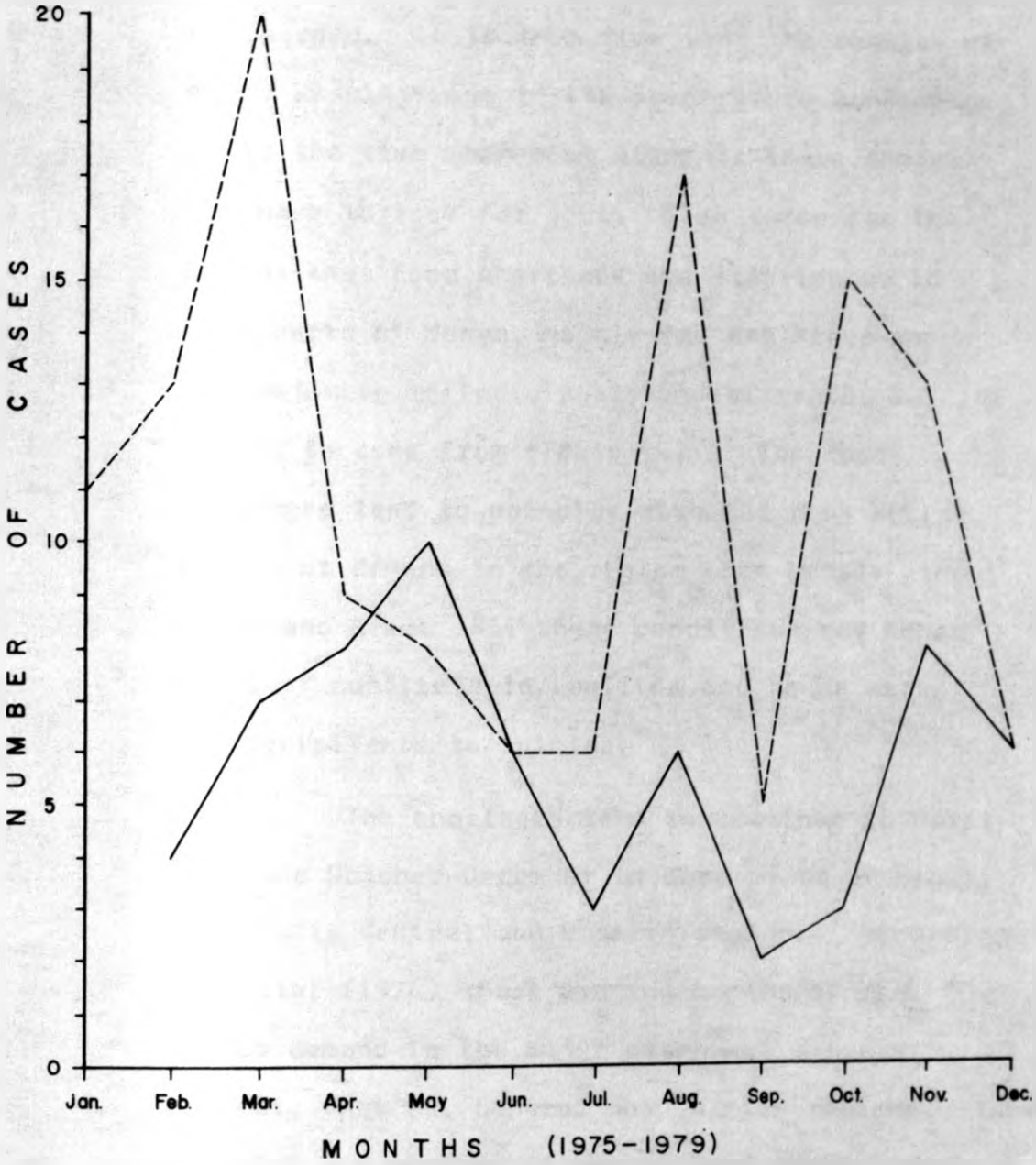
Months	Successful Suicide	Attempted Suicide	%	N
Jan. - March	23	77	100	53
April - June	52	48	100	42
July -September	24	76	100	33
October-December	31	69	100	45
N =	56	117	%	173

X^2 = 10.4, df = 3, Significance = 0.05

According to Table 63 the majority of subjects tended to attempt suicide between January - March, July-September and October - December while those who killed themselves tended to do so between April - June and October-December. This observation has been also shown in the illustrative graph of Table 63.

In Kenya, January-March are quite demanding months for most families. It is this time when schools actually start and fees and uniforms

An illustrative Graph of Successful and Attempted Suicide according to Months



KEY

_____ Successful suicide

_ _ _ _ _ _ Attempted suicide

This graph was drawn from Table 63.

are needed. It is this time that the results of major examinations in the country are announced. It is the time when most students leave school and have to look for jobs. Also these are the months that food shortages are experienced in some parts of Kenya, mainly Western Kenya where the majority of individuals who attempted suicide tended to come from (Table 54). The food shortages tend to coincide with the peak period of labour demand in the region when people plough, plant and weed. All these conditions may cause a lot of conflicts in families and hence serve as precipitants to suicide.

The shortages tend to continue in April-June and October-December in some parts of Kenya, especially Central and Eastern regions. According to Mbithi (1974) these are the months of peak labour demand in the major catchment areas of Nairobi, that is, Central and Eastern regions. These are also the seasons of lowest food supply especially protein and calorific foods. Mbithi observes that where there is low supply in protein and calorific foods, people are more likely to be susceptible

to disease infection and they may also have the least energy intake and hence low potential productivity. He observes that under such conditions most available money is used to buy food than hiring labour to work in the farms. This leads to endless toiling in falling rain and intense heat to plant in time, to weed before the crop is choked by weeds and to harvest before the yield is spoilt. He sums it up by concluding that all these activities tend to put man against nature year after year (Mbithi, 1974:71). The ingenious description by Mbithi of the ordinary man's state during ploughing, planting, weeding and harvesting periods in Kenya during the time when the regions actually experience shortages of food supply, explains implicitly why some people may decide to involve in suicidal activities during these periods. The periods according to the above seem to be anxiety - provoking in Kenya and it is possible that individuals who find it too stressful may decide to kill themselves.

In some parts of Kenya, between July-December food situation improves tremendously and life becomes quite interesting for most people as often there is enough food to eat and surplus to

sell for cash. This can explain the drop on successful suicide but not the attempted suicide. At this time some people may realize that they have not achieved what they had wanted. Besides they may realise that they have not harvested enough crops for various reasons, mainly, the crops may fail or they might have not planted enough. All these failures and their realization may create problems to an individual which may drive him to suicide attempts. This may also explain the sudden increase of those who attempt suicide in August (Graph of Table 63). During this month individuals who did not have successful harvesting and hence yielded less may be looking for ways and means of buying crops for storage. Besides most families may be saving for school fees to be paid in September. All this is likely to create conflicts in families with less resources like the ones studied. These conflicts and frustrations may in turn lead to suicidal attempts as a means of communicating problems.

Suicide and the Activities the Subjects did in Nairobi

The study attempted to find out whether suicide was related to those activities the subjects were doing in the town. The activities were divided into 4 categories (Table 64).

Table 64: Activities and Suicide

Activities	Successful Suicide	Attempted Suicide	%	N
Working	53	47	100	70
Looking for jobs	19	81	100	27
House wives	17	83	100	48
Learning	21	79	100	28
N =	56	117	%	173

X^2 = 22.9, df = 3, Significance = 0.001

According to the above table, the majority of individuals who succeeded in killing themselves tended to work while the majority of individuals

who attempted suicide were either housewives or looking for jobs. Besides a high proportion of those who attempted suicide were students and learning in Nairobi.

Attempted Suicide and the Control Group

The study attempted to compare certain characteristics of individuals who have attempted suicide and hence were admitted at the casualty department of Kenyatta National Hospital and those patients who were admitted into the same hospital through the casualty department. These subjects were matched in age, the channel of admission, that is, through the casualty department to Adults' Observation Ward and finally into the appropriate wards and the period covered in the study, that is, 1975 - 1979.

The results showed that there were no major differences among the two samples as regards sex composition, marital status, place of birth, occupation, place of residence, religion and the number of children. Thus according to these findings the control group, that is, individuals who get admitted at Kenyatta National Hospital

through casualty department did not differ much from those individuals who get admitted at the same hospital having attempted suicide. Nonetheless differences were observed in certain areas as follows:

Age Comparison

The study attempted to compare the ages of the two samples and when a chi-square test was done, the results were significant (Table 65).

Table 65: Age and Suicide

Age	Control Group	Attempted Suicide	N
13 - 20	24	35	56
21 - 28	42	44	78
29 - 36	21	12	27
37 - 44	3	7	10
45 - 52+	10	2	8
% =	100	100	
N =	62	117	179

x^2 = 10.5, df = 4, Significance = 0.05

According to Table 65, the majority of subjects who attempted suicide were young. While the general patient group seemed to be older. This observation seems to support other studies that have indicated that individuals who attempt suicide often tend to be young (Henry, 1954; Kessel, 1965, Kreitman, 1973; Stengel, 1967).

Employment Comparison

The employment situation of the two samples were compared and was categorized as "employed" and "unemployed". The employed individuals were those engaged in some form of work while the unemployed were those recorded as not working. The results were significant as shown in Table 66.

Table 66: Employment of Subjects and Suicide.

Employment	Control Group	Attempted Suicide	N
Employed	20	34	47
Unemployed	80	66	119
%	100	100	
N =	69	79	166

X^2 = 4.3, df = 1, Significance = 0.05

According to Table 66, individuals who attempted suicide tended to be over represented in the employed and unemployed categories.

Compared to the control group, those who attempted suicide were actually engaged in employment more than the control group. The control group tended to be unemployed.

Unemployment is one of the major problems in Kenya. As such most people are likely to experience the problem irrespective of the illness they have and whether they attempt suicide or not.

Education Comparison

The study looked into educational differences among the two groups and education was divided into 3 categories as shown in Table 67 below. A chi-square test was done and the results were significant (Table 67).

Table 67: Education of Subjects and Suicide

Education	Control Group	Attempted Suicide	N
No Education	58	15	52
Primary	30	48	75
Secondary +	12	37	50
% =	100	100	
N =	60	117	177

X^2 = 37, df = 2, Significance = 0.001

According to the above table, the majority of subjects in the control group had no education while those who attempted suicide had some education.

This observation supports the fact that the most of those who attempted suicide were actually working compared to the control group. The fact that individuals who attempted suicide seemed to have had better education compared to the control group may mean that individuals with

some education may be more sensitive to their problems compared to those individuals with little or no education. Education may create general awareness of problems and failure to resolve the problems, may drive one to suicidal acts. Besides it would be individual with some education who may feel more frustrated if he fails to get employment as he fails to see the difference between himself and those who never went to school. Besides, it is the individual with some education who may set himself some goals and failure to attain his goal, the individual may decide to kill himself.

In Kenya, people tend to expect alot from individuals with some education and failure to live up to others' expectations may lead one to suicidal acts. As such it is not again surprising that individuals who had attempted suicide had more education compared to the control group.

Tribal Representation Comparison

The study looked into difference among the groups in relation to their tribes. Again only 4 major tribes were selected for the Comparison,

mainly, the Kikuyus, Baluhyias, Luos and Kambas. The results were significant when a chi-square test was done (Table 68).

Table 68: Tribal Representation and Suicide

Tribal Representation	Control Group	Attempted Suicide	N
Kikuyu	54	37	75
Baluhyia	16	27	39
Luo	13	26	36
Kamba	17	10	22
% =	100	100	
N =	69	103	172

X^2 = 9.3, df = 3, Significance = 0.05

According to the above table the majority of Baluhyias and Luos who were admitted at Kenyatta National Hospital between 1975-1979 went there because of attempting suicide while the Kambas and

the Kikuyus went there for general illnesses as well.

Kenyatta National Hospital being closer to the Kikuyus and Kambas, it is possible that these two tribes could use the hospital quite frequently and their higher representation in the control group is expected. The high representation of the Baluhyias and the Luos in the attempted suicide group may be explained in terms of their status in the City of Nairobi. Most people from these two tribes come to Nairobi to look for jobs or visit their relatives. While looking for employment they have to stay with friends or relatives and while visiting they have to stay with their spouses or relatives. Quite a number of the children from these tribes come to Nairobi to seek for education, because Nairobi is supposed to have the best education facilities in the country. While they are in Nairobi they have to stay with their parents or relatives. As been observed earlier in Table 56, suicidal attempts tended to be common among individuals who stayed with their spouses, parents and relatives. As such the high represen-

tation of Baluhyias and Luos in attempted suicide group may be related to the type of life they are leading in Nairobi.

Unemployment is also a problem in Kenya, and the only jobs that at times are available are manual. Most people who come from far into Nairobi actually may have high expectations as regards to employment. After travelling well over 200 miles one might expect some green pastures in the city. On arrival he finds that jobs are not all that forthcoming and the venues open are mainly manual. Although the individual may accept the job, such individual may not be happy with the job, but he accepts the offer because he has no alternative. For example, he stays with relatives who are anxious to see him move away as he is causing them unnecessary expenses. Besides he realises that the help he had expected to give to his family when he is working is not forth coming. As such he accepts any job he gets around although discontented. While on the job he realises that what he earns cannot adequately support him and his relatives. He soon realises that he cannot afford to travel to his rural community as often as he would have liked.

With all these problems one faces in the city, it is not surprising that Baluhyias and Luos may actually end up attempting suicide more often compared to other tribes who stay closer to their original homes (see case illustration number 9).

Comparison of the types of persons the Subjects Stayed with

In this study most people stayed with either their spouses, parents, relatives and friends. A Chi-square test was done to find out whether there was difference between the two samples. The results showed that individuals who attempted suicide tended to stay with their spouses, relatives and friends (Table 69).

Table 69: The People with whom the Subjects Stayed and Suicide.

The people stayed with	Control Group	Attempted Suicide	N
Spouse & Children	41	44	77
Parents	25	21	41
Relatives	20	20	37
Friends	8	6	12
Alone	6	9	14
% =	100	100	
N =	64	117	181

X^2 = 0.94, df = 4, Significance = 0.05

Although the results were insignificant, still it seems that the majority of individuals who attempted suicide tended to stay either alone or with spouses or relatives or parents. On the other hand individuals who were admitted with physical problems (the control group) tended to stay

with either their friends or parents or relatives.

According to Table 69 quite a small proportion of the subjects (control group) stayed alone while a large proportion of those who attempted suicide stayed alone. This observation tends to support other studies that had indicated that individuals who stay alone tend to engage in suicidal acts.

As already discussed individuals staying alone may suffer from what Durkheim had termed lack of adequate integration and regulation of behaviour. In his early work on suicide, Durkheim observed that in situations where individual is not properly integrated in the society and in those situations where the behaviour of individual is not regulated, suicide tends to frequent (Durkheim, 1951). In both situations, the individual tends to be left too much on his own resources and depending on the individual's ability, suicidal acts are likely to be favoured by such individual. Thus an individual staying alone has very few venues of communicating problems if he encounters them. Besides, since such individual may not have any rules guarding him or anybody keeping

watch on what he does, it is possible that during a crisis such individual may actually involve himself in suicidal acts.

Comparison of Months Suicide was Committed.

The study attempted to look into differences between the months the subjects of the 2 samples were admitted into the hospital. The months were grouped as in Table 22. A chi-square test was done and the results were insignificant (Table 70).

Table 70: Comparison of Months in which Suicide was Attempted.

Months of Admission	Control Group	Attempted Suicide	N
January - March	30	35	65
April - June	18	17	34
July - September	30	21	49
October-December	22	27	48
% =	100	100	
N =	79	117	196

x^2 = 1.95, df = 3, Significance = 0.05

Although, according to Table 70, the results appeared to be insignificant, some differences could be observed in the percentages. In this study more subjects in the attempted suicide group tended to be admitted to the hospital between October to March while the individuals in the control group tended to be admitted to the hospital between July to September.

In Kenya, significant events happen between October and March that may lead one to suicide. For example, major examinations are taken between October and December in Kenya and parents have to face situations where they have to complete school fees before their children sit for examinations; they have to face problems of contemplating actions to be taken in case a child does not do well in the examinations; they also have to look for schools for their children either starting new schools or going to schools for the first time. The process provokes a lot of anxiety to most parents. As this is not enough, it is the period when most families have to prepare for Christmas and New Year Celebrations leave alone the Independence Celebrations. In most cases families plan to get together and

presents in form of clothes and food have to be bought. In most cases individuals who work in towns, Nairobi included go through a period of spending spree. In December, individuals who work even get their salaries earlier. This situation is complicated that between January - March, the parent have to face other expenses in terms of school fees and uniforms. In most cases the salaries are inadequate and individuals doing manual jobs like the majority of people studied, end up having no money at all to spend on other things. This period also coincides with general shortages in the country and the prices of commodities actually get increased. During this time Kenya also experiences other celebrations like Easter and again families have to spend on either travelling visiting relatives or feasting to remember the resurrection of Jesus. The situation becomes even more complicated than it is during this time when major examination results are announced and parents have to face the accompanied problems of looking for schools and school fees.

All these facts make the life of individuals that happened to be included in this study extremely miserable and it is therefore, not surprising that individuals who attempt suicide and hence be admitted to the hospital tend to do so during this period.

CHAPTER NINE

HYPOTHESES AND RELATIONSHIPS

Discussion of Hypotheses

In this study several assumptions were made that led to six hypotheses. The first hypothesis of this study, was that, differences in status among individuals would influence the frequency of suicide. It was felt that individuals who felt disadvantaged or less satisfied with some aspects of their lives would have the tendency to kill themselves.

To measure this twenty-five cases of individuals who had attempted suicide in Nairobi were followed and interviewed. Questions 6a, 9 14b, 15b, 16c, 26, 27c and 32a in Appendix II were used. The variables used were marriage, occupation, income, education, place of residence, life achievement. Together with this the subjects were also asked what they would do if disappointed with their spouses. This question was asked to all subjects irrespective of their

marital status. This was to determine which sex actually seemed to be disadvantaged. Also, those subjects who were either separated or divorced were also asked whether they felt the process of separation or divorce was fair.

The six variables (marriage, occupation, income, education, place of residence, life achievement) were weighted and given a value of one score. Since not every respondent was either married or working, marriage and income variables were treated independently. Hence the 25 respondents were measured together in occupation, education, place of residence and life achievement in terms of satisfaction.

To measure hypothesis number one, the study looked into how those subjects who were separated from their spouses felt about the separation process. Only 2 subjects in the 25 sampled were separated and both felt that the process was very unfair (one male and one female). Thus both sexes felt disatisfied with the manner in which separation took place. The male subject felt that he was denied the right to stay with his children,

although he was a busy person while the female subject felt that everybody harrassed her and it was as if she had made a terrible crime on earth. Besides, she had to leave ouite a lot of her property behind, a thing that made her almost became a beggar. This subject even went into tears when discussing the ouestion. Although the sample was too small to make any generalization, it seems that individuals who tend to experience some differences in situations they regard to be important in their lives may attempt suicide.

The subjects were also asked of what they would do if disappointed with their spouse irrespective of whether they were married or not. Table 71 shows the results.

Table 71: A Summary of What Subjects would do if disappointed with their spouse.

(Percentage)

	Beat	Send away	Leave home	No Response	%	N
Male	33	67	0	0	100	12
Female	0	0	77	23	100	13
N =	4	8	10	3	%	25

According to Table 71, all male subjects said that if their spouses disappoint them they either beat them or send them away. Sixty-seven percent of the male sample said that they would send their spouses away, while 33 per cent said that they would beat their spouses if they disappoint them. On the other hand, female subjects said that they would leave their homes if disappointed by their spouses (77 per cent of the female sample). Here, one clearly sees differences between men and women in terms of their status especially when there are family disagreements. The difference can be related to the fact that in Africa, Kenya included, the man wields the highest authority in marriage and sees his wife as one of his children who actually may need some discipline now and then. During a crisis, the man may be inclined to use his power to discipline the wife rather than mutually discuss the difference with her. On the other hand, the woman in Africa, has been moulded in a away which makes her easily surrender. In times of crisis or disappointment, if she cannot placate to her husband, she has been trained to run away from problems. Hence, every time she faces

disappointment with the spouse, mentally, she prepares herself to temporarily leave the home to allow the situation to become less volatile. Hence it is no wonder that the majority of the women actually said that they would leave home.

Marriage, Income and Suicide

As already been stated marriage and income were each measured independently to measure hypothesis number one.

The 16 married subjects were asked whether they were satisfied with their marriage. The majority of male and female subjects were not satisfied with their marriage (Table 72).

Table 72: Sex, Marriage, Satisfaction and Suicide

	Satisfied	Not Satisfied	%	N
Male	29	71	100	7
Female	22	78	100	9
	4	12	%	16

X^2 = 1.1, df = 1, Significance = 0.05

The study attempted to find out whether there were differences between the sexes as regards marital satisfaction. A chi-square test with Yates' correction was done and the results were insignificant as shown on Table 72 above. Thus both sexes were dissatisfied with their marriage. The hypothesis that relative differences in status among individuals influences the frequency of suicide has been proven and individuals who were married and involved in suicidal acts were actually dissatisfied with their marital status.

The study also attempted to find out whether those 11 subjects who were working were actually satisfied with their work. Seven male subjects (64 per cent) were not satisfied while 4 female subjects (34 per cent) felt the same. Thus all the subjects who were employed were dissatisfied with what they were doing and what they were getting as salaries. This finding confirms the observation that individuals who attempt suicide experience some relative difference in their employment status.

The study still attempted to look into general satisfaction of the subjects with whatever was going on in their lives and related this to suicide as shown on Table 73.

Table 73: A Summary of Proportions of Satisfaction in Percentages:

	Marriage		Occupation		Income		Education		Place of Residence		Life Achievement	
	Satis.	Dissat.	Satis.	Diss.	Sats.	Diss.	Satis.	Diss.	Satis	Diss.	Satis	Diss.
Male	13	31	20	28	0	64	4	44	16	32	12	36
Female	13	44	20	32	0	36	12	40	16	36	8	44
N =	4	12	10	15	0	11	4	21	8	17	5	20

The above Table was altered somewhat for a chi-square test. Marriage and Income were excluded as they have already been discussed. Therefore 4 variables, namely, occupation, education, place of residence and life achievement were tested together. Each variable was given one point if the respondent was satisfied with that aspect. Thus the highest score one could get was 4.. Respondents who scored 4 points were considered very satisfied while those who scored 0 - 1 were considered not satisfied (Table 74).

Table 74: Sex, Subjects' Satisfaction and Suicide

	Not Satisfied * (0 - 1)	Satisfied (2 - 3)	%	N
Male	67	33	100	12
Female	54	46	100	13
N =	15	10	%	25

X^2 = 0.67, df = 1, Significance = 0.01

* not satisfied = 0-1 Scores
satisfied = 2-3 Scores.
very satisfied = 4 Scores
no respondent got 4 Scores

According to Table 74, the majority of male subjects tended to be dissatisfied with their occupation, education, place of residence and their life achievement. This observation was not significant when a chi-square test was done to find out the difference between the sexes. Thus both groups seemed to be dissatisfied with their status.

In summary, this study tended to confirm the assumption that suicide may occur in situations where an individual feels not satisfied with his marriage, occupation, income, education, place of residence and his life achievement. This feeling was found not to be related to an individual's sex. But in situations where there is disappointment among the spouses, the male subjects tended to be better advantaged in terms of the usage of authority. The women tend to be disadvantaged and opt for withdrawal from the disappointment.

Hypothesis Two

The second hypothesis of this study was that suicide would be related to current Kenyan major social problems. This hypothesis was tested in two parts. The first part dealt with age, sex and

employment while the second part dealt with migration, marital problems and parent-child conflicts. The sample used was from the total sample of all subjects who had committed and attempted suicide. A total of seventy-four subjects were selected.

Age, Sex, Employment and Suicide

This study attempted to find out whether there was any relationship between age, sex, employment and suicide. Most studies done in developed countries have observed that there are differences in age and sex composition in suicide and that suicide tends to occur in situations where there is unemployment. Unemployment was considered to be one of the current Kenyan major social problems (Table 75).

Table 75: Age, Sex, Employment and Suicide

Sex	Age	Employment	Successful Suicide	Attempted Suicide	%	N
Men	Young	Employed	55	45	100	20
		Unemployed	19	81	100	16
	Old	Employed	76	24	100	21
		Unemployed	35	65	100	17
		N =	36	38	%	74

X^2 = 14.2, df = 3, Significance = 0.001

Table 76: Age, Sex, Employment and Suicide

Sex	Age	Employment	Successful Suicide	Attempted Suicide	%	N
Female	Young	Employed	14	86	100	22
		Unemployed	8	92	100	61
	Old	Employed	100	-	100	7
		Unemployed	56	44	100	9
		N =	20	79	%	99

X^2 = 40.3, df = 3, Significance = 0.001

A chi-square test was done in both Tables 75 and 76 to determine whether there was any relationship between suicide and age, sex and employment. The results were significant in both groups. The results tend to show that both male and female subjects who succeeded in killing themselves tended to be older than those who attempted suicide (61 per cent of the male sample and 60 per cent of the female sample). In general female subjects who attempted suicide were younger than the male subjects (95 per cent of the female sample and 58 per cent of the male sample).

According to Table 75 and 76 the majority of men and women who were young and attempted suicide tended to be unemployed while those individuals who were old and succeeded in killing themselves tended to be employed. This observation partially confirmed the second hypothesis though these are differences related to age, sex and the type of suicide. Thus suicide seems to be related to unemployment in this study.

In Kenya unemployment is a major problem and is likely to affect all groups whether younger or old. Nonetheless, the high representation of young people in the unemployment category may be related

to the young people's attitude to work. As has been observed in earlier chapters most of the subjects who were employed were manual workers. In Kenya, young people, for the most part, do not appreciate manual work as this is associated with being an "uneducated" person. Hence the younger person is likely to be unemployed for a very long time while looking for a white collar job. In this process they are faced with a situation where they have to stay with their relatives, a thing which creates a lot of friction as already been indicated elsewhere in the study.

In assessing employment in Kenya, the International Labour Organization (1972) observed that the weight of unemployment in Kenyan towns, Nairobi included, tended to fall upon young people and on female subjects more than their male counterparts. They also observed that the rate of unemployment was worse for those with lower educational qualifications. Thus according to this report Kenyan job seekers tend to be young, uneducated and female. The present study tends to support the above observations. The majority of subjects in this study were found either to have no education or had only

lower primary education. This situation did not enable these subjects to readily obtain jobs in Nairobi.

Traditionally women stayed in their homes and attended to the household chores. With the changes that have been penetrating Kenya, women do not only have to work to subsidize the family income, but they have to work and support themselves as some may not have been married. Since the majority of them may not have education beyond the primary type of education, it may be extremely difficult for them to get jobs as the jobs that may be available in the towns are of manual nature and may require men. Besides the employers for the most part, prefer men to women. This may explain the high rate of unemployment among women.

The second part to help test the second hypothesis was migration, marital problems, parental-child conflicts.

Migration, Marital Problems, Parental-Child Conflicts and Suicide.

The study looked into the relationship between

suicide and two major problems that became evident in the study. These were poor relationships and family disorganization measured in terms of marital problems, conflicts between children and their parents and migration measured in terms of distance one has to travel to Nairobi to look for either employment or education. As shown on Table 54 in Chapter Eight, individuals who succeeded in killing themselves tended to come from those places near Nairobi while those who attempted suicide tended to come from those places that can be considered to be far.

The distance in this study referred to situations where the subjects came from those places closer to Nairobi like Kiambu, Machakos, Nyeri and those places near Nairobi. Those subjects considered to come from far included individuals from Kakamega, Kisii, Kisumu, Kwale, Taita and other places where one has to travel over 200 miles to Nairobi. The distance was then categorised as short-distance-migration and long-distance-migration. A chi-square test was done and the results were significant (Table 77).

Table 77: Distance, Poor Relationships and Suicide

Distance	Poor Relationships	Successful Suicide	Attempted Suicide	%	N
Long-Distance Migration	Marital	13	87	100	46
	Parent-child	13	87	100	15
Short-Distance Migration	Marital	40	60	100	25
	Parent-child	23	77	100	22
	N =	23	85	%	108

X^2 = 8.7, df = 3, Significance = 0.05

According to the above Table, distance, marital problems and parental-child conflicts tend to have some relationship with suicide. Hence the findings tended to support the second hypothesis of this study.

Nonetheless differences have been observed among the two samples and individuals who succeeded

in killing themselves tended to have marital problems and came from short-distance migration (40 percent) compared to individuals who attempted suicide where the majority of subjects had marital problems and came from long distance migration (87 per cent). According to these findings, few subjects who killed themselves tended to come from long-distance migration and had either marital problems or parental-child conflicts. On the other hand the majority of subjects who attempted to kill themselves tended to come from long - distance migration and had either marital problems or parental-child conflicts.

Comparing individuals who came from far and those who came from near Nairobi using Table 77, it appeared that individuals who came from near and who succeeded in killing themselves tended to have more marital problems and parental-child conflicts compared to those subjects who succeeded in killing themselves and came from far.

The differences among the samples can be explained in terms of the fact that individuals who came from far tended to stay alone with their spouses

while those from near either stayed with their parents or children (Table 80) of this chapter. Since education is highly valued in Kenya, most parents while in Nairobi working, bring their children to get 'good' education. Therefore, it is likely that both groups must have been staying with their children and one would expect that individuals who live closer Nairobi would stay with their children more compared to those who came from far. Besides individuals who stay closer to Nairobi may not bring their spouses to stay with them in town as they can afford to visit them regularly. However, those who stay near their rural homes may be disadvantaged when they have either marital problems or parent-child conflict. Since they stay closer to each other, the poor relationship can be so prolonged that in the end the party feeling more disadvantaged may quit the stage by killing himself. Therefore, it is not surprising that the majority of individuals who stay closer town and have either marital problems or parent-child disputes actually end up killing themselves.

Individuals who have their homes far from Nairobi, for the most part, come either to work or to look for employment. In most cases, their spouses and few of their children pay them visits. Since the majority of the people do have manual jobs their economic situation does not allow them to keep their teenage children with them. Most of them stay in small houses of one room while in Nairobi. Since big children in some tribes are not allowed to sleep with their parents in one room,those grown-up children are often left behind while their parents stay in towns. Besides, the grownup children are at times left in charge of the rural homes while their mother is away. This can, therefore, explain the lower rate of subjects who experienced the parental-child conflicts. But these individuals are disadvantaged in that they cannot visit their rural homes regularly once settled in Nairobi. With their meagre income, the majority of people in this group can neither afford bus fares to their respective rural homes nor can they afford keeping their large families in the towns. Because such an individual cannot often afford to send money to his family in the rural home, the wife may decide to come to town even

without his invitation. Furthermore, the prolonged separation between an individual in the town and his family in the rural community may cause a lot of problems. Thus in situations when the spouses come together to the town a lot of friction may emerge simply because the husband might have involved himself in other forms of relationships or cannot afford to support a wife and some children in the town. Faced with a situation where he has to pay for everything he uses, he may find it rather difficult to keep a wife who does not contribute to the family income as the situation would be in their rural community. All this may reduce the couple's level of tolerance of their differences. Faced with a situation with no support systems from the relatives and friends, operating the couple seems to be left to their own resources as far as problem solving mechanisms are concerned. As such it is not surprising that individuals coming from far and living in Nairobi should excel in suicidal acts that are related to marital disputes.

Researchers from the developed world have observed that marriage can make individuals rather immune to suicide. Thus Durkheim (1951) in his early

work on suicide observed that individuals who are single are more likely to commit suicide. Subsequent studies have observed that domestic problems, poor relationships in marriage included, may lead people to suicidal acts (Shneidman, 1976; Stengel, 1977; Sainsbury, 1955). Hence the same marriage that can prevent suicide through its integrating mechanisms, can actually lead one to suicide, especially where the spouses stay away from their original homes and are faced with high demands or responsibility. For example, the majority of the subjects who had marital problems reported lack of support from the spouses as well as infidelity where the spouses have involved themselves in other forms of relationships. The involvement in other forms of relationships would be expected in situations where an individual finds himself away from his spouse and family members and may look for companionship from other women in their town. In this process they may even misappropriate the little money they get ; a thing that creates more problems in relationships.

In Kenya as in many other developing countries, the educational achievements and hence the general

achievement of parents are actually seen to be possible through one's children. As a result the parents tend to have very high expectations about their children. As such, the majority of parents expect their children to pass examinations which means that the children are expected to study and leisure activities are considered to be a luxury. Parents often demand that their children look at books every time they are free and are very selective with regards to the friends with whom their children are associating. Therefore, the children are not allowed to bring anybody not approved by parents at home. This restriction actually creates a lot of friction between parents and children. Since parents expect help from their children, in most cases parents do not expect their children to marry early. So any partner brought for approval often ends up being rejected by the parents a situation that actually leads some children to acts of suicide. Unmarried motherhood has become quite a common phenomenon in Kenya, although the majority of parents find it hard to tolerate it as it means the disruption of the girl's education.

Therefore, in situations where a daughter gets pregnant, the parents often become extremely unsupportive and at times the girl gets driven to suicidal acts because she feels that she has let the parents down. With all this it is not surprising that individuals who either attempt or commit suicide tend to have poor relationships with their parents.

The children staying with their parents in the towns and yet closer to their rural homes are also disadvantaged. In most cases these children stay with one parent while attending schools. Often they do not visit their rural communities, although they may stay close, as the parents often expect them to spend most of their time studying. Often the bus fares may not be available and at times they are expected to help their parents when they are out of school. Since their mothers may be away, they may play the role of a mother in their town house and although their parents expect them to study and do well in school, they may not have time to study and end up doing poorly in school, a situation that creates problems between them and their parents.

At times they stay in such small houses where the study facilities are not available and although parents expect them to study and do well in school, the same parents, for the most part, do not provide them with the tools for study. This is so either because the parents may not afford to buy the equipment or they may be ignorant of what is expected. All this results in poor performance in school and hence failure, a situation that leads to frictions between parents and the children.

Hypothesis Three

Suicide and Personal Crisis

The third hypothesis of this study was that the incidence of suicide among the youth would be related to their personal crises. Although, the study had intended to limit the age to be considered at 18 years, it was realised that individuals who had either committed suicide or attempted suicide and gave reasons of personal crisis for doing so, were actually young and the majority ranged from 13 - 25 years. As such the study considered the subjects in this age group to be young and were included while considering the personal crisis analysis.

Personal crisis in this study was taken to mean situations where the subjects have indicated some loss in terms of employment, death of a loved one, failing an important examination, being jilted by a lover and those situations where the subjects reported disagreement with parents, and relatives. Fifty-nine subjects were identified to have fallen within this category (Table 78). The sample here was drawn from the total sample of all the subjects who committed and attempted suicide, fifty-nine subjects (14 subjects who committed and 45 subjects who attempted suicide).

Table 78: Relationship between Suicide and Personal Crisis among Young People

	Successful Suicide	Attempted Suicide	%	N
Personal Loss	35	65	100	23
Disagreement with parents and relatives	17	83	100	36
N =	14	45		59

X^2 = 3.63, df = 1, Significance = 0.05

Although the results as shown on Table 78 were not statistically significant when a Chi-square test was done, it seems that individuals who are young and experience some losses like death, jilting, failures and some form of disagreement with either their parents or relatives tend to attempt suicide. For example 65 per cent of the young people (age 13 - 25 years) who attempted suicide had actually experienced some loss and 83 percent of the young suicide attempt group had experienced some diagreements with either their parents or relatives. The individuals who are young and succeed in killing themselves also tended to experience some loss (35 per cent of individuals who had experienced some loss).

The above observations tend to support the view that individuals who attempt suicide actually aim at alerting other people of their problems. In situations where one is young, suicide can be aimed at influencing other people's decisions. For example in situations where one has been jilted by a lover, one may actually attempt suicide hoping that the jilter would change his or her mind after the incident. In situations

where parents do not allow an individual to marry a person of the individual's choice, suicide attempts may be made with the hope that parents would change their opinion and allow the marriage after experiencing the shock. On the other hand individuals who succeed in killing themselves may not have a similar motive. As indicated in the study, their loss was centered on death, money, failing to achieve, and loss of employment.

Hypothesis Four

The fourth hypothesis of this study was that the African life style will influence the occurrence of suicide. The African life style was measured in terms of polygamy and the extended family systems. Here 89 of the married subjects and 139 subjects reported to have been staying with relatives were included to test the hypothesis.

Marriage Patterns and Suicide

In Kenya polygamy still features in most marriages and this study attempted to find out whether the patterns of marriage may have some influence on suicide. The marriage was divided

into two, namely monogamous and polygamous marriage. When a chi-square test was done the results were significant (Table 79). Eighty-nine married subjects were selected to test the hypothesis (30 subjects committed suicide and 59 subjects attempted suicide).

Table 79: Marriage Patterns and Suicide

Marriage Patterns	Successful Suicide	Attempted Suicide	%	N
Monogamous Marriage	26	74	100	73
Polygamous Marriage	69	31	100	16
N =	30	59	%	89

X^2 = 12.7, df = 1, Significance = 0.001

While not underestimating documentation problems that might have been encountered both at police stations and at Kenyatta National Hospital, it seems that individuals who attempted suicide in this study were in monogamous marriages while those

who succeeded in killing themselves tended to come from polygamous marriages (31 and 69 per cent respectively).

Thus it seems in Nairobi, polygamy actually made some people kill themselves. Although in Kenya polygamous marriages are still allowed, the social and economic changes that have been taking place in the country are not conducive to the continuance of this practice. In traditional society, the women who were in the polygamous marriages never shared one house let alone a room. The roles and expectations of the polygamous marriages were well defined and understood. The man in the polygamous marriages was expected to be objective and fair to all the wives. The wives in turn enjoyed their privacy as they did not only have their houses within the homestead, but could choose independent homesteads if they so wished.

With societal change, men have to travel to towns to look for jobs. Once they acquire the jobs, and after working for sometime, some tend to look for a second or several wives. Like the majority of people studied in this study, the majority of

these men earn meagre salaries and as such they cannot afford to rent other houses for their second wives. In most cases he brings his young wife to share the house with the first wife. The sharing creates a lot of problems between the wives. Faced with frequent quarrels and the burden of having to support two or more wives from his meagre salary he often demands that the first wife goes to stay in his rural home. Since quite a large number of Kenyan women have realized that in order to be supported, they have to stay closer to their husband, often the first wife refuses to go to the rural community. Such a situation generates a lot of friction in the house. With constant friction and occasional beatings from the husband aimed at making her go to the rural area, it is not surprising that in the process, she may actually become involved in suicidal acts. Given a prolonged poor relationship, one of the wives may actually end up killing herself.

Extended Family System and Suicide

To further test the fourth hypothesis, the study attempted to find out whether there was any relationship between staying with relatives (measuring the extended family system) and suicide.

To measure this Table 56 in Chapter Eight of the comparison group of those who succeeded in killing themselves and those who attempted suicide was regrouped for a chi-square test. When a chi-square test was done to determine the relationship the results were not significant (Table 80). Here one hundred and thirty-nine subjects were selected to test this hypothesis. This included 39 subjects who had killed themselves and 100 subjects who had attempted suicide.

Table 80: Persons the Subjects Stayed with and Type of Suicide.

	Successful Suicide	Attempted Suicide	%	N
Spouse and Children	24	76	100	67
Parents	19	81	100	31
Relatives	41	59	100	41
N =	39	100	%	139

x^2 = 4.5, df = 2, Significance = 0.05

According to the above table the majority of subjects who succeeded in killing themselves tended to stay with their relatives (41 per cent) while individuals who attempted suicide tended to stay with either their parents or spouses and children.

In Kenya, the idea of extending help to one's relatives is still cherished and expected. As such individuals looking for jobs or education in the towns still expect to be welcomed with their relatives in the towns. Although the individuals with no parents or spouses and children are often welcomed by the relatives that live in the towns, the welcome often does not last long before frictions start between the guest and the relatives. In subtle ways, the individual is often made to understand he is not fully welcomed. This becomes worse when the employment is not forth coming. Coupled with the high cost of living in the towns the hosts at times may fail to feed their guest as the African generosity becomes almost impossible in situations where one has to feed a large family with meagre resources. At times the accommodation is so small that the family members may find the

relative-job seeker, more of a burden than a guest.

Since most of these relatives may be staying far from the centre of the city where jobs are allocated, the job seeker may find himself walking long distances in search of jobs, often without eating anything the whole day. Given these demeaning conditions, the job seeker becomes highly sensitive. Coupled with the fact that he may be having children at home waiting for his help and may be extremely anxious to get a job. Constant failure to do so, constant demands from his family in the rural area for help, and the unwelcoming nature of the relative he stays with in the town, may depress the individual. These feelings may lead the individual into deeper depression and finally to committing suicide. Thus it was not surprising to find subjects who have killed themselves leaving statements like, "life is unbearable" and "I can no longer face life".

Therefore, given the economic situation in Kenya generally, and Nairobi in particular, and above all considering that Kenya like most developing countries, experiences the problem of unemployment

the extendend family system may not be helpful to individuals looking for jobs in the towns. According to this study, staying with relatives in the towns may actually create problems that may lead one to fatal suicide. On the other hand staying with parents or spouses may create certain problems that may lead an individual to attempting suicide.

Hypothesis Five :

Means used and the Type of Suicide

The fifth hypothesis of this study was that the methods used in suicide will vary with the availability of the means, and the type of suicide.

The means used in suicide were divided into four categories, namely individuals who used drugs, those who used ropes or pieces of cloth, those who used tall buildings, and those who used other means like knives, paraffin, gun, bottles, and dams. Table 59 in Chapter Eight comparing those who succeeded and those who attempted to kill themselves was used to calculate a chi-square test. All subjects who committed and attempted suicide

were included.

According to Table 59 in Chapter Eight the majority of individuals who kill themselves tend to use tall buildings, or ropes and pieces of cloths. The majority of those individuals who attempt suicide tend to use drugs and poisons. Table 58 in Chapter Eight of this study was regrouped to constitute a chi-square test (Table 81). The common drugs and poisons used were chloroquine, asprins, piriton, valium, lagactil and insecticides for killing insects on animals and crops like coffee.

Table 81. The Means Used and Type of Suicide

Means	Successful Suicide	Attempted Suicide	%	N
Drugs & Poisons	10	90	100	115
Ropes/Cloths/ Paraffin/Bottles	76	24	100	34
Tall buildings/ Knives/Gun/Dam	79	21	100	24
N =	56	117	%	173

X^2 = 80.0, df = 3, Significance = 0.001

According to Table 81 the means by subjects used to be related to the type of suicide. This study seems to have supported the observations made in the developed countries that individuals who attempt suicide tend to use drugs or poisons. Also that the individuals who succeed in killing themselves tend to use violent means. It also supports the observation that the individuals who engage in suicidal acts tend to use the means that are readily available to them. In this study, the available means like ropes, tall buildings were commonly utilized, where one succeeded in killing oneself, while insecticides like gamatox, D.D.T. were used where one attempted suicide.

Hypothesis Six

Impact of Suicide on Relatives

The sixth hypothesis of this study was that the effects of suicide on the family members would vary with the type of suicide.

Research work on suicide has observed that suicide brings a lot of changes in the families where it has occurred. These changes have been observed to

be either positive like improved relations or negative like other members of the family trying or killing themselves. This study attempted to find out whether these changes have any relationship with the type of suicide. Only the relatives of those who committed or attempted suicide were included to test this hypothesis (17 relatives of those who committed suicide and 13 relatives of those who attempted suicide).

To test this assumption questions 6, 13 and 24 of Appendix III were used. Table 82 shows the results.

Table 82: A Summary of Changes that took place in the Families after Suicide

Changes	Successful Suicide	Attempted Suicide	%	N
Loss of friends	69	31	100	16
Feelings of let down	0	100	100	5
Mental break down	100	0	100	3
Improved relation-ships	75	25	100	4
Other Suicide attempts	0	100	100	2
N =	17	13	%	30

The majority of subjects in both groups reported loss of friendships. This seems to be more in situations where suicide had been successful. Although the sample was rather small, where suicide attempts were made, the family members tended to have feelings of let down and resentment of the victims (survivors). This can explain the fact that, the families reported subsequent suicide attempts and only one subject in this group reported the relationship to have improved. On the other hand, although where individuals succeeded in killing themselves relationships tended to improve, it is in the same group where some family members were reported to have experienced mental breakdown after the incidence (case illustration number 8).

Table 82 was regrouped to test the significance of the observations made above. When a chi-square test was done the results were insignificant (Table 83).

Table 83: The Changes Experienced By Families According to Type of Suicide.

Changes	Successful Suicide	Attempted Suicide	%	N
Loss of friends	69	31	100	16
Improved relations/ Mental breakdown/ Feelings of let down/Other attempts	43	57	100	14
N =	17	13	%	30

X^2 = 2.18, df = 1, Significance = 0.05

According to Table 83 there was no relationship between the type of suicide and the changes experienced in the family after suicide. Both types tend to have changes although, there seems to be an inclination of those who attempt suicide to experience resentment in their families after the event, while the families of those who succeed in killing themselves tended to experience higher incidence of mental break down.

The families of individuals who attempt suicide

may experience some resentment and a feeling of being let down by survivors for various reasons. In most cases as has been illustrated in this study, most suicidal attempts occur because of poor relationships between spouses and children and their parents (Table 61 in Chapter Eight comparing successful and attempted suicide). Since relationships are always poor prior to the attempt, the incidence seems to generate a lot of anger from the relatives especially where there has been disagreement on issues. Since the attempter survives, the relatives especially where there has been disagreement, often do not take him seriously and he is seen as a person who is out to create problems for the family. In such situations relationships are difficult to improve unless there has been an intervention from outside the family, where perhaps some counselling services have been offered. According to this study, the majority of individuals who attempted suicide actually did not take the psychiatric services offered to them after they had been discharged from the hospital. This meant that the majority of individuals who attempted suicide because of the interpersonal conflicts went back to the same conflicts

unresolved. Hence it is not surprising that feelings of resentment and let down were still being expressed.

On the other hand, the families of individuals who succeed in killing themselves may report some changes in relations especially improved relationships because the person who might have been seen as the person causing problems in the family is now absent. Hence the improved relationship may be actually ecuated to the absence of the trouble makers (case illustration number 11).

Nonetheless, the families of individuals who succeed in killing themselves may be disadvantaged in several ways. In the first place, the relatives of individauls who kill themselves have no way of hiding what had happened and everybody close to the family knows what had happened. In most cases people gossip about them and they develop their defences and actually withdraw from public life. As Goffman observes, the response of the individual being stigmatized has some significance in his relationships to other people (Goffman, 1960). According to Goffman such an individual

thinks and feels that he is being stigmatized and hence isolates himself from others as he perceives others in terms of his self perception. To retain and establish friendships becomes a difficult exercise for such an individual. As such it is not surprising that the majority of the relatives of those who had killed themselves reported that they had lost their friends. Besides often the relatives are blamed by their relatives and friends for what had happened. According to this study the majority of the relatives whose relatives succeeded in killing themselves reported that things were terrible after the incidence, mainly because they were blamed for what had happened. The isolation, the blame and the shock that one member of the family has killed himself or herself may explain the mental breakdown of some of the family members (case illustration number 8).

In conclusion, considering that only 4 relatives reported improved relationships after suicide, it seems that the majority of the relatives whose relatives get involved in suicidal acts

actually experience negative changes in their families. This however, is consistent with the general views about suicide in the society, for the families in which there has been incidence of suicide are often treated with contempt. These changes tend to include loss of friendships, feelings of let down and resentment, mental breakdown and other suicide attempts.

Relationships Between most Important Variables and Suicide.

Distance, Employment and Suicide

The study attempted to find out whether distance and employment are related to suicide. Distance included individuals who reported to have come from places far from Nairobi as Kakamega, Kisumu, Kisii, Mombasa, Kwale and others while near places included individuals who reported to have come near Nairobi like, Kiambu, Machakos, Ngong, and the like. Employment was divided into two categories, mainly employed and unemployed.

A chi-square test was done and the results were significant (Table 84).

Table 84: Relationship between Distance, Employment and Suicide.

Distance	Employment	Successful Suicide	Attempted Suicide	%	N
Near Town	Employed	56	44	100	41
	Unemployed	26	74	100	35
Far from Town	Employed	48	52	100	29
	Unemployed	10	90	100	40
	N =	50	95	%	145

X^2 = 23.3, df = 3, Significance = 0.05

According to Table 84, there seems to be relationship between distance one comes from, employment and suicide. Thus the majority of individuals who succeeded in killing themselves tended to have their rural homes closer to Nairobi and were employed

when they killed themselves. On the other hand, the majority of individuals who attempted suicide tended to come from far and were unemployed.

The above difference may have many explanations. But the major explanation can be related to the fact that most of the subjects included in the study were manual labourers and individuals travelling long distances to look for jobs may not really get appropriate jobs as these jobs might have been given to those individuals who stay closer the town. Besides individuals coming from far may have high expectations as regards to the job he is looking for and may not accept the manual offer having not known the nature of jobs in the town. On the other hand the individual coming closer town might have known the realities of the employment situation and may actually accept any job that comes his way.

These two opposing views, where one chooses jobs and where one accepts whatever is available in the market may pose problems to the individuals concerned. For example, the individual

who chooses jobs may take a very long time looking for jobs and in the process get demoralized as already been mentioned in the study. Coupled with the fact that such individual still has to stay and be looked after by the relatives, he faces a problem of acceptance by the relatives, especially if he is seen as draining the little resources the relatives might have. This may produce lots of conflicts leading to suicide attempts.

In situations where one accepts any job because he has to, also produce a lot of problems. For example, an individual who accepts a job he does not like but had to, soon finds that he cannot withstand the job. In most cases the salaries offered may not be enough for the individual. In the end the individual finds himself in a situation where he cannot only support himself but the family as well, although is considered employed. These situations as been observed earlier are highly demeaning and it is not surprising that individuals who stay closer their rural homes and are working in Nairobi were found in this study to actually succeed in killing themselves.

According to the International Labour Organisation report unemployment is not the only employment problem in Kenya as there is the problem of the employed poor (I.L.O. 1972). This report observes that in Kenyan towns, especially, Nairobi, the working poor in general work long hours for low incomes. Thus following the observation made in this study that the majority of the subjects had low education and actually worked as manual workers, it is possible that the individuals who were working actually were lowly paid. Faced with the situation where the individual has to remit part of his meagre income to his family in the rural community, it is likely that such an individual may face a lot of difficulties in attempt to adjust his little income in the town. The process leads to frustrations and disappointments which by themselves may drive one into suicide.

Migration, the Persons Subjects Stayed with and Suicide

The study attempted to find out whether there was a relationship between migration, the persons with whom subjects stayed and suicide.

Migration was categorised as short-distance migration where individuals came from homes closer to Nairobi and long-distance-migration where the individuals came from far homes to live in Nairobi. The persons the individuals stayed with were categorised into 2 groups only, namely those subjects who stayed alone and those who stayed with other people (Table 85). When a Chi-square test was done the results appeared to be significant.

Table 85: Relationship between Migration, the Persons Stayed with and Suicide

Migration	Persons stayed with	Successful Suicide	Attempted Suicide	%	N
Long-Distance Migration	Alone	57	43	100	7
	Others	23	77	100	77
Short-Distance Migration	Alone	50	50	100	12
	Others	36	64	100	77
	N =	56	117	%	173

X2 = 7.9, df = 3, Significance = 0.05

According to Table 85, the majority of subjects who attempted suicide in both groups, tended to stay with other people. But individuals in the short-distance migration who succeeded in killing themselves tended to stay alone while those in the long-distance migration and attempted suicide stayed with others.

In general individuals who succeeded in killing themselves stayed alone (18 per cent of the successful suicide group) while those who attempted suicide tended to stay with others (92 per cent of the attempted suicide group). Also individuals in the short-distance migration category tended to stay alone compared to the individuals in the long-distance migration. Thus according to the findings suicide seems to be related to the distance one's original home is from Nairobi and whether one stays alone or with others.

Marital Status, Sex and Suicide

Studies done in the developed world have observed that suicide tend to have some relationship between marital status and sex. It has been observed

in these studies that single individuals tend to engage in suicidal acts and marriage may actually save one from suicide. Besides these researchers have observed that female subjects tend to attempt suicide compared to their male counter-parts who actually kill themselves (Bohannan, 1960; Harrington, 1959; Meer, 1976; Whitlock et.al. 1967; Yap, 1958).

As such, this study attempted to find out the above observations and compared marital status, suicide and marital status were divided into two categories, namely single including individuals who were never married and those separated or widowed. A Chi-square test was done and thosewho were married the results were significant (Table 86).

Table 86: Relationship between Marital Status, Sex and Suicide.

Marital Status	Sex	Successful Suicide	Attempted Suicide	%	N
Single	Male	41	59	100	34
	Female	21	79	100	48
Married	Male	55	45	100	40
	Female	20	80	100	51
	N =	56	117	%	173

X^2 = 18.1, df = 3, Significance = 0.001

According to Table 86, male subjects tended to kill themselves more compared to their female counterparts. But the married male subjects tended to kill themselves more than the single males.

On the other hand female subjects tended to attempt suicide more than the male subjects and the married females attempted suicide more than the married male subjects (80 and 45 per cent respectively).

Also single male subjects killed themselves more compared to their single female subjects (41 and 21 per cent respectively). More single female subjects attempted suicide than the single male subjects (79 and 59 per cent respectively).

In general male, married subjects tended to be represented more in successful suicide. Although Durkheim in his early studies on suicide did not tell us the type of suicide he was referring to when he made observation that men tend to be more vulnerable to suicide than women, this study seems to support his findings that married men in particular tended to commit suicide. According to

Durkheim, the married man enjoys privileges in marriage and when marriage either gets threatened or dissolved, it is the man who actually suffers more because he loses these privileges (Durkheim, 1951).

Although, it may be possible that some of the male subjects in this study committed suicide for the reasons described by Durkheim, it is also possible that in Kenya, men can actually kill themselves because of the expectations the society may have for them. As has been observed elsewhere in this study, although, the majority of the individuals who killed themselves were actually employed, most of them were manual workers getting meagre salaries. Besides most of these people were old according to Kenyan standards which means they might have large families although this was not possible to test. Faced with large families (assumed from experiences in Kenya) and high cost of living in Nairobi, accompanied with the fact that in Kenya men are expected to be the head of the families and should support their families, it is only proper that actually men who found themselves in the above described situation would have

the tendency to quit the miserable world they find themselves.

Apart from the demeaning working and living conditions in which the subjects studied generally found themselves, as has already been described; the majority of the subjects in the case studies felt that they had not achieved what they had intended in life. This means that the majority of subjects were actually very discontented in life. Naturally, men having been given rather high status in Kenyan society, by virtue of being a man, it is likely that men faced with no alternative in life, especially when married, may kill themselves as they may fear losing their position in the society (case illustration number 2). In this situation a man may kill himself because he cannot stand a situation where he is looked down upon by his wife because he cannot support his family. The above can be summarised by the following quotation by Francis Bacon 1607.

> "But to enumerate these things were endless. I have given the rule, where a man cannot fitly play his own part. If he have not a friend, he may quit the stage".

Bacon is quite explicit in his belief and he specifically feels that a man should actually quit the world if he does not play his role well. No reference is made about a woman who does not play her role well. Apparently most people in the society tend to hold a similar view and it may not be surprising for men to actually kill themselves.

Women's roles in Kenyan society have been changing and in certain situations especially where there is single parenting, women have become bread winners. Besides the high cost of living accompanied with cash economy, more women now get involved in employment outside the family. The process of getting jobs has been equally frustrating for women as it is for men. Accompanied with the unemployment problem, most jobs that are available are sometimes considered to be inappropriate for women. In situations where women work, the utilization of her salary in the family has often created a lot of problems especially if married. Equipped with some education and religious beliefs, the Kenyan woman no longer tolerates the polygamous nature of their male counterparts and yet the African man still

tends to enjoy what may be called promiscous life. Faced with a situation where all the job opportunities are centralised in Nairobi, the Kenyan woman, for the most part, has to be separated from her husband for long periods and most Kenyans have two homes, that is, one in the city and another in the rural areas. This separation creates a lot of problems to Kenyan women. Faced with a rural home with no help forthcoming from the husband in their Nairobi home, the Kenyan woman often abandons her rural home and joins her husband in the town. In the process she may realize that her husband still finds it hard to support her for reasons ranging from supporting other wives to alcohol abuse.

The above combined may explain the high rates of attempted suicide among the women. In Kenya, the individual who is supposed to hold the house together even if the conditions are too difficult is the woman and the society tends to employ rules and sanctions to keep the woman in her marital home irrespective of the problems she may face. For example, outlets for a woman when frustrated in her

marital life are almost nil in most African settings. A frustrated man in Kenya can have an extra marital relationship in the most open manner. Such an individual can take into excessive drinking if so wished. A woman with similar frustration has to swallow her frustration and appear as everything is alright as she is expected to do so. In situations where a man can rightly channel his aggression outwardly, for example, fighting the offender, the woman is supposed to turn hers inwardly. Put in this situation, the only way a woman can show her frustrations to those concerned is through suicide attempts. Thus the high rates of attempted suicide among women may be a way of communicating their problems. Hence it is not surprising that in Kenya according to this study, women tend to be over represented in suicide irrespective of their marital status.

Sex, Occupation and Suicide

The study attempted to find out whether there was any relationship between sex, occupation and suicide. The occupation of the subjects were divided into 2 broad categories, that is those who

were considered to be doing office work and those doing manual work. Those subjects who were recorded as housewives were included in the manual workers. Those recorded as students and self-employed were not included. The occupations were regrouped mainly for test purposes. A chi-square test was calculated and the results were highly significant (Table 87).

Table 87: Relationship between Sex, Occupation and Suicide.

Sex	Occupation	Successful Suicide	Attempted Suicide	%	N
Male	Office work	68	32	100	19
	Manual work	41	59	100	46
Female	Office work	40	60	100	10
	Manual work	16	84	100	62
	N =	46	91	%	137

X^2 = 22.8, df = 3, Significance = 0.001

According to Table 87, the majority of subjects who succeeded in killing themselves were office workers while those who attempted suicide were manual workers. However, more women who attempted suicide were in the manual work group. This over-representation of female sample is a reflection of the fact that the majority of female subjects were housewives.

In general individuals who succeeded in killing themselves were doing office work while those who attempted suicide were actually involved in manual work. This is consistent with the observation made in this study that the majority of the subjects who succeeded in killing themselves were employed while those who attempted suicide were unemployed. For example comparing the successful suicide sample and the attempted suicide sample, 37 per cent of the successful sample reported doing office work while only 13 per cent of the attempted suicide reported the same.

CHAPTER TEN

SUMMARY, DISCUSSION AND CONCLUSION

Summary of the Findings.

The purposes of this study were:

1. To investigate the extent and nature of suicide and attempted suicide in Kenya, mainly in Nairobi.

2. To examine the relationship between suicidal acts and the African life style, particularly, the extended family systems, polygamous marriages and place of residence.

3 To investigate the relationship between current Kenyan socio-economic problems and suicide, that is, unemployment, family disorganization (seperation, divorce and marital problems), rural-urban migration and alcohol abuse.

4 To find out the impact of suicide on the family of individuals who committed suicide,and

5 To sensitize Kenyan people to the fact that most cases of suicidal acts are really a cry for help and that the survivors need treatment rather than punishment.

The important facts that came out of this study are summarized below:

1. That suicide acts seem to be on the increase in Nairobi and in Kenya as a whole. For example, successful suicide in Nairobi shows an increase of 300 per cent between 1975 and 1979 while attempted suicide shows an increase of 550 per cent during the same period.[1] Compared to

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1. The formula used for suicide increase was:

$$\text{Successful Suicide} = \frac{(56 - 14)}{14} \times 100$$

Where 56 are cases of successful suicide in 1979 while 14 are cases in 1975.

$$\text{Attempted Suicide} = \frac{(117 - 18)}{18} \times 100$$

Where 117 are attempted suicide cases of 1979 and 18 are cases of 1975

$$\text{Population of Nairobi} = \frac{(835{,}000 - 776{,}000)}{776{,}000} \times 100$$

Where 835,000 was the Population in 1979 and 776,000 population in 1975

Nairobi's population rise during the same period, the increase for both suicide and attempted suicide were still higher For example, Nairobi's population increase between 1975 and 1979 was 7 5 per cent Thus the possible argument that the increase in suicide reflects population increase in Nairobi is not tenable and the population increased slowly compared to the suicide rates.

2. The study has shown that there are more suicidal attempts than successful suicides in Nairobi. The majority of individuals who attempted suicide tended to be young, unemployed, had some formal education and were mainly married women. On the other hand, the majority of individuals who succeeded in killing themselves were older, employed either in offices or in manual work and were mainly men most of whom were married and had no formal education.

3. The majority of individuals who attempted suicide had come from Western and Nyanza Provinces of Kenya, mainly Baluhyias and Luos, while those who succeeded in killing themselves had come from Central and Eastern Provinces, mainly the Kikuyus and Kambas.

4. The individuals who succeeded in killing themselves tended either to stay alone or with their extended kin members while those who attempted suicide tended to stay either with their spouses and children or parents and relatives. Staying alone seemed to lead to successful suicide while staying with others was more associated with attempted suicide regardless whether an individual had come from near Nairobi or far from it.

5 The methods used in the suicide act varied according to the type of suicide. Thus individuals who succeeded in killing themselves tended to use violent methods while those who attempted suicide used nonviolent methods. The means used also depended on their availability and individuals who killed themselves tended either to use ropes and 'leso cloth' to hang themselves or jumped from tall buildings in the city centre. The majority of individuals who attempted suicide used insecticides, mainly gammatox and D.D.T.

6 The main reasons that led to suicide attempts were disagreement with parents; poor relationships with spouses; loss of a job; property; spouse and a

loved one, mental mainly, depression and physical problems especially where there is a prolonged illness. On the other hand, individuals who killed themselves tended to do so because of problems with their spouses and unemployment or poverty.

7. The majority of individuals who succeeded in killing themselves and had come from places near Nairobi had experienced more marital problems and parent-child conflicts than individuals who had come from those places far from Nairobi and had succeeded in killing themselves.

8. The married individuals who attempted suicide tended to come from monogamous marriages while the majority of the married individuals who succeeded in killing themselves came from polygamous marriages.

9. Most of suicidal attempts occurred between January-March; July-September and October-December while successful suicide tend to occur in April-June and October-December

10. The findings show that although individuals who attempt suicide and are treated in Kenyattta National Hospital are usually referred to the psychiatric

clinic of that hospital, very few of them actually attend the clinic after being discharged from the ward. Virtually very little is known about those individuals who fail to attend the clinic.

11. Most relatives of individuals involved in suicidal acts tended to be very resentful about the suicide victims They tended to have feelings of being let down by the suicide victims. In most cases the families of these people experienced some changes as a result of suicidal acts and most of these changes were negative to the families.

12. This study found out that individuals who attempted suicide tended to be dissatisfied with life in general, especially with their marriage, occupation, income, education, place of residence and life-achievement

Discussion of the Findings

Although several studies in Africa have shown that women tend to kill themselves more often than men (Bohannan, 1960; Meer, 1976), the findings in this study have not supported that observation Instead, the findings tend to indicate that more men actually end up killing themselves than women and that young persons attempt suicide more frequently

This observation, therefore has supported the studies made in the western world, that men tend to be overpresented in successful suicide while women and young persons are over-represented in attempted suicide (Henry, 1954; Kessel, 1965; Kreitman, 1973; Stengel, 1967; Whitlock et al, 1965).

Different explanations have been given about the sex differences. For example, Durkheim thought that men especially those married could kill themselves when divorced or widowed because they seem to be advantaged in their marital relationships (Durkheim, 1951) According to Durkheim, man is not so restrained by marriage while women are and the women seem to gain when the marriage bond gets loosened.

Nonetheless, the rates of men killing themselves when compared to the rates of women attempting suicide, tends to remain low Hence the rates of women who attempt suicide remain very high all over the world This state has led some researchers like Whitlock and others to conclude that the high rates of suicide attempts among women may actually be a reflection of a

higher incidence of neurotic illness among women (Whitlock et.a , 1967). Whitlock and others see men as having greater opportunities outside their homes for working out their domestic anxieties than women. While not accepting the argument that women are more neurotic than men, the other observation made by Whitlock and others that men tend to have better and more opportunities for working out their frustrations than women, may hold true in Kenya. Actually in Nairobi itself, the local social amenities tend to be of a masculine nature and hence it makes it rather difficult for a frustrated woman to readily find an out let. For example, in Nairobi women are not usually allowed to go to a bar unaccompanied and yet we know that frequent bar attendance could be one way of letting out the steam. In Kenya, the non-family affairs are men's responsibilities, while domestic affairs are supposed to be women's responsibilities. Hence, women in general find it rather difficult to enter those areas they are expected not to enter, hence, suicide would be used not to destroy self, but to communicate problems being faced in one's domain.

Yap (1958) saw the high rates of suicide attempts among women in terms of women's status

in the society rather than social sanctions According to Yap women are not allowed to retaliate against those who frustrate them and actually they do not possess the right to organize their own lives since the patriarchal traditions still persist. This statement has been supported in this study. For example when the respondents were asked what they would do if disappointed with their spouse, female respondents said that they would go away meaning that they would leave their homes. On the other hand, male respondents said that they would either beat or send away their spouse. This demonstrates a situation where women are not supposed to retaliate against those frustrating them. This puts the African woman in a situation where she has to use threats in order to be heard.

In Kenya, one can safely say that women still do not possess the right to control or organise their own lives as stated by Yap. This allegation can be supported by case numbers 4, 5 and 7 where these women hardly had any say as to how they should be leading their lives. In Kenya, although socio-economic development has gathered momentum after independence, leading to an increase

in urbanization and industrialization, some customs and traditions, leave alone values have not been changing at the same pace. Thus practices like polygamy and extended family systems are still with us. These practices apparently may not be compatible with high standards of living associated with urbanization and industrialization in which the Kenyan woman finds herself. For example, the African woman may go and work and earn money, but for the most part, her husband will decide how that money will be used. Besides, she may prefer to have a small family and enjoy her privacy because, the western education and values have made her that way, but her husband has still to decide and his decisions and hers are not always compatible. In most cases, it appears as if the woman is struggling to emancipate herself from the traditions and customs, while the man struggles to maintain them. In situations where the woman realizes that her voice is not being heard in the struggle, she may decide to attempt suicide as the last result. Hence suicide becomes an effective way of conveying her message. Thus the global societal systems that tend to favour men and discri-

minate against women will actually perpetuate the overrepresentation of women in attempted suicide.

Researchers in western world have observed that older people tend to succeed in killing themselves compared to the younger persons who tend to frequently attempt suicide. This study has supported this observation and individuals who killed themselves tended to be older according to Kenyan age standards. For example the mean age of those who succeeded in killing themselves was 35.2 years while that of those who attempted suicide was 24.2 years. The high rate of suicide among the old people in developed countries has been associated with the long life expectancy enjoyed in those countries. Besides other studies have shown that elderly people who attempt suicide hardly seek help after the attempt while young people who attempt suicide actually go for help afterwards (Whitlock et al, 1967).

Other researchers have also shown that individuals who attempt suicide often end up repeating the act, a situation that leads them to kill themselves (Bagley, 1971; Dahlgren, 1945; Ettlinger,

1964; Pokorny, 1965). This may explain the observation that the elderly people kill themselves more than the young persons since these elderly people might have been attempting suicide since they were young.

In this study individuals who killed themselves tended to be married, had domestic problems, were working and most of them held lowly paid jobs and although residing in Nairobi, the majority of them came from homes closer to Nairobi. In Kenya an individual over 35 years old is indeed expected to have organised his life well. Most of them are expected to have been married and be in the process of educating their children and living happily with their families. In situations where one faces poor relationships with his family, where he feels disadvantaged in the type of job he is doing and where he feels that he has not achieved much in his life, as shown in the study, one may actually lose meaning in life and may decide to kill himself. This may be made worse if such a person is closer to his home where now and then he has to witness the miseries in his family and yet he feels helpless in the situation.

Often it is the older person who may actually have more of a feeling of failure than a young person who may still have his ambitions and aspirations intact. The situation is worse in places like Kenya where the society still expects the man to be the sole head of the family. Therefore, it is not accidental that older people would actually kill themselves in Kenya. In situations where one feels and, realizes that he has reached his maximum in life and yet there is very little he can do to improve his life either in terms of job satisfaction, relationships and the like, one is likely to kill himself. On the other hand, in situations where one is either young and/or dependent on others as children are to parents and women to men, and when one is faced with problems of poor relationships or any form of a crisis, one is likely to yell for help. Thus, it is not surprising that in Kenya women and younger persons attempted suicide and this may be seen as a cry for help. In Kenya, parents have high expectations about their children as most parents see their success through their children (case number 10). Hence decisions pertaining

to friendships, marriage, career selection, leisure time activities and the like are actually controlled by parents. Accompanied with the turbulent period of adolescence, the Kenyan young person would actually be highly exposed to suicide attempts, mainly to sensitize their parents to their disagreement with imposed decisions and to let others know that they have problems.

Another major finding of this study was that individuals who attempted suicide tended to come from long-distance migration while those who succeeded in killing themselves came from short-distance migration. Among the four major tribes in this study Baluhyias and Luos were over represented in attempted suicide while Kikuyus and Kambas were overrepresented in successful suicide. The Baluhyias and the Luos represented the long-distance migration while Kikuyus and Kambas represented the short-distance migration. Individuals who live in the town, but come from far will have the tendency of letting their relatives, mainly their spouses and children, come to stay with them. In most cases the relatives come either to visit or look for jobs or education

In Kenya, most of the services are centralized in Nairobi as such many people move from rural areas into the city mainly to look for employment and education. Once jobs are obtained the relatives often come to live with those who are working. This practice is frequent where people come from far to the city, because for the most part, those working can only afford to visit their rural homes perhaps once a year considering the distance and the costs involved. On the other hand, those living closer to their rural homes can actually afford to travel to their homes more frequently and hence need not bring their families to live with them in the city. Therefore, it is not surprising that individuals who were closer to their rural homes were actually staying alone and those from far were staying with their spouses, parents and children, yet this is the group that actually attempted suicide more than those whose homes were closer to the city.

Migration from rural-urban creates many problems for the migrants. The migrants once arrive in the town, soon realize that the situation is not

as promising as it seemed The cost of living obviously is higher in the towns than in the rural areas and the migrant soon finds himself in a situation where he can no longer feed his family. Individuals coming closer to their rural homes may be advantaged in that they can get some food supplies from their rural homes, while those who come from far have to buy everything that they eat. Coupled with the problem of unemployment, not all people who live in Nairobi actually work, which means that the dependants are usually more than those who work. This leads to a real imbalance in the support systems in the city. Hence the migrant faces a situation where money is actually scarce and yet he is still to live in the system. Faced with the family he cannot adequately support, he may turn to other activities, mainly to avoid the painful situation as illustrated in case number one. All these may lead to frictions that in turn may lead one to suicidal attempts

Accommodation in most urban areas is a problem. It is worse in big cities like Nairobi, where one can get a job and fail to get a place to live. With limited income, most workers find themselves living in slum areas characterised with

overcrowding, poor sanitation, stealing and lack of privacy. For those who work and support their families and relatives, these conditions are demoralizing but still better than nothing. In most cases they develop other means of handling the situation. Faced with a situation where he cannot meet the family demands and being constantly faced with financial worries, the men in Nairobi, especially those from long distances have the tendency to spend most of their time outside their homes. The implication of this habit is that the little money he earns is spent on those outside activities leaving the families with nothing to spend on themselves. This habit may generate hostility leading to strained relationships in the families.

For the women who join their husbands, the expectations are indeed frustrated as in most cases the expectations are at variance with the urban reality. Faced with a situation wherein she cannot afford to feed her children, let alone buying herself some new dresses, the woman may actually regret her journey to the city. Coupled with boredom, as in most cases, she has very little to do in a one roomed house, and cannot afford the entertainment facilities

in the city, the woman may actually find herself being very sensitive and may involve herself in constant quarrels. Where a husband turns a deaf ear to her problems and comes home very late and drunk, she may decide to attempt suicide just to make her case be heard.

For children who come to town to seek education the situation may be perplexing not only because of the high expectations parents have towards them, but because the superior type of education they were expecting may not be forthcoming. Soon the student realises that he has to walk many miles to go to school as his parents cannot afford bus fares. He sometimes has to do without lunches and he may not have shoes, although other children in the school have them. Besides, he may not even have a place to do his homework. Above all, his movements have to be controlled lest he is arrested by police for vagrancy. In short, the student finds himself in a very limiting, controlling atmosphere with little recreational facilities contrary to his expectations. These inconsistencies need only minimal provocations to lead to suicidal attempts.

Life is even more difficult for job seekers in the town, especially Nairobi. Considering that unemployment is one of Kenya's social problems, individuals looking for jobs take a very long time before they get jobs. This means that the job seekers have to depend on their relatives. Individuals coming from far are disadvantaged in the process of looking for jobs for various reasons. Firstly, the distance involved is too great, hence the job seeker actually tends to want jobs of his choice. At least he is expecting a better job after travelling such a distance. Secondly, he may not be aware of the locally available jobs as his connections may be restricted as if they may be based only on his close relatives. Thirdly, such an individual may be actually thrilled with city life as this might have been his first trip to the city and he may spend time adjusting to city life rather than looking for jobs. Therefore, such an individual takes a longer time to get a job. This means that he has to depend on relatives who are also under pressure of the high cost of living in the city. The relatives may in the end directly

communicate to him that they can no longer support him.

All this may make one lose meaning in life. His family in the rural home may actually expect him to help them. Not being in a position to do so and faced with a situation where he has no idea as to when he would get a job, such a person may engage in sucidal activities. With all these one can support Caldwell's observation that urban life does not provide all the anticipated money, a situation that leads to lots of frustrations to the migrants (Caldwell, 1969). Thus individuals who come to towns either to join or visit their spouses or to get education or employment are likely to go through experiences that may lead them to suicidal acts. This has been supported by the findings in this study, that it is those individuals who either stay with their spouses and children or parents or relatives who are more involved in attempted suicide.

Another significant finding of this study is that the majority of individuals who attempt suicide hardly went to seek help. Little is known

about the fate of these people after they have been discharged from hospital. According to the findings, only 55 per cent of the total sample were referred to the psychiatric clinic. The majority of these individuals attended the clinic only once. This finding supported other findings made in the western world that individuals who attempt suicide usually do not cooperate with treatment programmes and only a few manage to complete the treatment (Bridges et.al, 1966, Greer, et.al, 1967; Morgan et.al, 1976).

This state is disheartening since observations have been made that those individuals who attempt suicide and remain untreated tend to be vulnerable to repeat suicide attempts and the majority end up killing themselves (Greer et.al., 1971). In Kenya individuals who fail to go for psychiatric treatment after suicidal attempts may refuse treatment for various reasons. Firstly, suicide in Kenya is an offence and punishable by Kenyan laws (The Penal Code 1962). This means that an individual if caught in or after the act, may be charged and either be placed on probation or actually sent into

prison for a period ranging from 3-24 months. As such most of suicidal attempters actually try to conceal the act and would not like to be associated with the hospital after the discharge. This was evidenced during the follow up case studies where the subjects became very apprehensive as to how the researcher got their names. Most of them only cooperated after the investigators had reassured them that there was no intention of arresting them.

The situation was also demonstrated by the massive return of the letters the researcher had returned to her because of wrong addresses. While not doubting the fact that some of the respondents might have changed addresses left at the hospital, it is possible that some of respondents left false addresses at the hospital in order not to be identified. This point is supported by key informants from Kenyatta National Hospital, where one of the nurses who had dealt with suicidal attempters said that, the police nowadays keep a watch on patients who have attempted suicide just as they do with other criminals. According to this respondent, the

police have learned that those who attempt suicide give them wrong addresses and it is hard to trace them after discharge.

The other factor that could make those who attempt suicide not co-operate with treatment is related to the attitude people have towards them. Infact, there are some studies that show that even medical personnel are biased towards those who attempt suicide (Ramon et al. 1975) and for the most part people tend not to be sympathetic to them. The researcher became disheartened after giving a talk to very high ranking church people attending a seminar on suicide. The participants asked very many questions and she thought that they must have understood reasons that may lead people to suicide. She thought of giving them the questionnaire she was using for the key informant in her study to test knowledge and attitude change. She was disappointed that after two weeks, the majority of participants still saw people who commit suicide as sinners and highly condemned the act. All of them felt that those who kill themselves should not be given a church burial. From the responses obtained, the researcher concluded that the punitive

attitude of the society towards those who become involved in suicidal acts is indeed grave and merely changing the laws may not be enough. Hence one can resent the services being offered.

In Kenya, the rejection of services by those who attempt suicide can also be related to distance and the money available for transport. The majority of those who attempt suicide were living far from the hospital. Besides, most of them came from low income groups, where the basic needs of the family were not even met. Hence it would have been expecting too much from a family, which is barely trying to survive in the city to part with hard earned money to use services which the members may not understand. Infact, most people in Kenya may not believe that suicide or suicide attempt is a psychiatric problem and therefore, they may not see the need to use their limited resources to visit a psychiatrist.

The duration of appointments given to those individuals who have to see a psychiatrist is often too long. For example the appointments for those seeking psychiatric help, those attempting suicide

included, are usually 2-4 months. This period is too long and it is not only likely that the suicide attempters might have left for their rural homes, but is it possible that some of them might have had their problems resolved and hence no need to return to the hospital.

Another finding from the study was that the majority of those who attempted suicide were dependents. That is, they were either wives visiting or joining their husbands or children living with their parents or those looking for jobs. This may mean that most women realizing that life in the city was not offering them what they expected might have opted for their rural homes. Besides the husbands after realizing that the relationship actually led to suicidal attempts must have unilaterally decided to send them home to avoid subsequent frictions. As for children, the cooperation of parents remains paramount. Since suicide is not one of those acceptable behaviours in African society, and given the fact that the parents still remain the major source of authority regarding the upbringing of children, it would be expecting too much to refer young persons to a psychiatrist without

parental consultation Hence, most of the majority of parents might have not seen the need of their children making other trips to the hospital especially when they were out of physical danger.

As for individuals who seek jobs, money for transport may be a major factor considering that they depend on their relatives for support and no relative would stretch his resources especially in a situation where the treatment is seen as a luxury Therefore, for the survivors of suicide to be cooperative to the services offered, it seems that all the above factors have to be taken into consideration. This means that the survivors' significant others have to be involved, perhaps at the admission time rather than waiting until the victim has recovered and make referrals. Contacts should be made before the victim is discharged.

Finally the study found that the majority of the relatives of those who attempted suicide were very resentful about what their relatives had done. Most of them actually blamed the victims and felt that they had been let down by the victims The families also experienced some changes in the families, mainly that other members attempted suicide

or even killed themselves. Others reported losing friends. Those who lost the relatives found the burial tedious not only because the other relatives were not supportive, but because the post mortem took too long and the police were not very understanding. The majority of the families had no problem with the property of those who had succeeded in killing themselves. All these observations except the observation on the victim's property, tend to support what other researchers have observed. Although the sample was small, it seems that even in Kenya, especially Nairobi, the family members of individuals who commit suicide go through traumatic experiences which may lead to family disintegration.

Johnson (1973) observed that the family members of those who have killed themselves may not only shut themselves off from external environment and its support, but the expected mutual family support may be absent because of the feud within the family in an attempt to explain why one of them had to kill himself. Johnson's observation can be illustrated by case number twelve where the family ended with two successful and one attempted suicide. This was also supported by the fact that the majority

of the relatives interviewed felt that what happened would have been avoided if one member in the family was considerate. This means that even the relatives themselves had managed to identify the person in the family who was responsible for the other member attempting or commiting suicide.

Goffman (1961) observed that stigmatization is really a two-way process where one gets those who stigmatize and those who are being stigmatized by others Hence, those being stigmatized tend to react in a way that may not only facilitate stigmatization but may reinforce it. Thus, the stigmatized persons, being unsure of how the 'normal' persons will receive them, often limit their interactions and associations with others. In this study, the majority of the relatives said that suicide was difficult to deal with because people tend to talk about the event and they are not sympathetic. There were others who said that they felt ashamed after the incident knowing that it could have been prevented. The statements support what Goffman had reported since the relatives are really subjective and this attitude is likely to limit individual's

responses since he may be preoccupied in his mind with how other people are feeling towards him. This process may isolate the individual and give such an individual a special position in the society. Thus, it is not surprising that most of those whose relatives died through suicide reported that they did not get much help from their relatives.

Suicide is supposed to bring some changes in relationships. The findings in this study showed that the changes are related to the type of suicide. For example, the changes reported by the relatives whose family members had succeeded in killing themselves were loneliness, family members having mental breakdown and, in situations where the victim had been very disturbing to the family, positive changes were also reported, for example, life being more peaceful after the death of the victim. On the other hand the relatives of those who attempted suicide reported not being free with other relatives and friends They reported other suicidal attempts in the family and not being free with the victims (their relatives who had attempted suicide). Most of the respondents felt that the act would spoil their names and hence relationships with others.

Death in most cases means a loss to the family members which is irreversible. The situation becomes worse when one loses a relative through suicide as in most cases the family members are blamed This leads to the feelings of guilt which can lead to isolation and mental problems as demonstrated by the findings. However, in situations where one family member has been difficult in behaviour, the relatives and friends often come to know the problem the family members are facing. Often they are sympathetic and this tends to continue even if the member kills himself. In such situations the family members are saved from guilt feelings associated with suicide and hence one may actually expect positive change within the family.

At times suicide can also serve as a shock to the relative who has been causing problems to the victim and after death the relative may stop the behaviour, partly because the person the behaviour used to be directed is no longer present and so there is no secondary gain. It is also most likely that the shock of death was so much that the individual

decides to have self-evaluation resulting in positive change.

On the other hand, the relatives of those who have attempted suicide may not experience any guilt feelings as the victim is alive and they can discuss their feelings. But they may be ambivalent about the victim and instead blame the victim for shaming them (revealing family secrets) and being manipulative and hence they may not take the act of the victims seriously. Turning a deaf ear to the victims may lead to subsequent suicidal attempts. Therefore, it is not surprising that there have been other suicidal attempts in this group.

In conclusion, this study has achieved several ends. By showing that suicide is a problem in the country and seems to be on increase in Nairobi and this has nothing to do with the population increase of this city. That in Nairobi the individual who succeeds in killing himself tends to be old, male, working as either manual and office workers with no or little education, comes from short-distance migration and tends to stay alone. On the other hand individuals who attempt suicide in

Nairobi tend to be young women, most of them have some education, stay with spouses, parents or relatives and come from long-distances. It has shown that factors that may lead people to suicide in Nairobi do not differ much from those which lead people to suicide in the western world. However in Nairobi factors as extended family systems, polygamous marriages, unemployment and educational values may be associated with suicide. The study has also shown that individuals who attempt suicide when compared with the individuals who get admitted to Kenyatta National Hospital with physical complaints (control group) tend to be older than the control group. But both groups do not differ in their level of education, state of employment and the people they stay with when in Nairobi. Besides the study has shown that the majority of individuals who attempt suicide find it difficult to accept help offered to them after they have been discharged from the hospital, and their relatives face tremendous problems after the act. Finally the study has shown that suicide as demonstrated in Nairobi seems to be a way of communicating problems, although it is still punishable by law, a situation that makes follow up of the cases rather difficult. .

Implications of the Findings

The design of this study limits itself to the respondents who were seen either at Kenyatta National Hospital or their cases reported at police stations and those reported by the newspapers in Nairobi. This means that a large proportion of individuals who attempt or commit suicide and do not appear in the available data systems in Nairobi are not included. The second limitation is that the study has been done in an urban setting among low income groups leaving out the rural communities and those subjects from high income groups. This has been supported by the observation that one key informant reported seeing 8 individuals from high income group, who had attempted suicide within a period of ten days. With these limitations in mind, the implications of the findings of this study are examined for theory, practice and research.

Implications for theory

Durkheim and Freud indicated that for one to commit suicide one needed some forces from either the society or from within the individual to trigger

the act. The findings in this study tend to show that many factors both societal and individual can be associated with suicide and in fact they vary according to the type of suicide. The causes of suicide are much more complex and numerous than the theories of Durkheim and Freud which deal with very few specific causes which tend to support situations where one succeeds in killing oneself.

The situation becomes even more complicated where one attempts suicide. According to the findings those individuals involved in suicidal attempts seemed to have been looking for help. They were communicating their problems rather than not being integrated or regulated by the society. Thus Durkheim's and Freudian theories of an integration regulation continuum versus aggression turned against self, actually have to be treated with caution, especially when dealing with attempted suicide in Kenya, where factors like distance, extended family systems, education, women's status, infertility and the like have to be considered and are only vaguely related to Durkheim's or Freud's theories.

Implication for Practice.

The causes of suicide are indeed multifactorious and tend to vary with the type of suicide. They even vary from one case to another and by age of the individual. This means that those who would like to help the victims would have to deal with many factors before they really discover the core problem of the individual. Another implication for practice is that individuals who attempt suicide often do not cooperate with the treatment. This could be as a result of the fact that suicide is still illegal in Kenya or because the majority of the subjects in this study were actually poor and could not afford the fares to the hospital for follow up services. Other studies have shown that individuals who cooperate with treatment tended to improve their relationships with others, while suicide rates tended to be higher in situations where there was no follow-up (Greer et.al., 1971). This situation becomes more complex because individuals who engage in suicide attempts tend to be young and unless they are helped their future would be ruined. This observation may call for various changes to improve the cooperation namely:

1. Closer cooperation between researchers, practitioners and law makers so that they can share views that may be useful to suicide victims.

2. The need for social workers' involvement at the initial stage when the individuals who have attempted suicide are admitted at the hospital, mainly to make sure that initial contact is made with the family members and proper assessment of the problem is done. This will initiate situations where help can be given to the entire family members rather than isolating the patient who might be presenting the family's problem. According to family therapists, individuals who present themselves at the clinics with problems, often represent the family pathology and may be they are either the most sensitive or affected members of the family (Munichin, 1974; Satir, 1967; Skynner, 1976). Hence the individual who have attempted suicide, coming for treatment at the hospital may actually be revealing much about the problems that exist in the family.

3. The need to engage social work services at the Casualty Department to engage the relatives in the treatment at the admission time rather than making referrals when the victim is being discharged.

It would seem easier to engage the help of the relatives at the time when they are experiencing a crisis than talking to them when the crisis is over. When help is offered after discharge, the relatives may not clearly associate the help being given with the problem they have just experienced.

Another implication for the practitioners is that the findings showed no major differences in level of education, status of employment and the persons stayed with between those who attempted suicide and those who got admitted to the hospital with other illnesses. This means that individuals who suffer from other illnesses were just as unemployed, had less education and stayed with their spouses, children and relatives as the individuals who attempted suicide. This creates a problem for the practitioners as it seems to indicate that reasons that lead people to suicide are not conclusive, and their efforts to curb the problems may be wasted dwelling on reasons which may not be major causes of suicide. This may explain the fact that with well developed services in the western world, the rate of suicide has not been decreasing as one would expect

and infact suicide is one of those acts that tends to increase with affluence. This situation is indeed discouraging for practice and may lead to waste of resources as the phenomena behind suicide seems to be unknown.

In Kenya, suicide is still illegal and individuals who attempt suicide if caught are punished. This means that most of those who are involved in suicide acts would not disclose what had happened. One way of not disclosing what had happened is not to attend psychiatric clinic as the attendance may reveal the intentions. This may not only lead to underutilization and underdevelopment of counselling services in Kenya, but may lead to more loss of life through suicide.

The negative attitude of the relatives of those who attempt suicide as shown in this study may lead to more suicidal attempts as the survivors of suicide may feel rejected by their relatives who appear unsympathetic to their behaviour. Studies in the western world have shown that the incidence of suicide tend to be higher among those who had had previous suicidal attempts (Bagley, 1971; Dahlgren, 1945; Ettlinger, 1964; Greer et.al. 1967). According

to this study, the relatives, especially, those whose relatives attempt suicide do not consider the act as a cry for help, a situation that leads to more blame on the victims and subsequent suicidal attempts. The above implications may call for the following considerations:

1. An urgent need for the legal act on suicide to be revised. This act is really outdated and although it may not necessarily reduce the rates of suicide it may improve the collection of statistics on suicide.

2. Although it has been observed that reports of suicide in newspapers may lead to increase of suicide as people tend to imitate others, one can still advocate for the general public to be informed about suicide and the reasons that may lead to suicide. As it has been shown in this study, the attitudes of the people in the society can influence the attitudes of the relatives which have great effect on those who attempt suicide.

3. The relatives of those who attempt suicide should be involved in the treatment from the time of the act and one is being admitted at the hospital. This would minimize the possibility of disappearance

of the victims after discharge from the hospital. The relatives would also leave the hospital with full knowledge of the reasons that can lead one to kill oneself and that they have the assistance of the hospital in helping the patient.

4. Attitudes tend to change better if decisions are made in groups. Hence deliberate attempts should be made by the practitioners to meet the family as a group and the family members decide on how they would like to help their members who attempts suicide. This approach seems to be consistent with the manner in which most African problems were traditionally solved.

5. The problem of adequate resources tends to feature most in developing countries. Hence it is rather difficult to advocate for the establishment of crisis centres in these countries as practised in the western world. However, in Kenya close cooperation between the church system and the practitioners may be suggested as the move may ease the problem of resources. For example, most churches in Kenya have ample space that can be utilised as open centres, where individuals with problems of living, that may lead them to suicide, can go to any time and get

some help. Such a move may not only lead to maximum utilization of the space that exists in most churches, but will help in changing the attitudes of the church authority and the public at large towards those who commit suicide.

Implications for Research

This study has shown that suicide records are indeed scanty in Kenya. The information found in the few available records is very inadequate. The recording system is worse in the hospital casualty records The police records seemed to be well kept and information well recorded in police stations where they were available. The hospital records are even more complicated because suicide attempts are sometimes not recorded as such. For example, quite a number of patients who attempt suicide by burning themselves get admitted to the burns unit and unless the doctors or the nurses attending to such patients inquire, many such cases leave the hospital without suspicion of attempted suicide. Similarly, quite a number of young girls who get jilted by their boyfriends after pregnancies often end up labelled attempted abortion, rather than suicide attempt.

A man who drinks insecticide for suicide purpose is usually discharged with the diagnosis of accidental poisoning or organophosphate poisoning, meaning that the person got poisoned by mistake. The accidental poisoning includes conditions where one in the process of spraying coffee or cleaning the house using some insecticides or fluid may end up poisoning oneself if one fails either to wash hands or change clothes after the job. Similarly, one may eat poisonous food without realising. All these conditions are recorded at Kenyatta National Hospital under accidental or organophosphate poisoning. This recording system may create problems for both practitioners and researchers as such cases do not appear in records as having attempted suicide. The implication here is that quite a large number of patients who attempt suicide leave the hospital undetected and not given psychiatric help.

In both settings, that is, the police stations and the hospital, there seems to be no deliberate effort to keep proper records on suicide, a situation that can lead to under reporting or under estimation of suicide. This state of affairs led the researcher to

make the following suggestions:

1. That there is a real need for both hospital and police authority to look into their recording system This may call for short courses or seminars for people involved with recording cases in hospital or at police stations. The authorities need to be aware that planning and provision of services may only be effective if one gets proper information about situations. With the recording system currently in use in this country, one cannot claim any knowledge about the magnitude of suicide and attempted suicide in Kenya today.

2. Perhaps, the most akin department to suicide is Psychiatry. The recording of those patients who attended the psychiatric clinic did not show much improvement in record keeping. This could be so, partly, because most patients attended the clinic only once or twice, or because the patients might have been too many for the few medical staff manning the clinic. Nonetheless, the above may be helped if the Department of Psychiatry can provide a format that can be used in the Casualty Department, since it is the only place one can obtain accurate information on suicide in a general hospital.

3. That all patients admitted to the hospital with burns and other forms of accidents and poisonings as well as abortions, should be thoroughly screened by a qualified person who can be able to identify and separate attempts from the ordinary accidents. The three units, especially the Casualty Department need a full time social worker with psychiatric knowledge for screening and counselling cases of suicide attempts. At the moment, it seems that many patients in these settings leave the hospital unattended as suicidal attempters.

The final implication of this study to researchers is that it was indeed broad. This means that no one factor was really looked into thoroughly. It has made some generalised observations that may need indepth study. For example, the study has shown that many factors may lead people to suicide. Here one needs other studies to determine the major factors that may lead a Kenyan in the town to attempt or commit suicide and those factors which may lead a Kenyan living in a rural community to do the same. The study has also shown that individuals who attempt

suicide may not differ very much from the ordinary people as regards to certain personal characteristics. This observation calls for a more detailed research to determine the difference between people who commit or attempt suicide and the general population. It is after this, that one can confidently talk about the prevention of suicide.

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APPENDIX I

QUESTIONS FOR SUCCESSFUL SUICIDES

1. File Identification _____

2. Address of next of kin: _____

   _____

3. Age: _____

4. Sex: Male _____ Female _____

5. Marital Status:

   Single _____ Married (mono) _____

   Married (poly) _____ Separated _____

   Cohabiting _____ Divorced _____

   Widowed _____

6. Occupation _____

7. Employed _____ Unemployed _____

   Self-employed _____

8. Education: Years in school _____

   Standard reached _____

9. Place of Birth _____

10. Place of residence: _____

11. The person the deceased lived with _____

    _____

12. Tribe _____

13. Nationality _____

14. Date suicide was committed _____

15. Place suicide was committed _____

16. Means of suicide _____

_____

17. Circumstances leading to suicide _____

_____

_____

_____

18. Whether the deceased had attempted suicide?

Yes ____ No _____

19. If Yes how many times _____

(b) Circumstances leading to the act

_____

_____

_____

_____

20. Whether there has been suicidal death in the family? Yes _____ No _____

21. If yes, who _____

(b) Circumstances leadding to the act

_____

_____

_____

22. Whether there has been suicidal attempts in the family? Yes _____ No _____

23. If yes, who did it _____

(b) Circumstances leading to the act.

_____

_____

_____

_____

24. Whether there is a suicidal note left.

_____

25. Whether the deceased had given some warnings prior to the act. Yes _____ No _____

APPENDIX II

QUESTIONS FOR THOSE PERSONS WHO HAVE ATTEMPTED SUICIDE AND THE CONTROL GROUP

Good-day, I am a student from the University of Nairobi going around this area asking people like you some questions about people who try to kill or kill themselves. This information is needed for two main reasons, mainly to help me pass my examinations at the University and to help the government understand the problems of the people who try to kill or kill themselves. Therefore, I would be grateful if you could answer these questions (This statement to be used to suicide attempters, relatives of the victims and key informants).

(Questions for both Groups)

File identification and address: _____

_____

Date of Admission _____ Date of Discharge

_____

Reasons for admission _____

_____

Diagnosis _____

_____

1. Age _____

2. Sex: Male _____ Female _____

3. Marital status: Single _____

Married (mono) _____ Married

(poly) _____ Separated _____

Divorced _____ Widowed _____

Cohabiting _____

4. If polygamous marriage:

(a) How many wives _____

(b) Which number are you _____

5. If married:

(a) Do you have children? Yes ____ No ____

(b) How many? Boys _____ Girls _____

Total _____

6. (a) Would you say that you are:

Satisfied _____ Moderately satisfied

_____ Very satisfied _____

or dissatisfied _____ Moderately

dissatisfied _____ Very dissatisfied

with your marriage? _____

(b) Why? _____

_____

7. Place of Birth: _____

8. (a) Place of residence _____

(b) Which part of town? _____

(c) Type of accommodation: House _____

Flat _____ Shanti _____

(d) Number of Rooms _____

9. Do you feel: Satisfied _____

Moderately satisfied _____ Very

satisfied or _____ Dissatisfied

_____ Moderately dissatisfied _____

Very satisfied _____ with the place where

you stay? _____

10. (a) If accommodation is rented _____

Owned _____

(b) If accommodation is shared: Yes _____

No _____

(c) If shared with whom shared _____

(d) How many people do you share with? ____

11. Tribe _____

12. Nationality _____

13. Religion: Catholic _____ Protestant ____

Moslem _____ Others _____

14. (a) Education: Number of years in school _____ Standard reached _____

(b) Do you feel you are:

Satisfied _____ Moderately satisfied _____ Very Satisfied _____ or Dissatisfied _____ Moderately dissatisfied _____ Very dissatisfied with your education?

15. (a) Occupation _____

(b) Are you satisfied _____ Moderately satisfied _____ Very satisfied _____ or Dissatisfied _____ Moderately dissatisfied _____ Very dissatisfied with your occupation?

(c) Why? _____

16. Employed _____ Unemployed _____ Self-employed _____

(b) If employed: Type of work _____

(c) Are you satisfied _____ Moderately satisfied _____ Very satisfied ____

or dissatisfied _____ Moderately dissatisfied _____ Very dissatisfied _____ with your employment?

(d) Why? _____

17. The person the patient lived with in Nairobi _____

18. What problems do you face staying with

(a) Spouse _____

(b) Alone _____

(c) Parents _____

(d) Relatives _____

19. (a) Whether drinks: Yes _____ No ____

(b) If yes what type of drink _____

(c) How much? _____

(d) When? _____

20. Whether takes drugs: Yes _____ No _____

(b) If yes what type? _____

(c) How often? _____

21. (a) Whether has been in trouble with police?

Yes _____ No _____

(b) If yes what was the problem? _____

_____

22. Any losses recorded: Loss of relative (death) _____ Loss of job _____

Loss of money _____

Failing an examination _____

Jilted by a lover _____

Others _____ Specify _____

23. Any recorded Family Problems _____

_____

24. (a) Whether patient has suffered from other illness: Yes _____ No _____

(b) Type _____

25. (a) Whether has been hospitalised within 3 months: Yes _____ No _____

(b) What was the illness _____

(c) How long? _____

(Questions to those who attempted suicide only)

26. What would you very much like to have in life?

_____

27. (a) If separated or divorced, who lives with your children? _____

(b) What was the reason for separation or divorce? _____

_____

(c) Did you feel: advantaged _____
moderately advantaged _____
very advantaged _____
or disadvantaged _____
moderately disadvantaged _____
very disadvantaged with the whole process of separation/divorce?

28. (a) Do you belong to any association? Yes__
No _____

(b) If yes which one? _____

29. (a) Do you have old people in your family (including old parents, grandparents etc.)
Yes _____ No _____

(b) What part do you see them play in your family? _____

30. Do you go to any social gatherings or events?
Yes _____ No _____

(b) What types do you go to? _____

(c) If no, why do you not go to any? _____

_____

31. Supposing you have been very much disappointed with your spouse, what practical thing would you do? _____

_____

32. (a) In life do you feel that you have achieved what you expected? Yes _____ No _____

(b) If yes, what have you achieved? _____

_____

(c) If no, why do you think you have failed to achieve your expectations? _____

_____

_____

33. (a) Have you tried to kill yourself? Yes ___ No _____

(b) If yes, when? _____

(c) Why? _____

_____

(d) where? _____

34. How many times have you tried to kill yourself?

_____

1. Reason :_____

By what means? _____

2. Reason: _____

By what means?_____

3. Reason:_____

By what means? _____

4. Reason:_____

By what means?_____

5. Reason: _____

By what means?_____

35. What happened after your previous suicidal attempts?

1. Taken to hospital _____
2. Went to hospital by myself _____
3. Went to my relatives _____
4. Taken to court _____
5. Others _____

Specify _____

36. (a) After discharge from the ward did you attend the out patient medical clinic?

Yes _____ No _____

(b) If yes, whom did you see? _____

37. (a) This time when you wanted to kill yourself were you alone in the house?

Yes _____ No _____

(b) If no, who saw you doing it? _____

_____

38. (a) Did you tell anybody that you are likely to do it? Yes _____ No _____

(b) If yes, when was this? _____

(c) Who did you tell? _____

_____

39. (a) How did you do it? _____

_____

40. I would like to ask you some questions about how you were feeling at the time you actually wanted to kill yourself. I shall read you a list of things and pick which refer to you.

(a) Worried about my future_____

What? _____

(b) Angry with someone _____

Who? _____

(c) Feeling lonely or unwanted? _____

Why? _____

(d) Sorry and ashamed of what had happened

_____

What? _____

(e) Feeling that I had failed in life

_____

Why? _____

41. There are various reasons why people kill themselves or may want to kill themselves. I have a list of 4 reasons. Loking back of what happened to you which of these reasons apply to you?

(a) Seek help from someone _____

Who _____

(b) Escape for a while from an impossible situation _____

What happened _____

(c) Get relief from a terrible state of mind

_____

What happened? _____

_____

(d) Try to influence some particular person or get them change their mind _____

_____

Who? _____

42. I would like to ask you what you thought at that time you were trying to kill yourself the effect would be:

(a) Show how much you loved your spouse ___

_____

(b) Make things easier to others _____

Especially who? _____

(c) Make people feel sorry for the way they have treated you _____

Who in particular? _____

(d) Felt sad and depressed _____

43. Before you tried to kill yourself what had happened? _____

_____

44. (a) Have you been accused to court?

Yes _____ No _____

(b) If yes, what was the problem? _____

_____

(c) When? _____

(d) How many times? _____

45. (a) Have you been in prison? Yes _____

No _____

(b) If yes, when? _____

(c) How many times? _____

(d) What was the problem? _____

_____

(e) For how long? _____

46. (a) Do you support anybody? Yes _____ No _____

(b) If yes, how many people do you support?

_____

(c) For how long have you been supporting them? _____

47. (a) Do you know any one who has tried to kill himself/herself? Yes _____

No _____

(b) If yes, who? _____

(c) When? _____

(d) Why? _____

APPENDIX III

QUESTIONS FOR FAMILY MEMBERS (RELATIVES)

1. What do you think make people kill or try to kill themselves? _____

_____

_____

2. In your case what had happened? _____

_____

_____

_____

_____

_____

3. Where were you when this happened? _____

_____

_____

_____

4. How did you discover the news? _____

_____

_____

5. (a) Do you think what happened was:

Fair _____ Unfair _____

(b) Why? _____

_____

_____

_____

6. How were things after what happened?

Alright _____ Terrible _____

Very terrible _____

7. Now looking back do you think what happened would have been avoided? (a) Yes _____

No _____

(b) If yes how? _____

_____

_____

_____

(c) If No why? _____

_____

_____

_____

8. (a) If the relative died after the act, how did you find the burial process?

Easy _____ Very Easy _____

Difficult _____ Very Difficult ___

(b) Why? _____

_____

_____

_____

9. (a) Compared to a situation where one has died through normal illness, which type of death did you find easy to handle?

_____

_____

_____

_____

(b) Why? _____

_____

_____

_____

10. Did you find help forthcoming from others?

Yes _____ No _____ Who in particular?

_____

_____

11. Who actually participated in the burial ceremony? _____

_____

_____

12. What happened to your relatives possessions?

_____

_____

_____

13. Did you have to loose friends after this?

Yes _____ No _____

14. Have you ever felt that the situation would have been prevented?

(a) Yes _____ No _____

(b) If Yes who would have done it?

_____

_____

(c) If No why? _____

_____

_____

15. Do you think your friends, or relatives have actually held you responsible for what happened? Yes _____ No _____

16. What help would you like to be given to the relatives of those who have killed or tried to kill themselves? _____

_____

_____

17. What help do you think should be given to those who have tried to kill themselves?

_____

_____

_____

18. What advice would you like to give to the relatives of those who have killed themselves?

_____

_____

_____

19. (a) Do you think those who have killed themselves should be buried as those who die from illness? Yes _____ No _____

(b) Why? _____

_____

_____

20. (a) Do you think those who kill themselves are sick? Yes _____ No _____

(b) If yes what kind of illness? _____

_____

_____

21. Why do you think those who try to kill themselves sometimes fail to do so? _____

_____

_____

22. Do you think those who try to kill themselves are sick?

(a) Yes _____ No _____

(b) If Yes what illness? _____

_____

23. Do you think the body of a person who has killed himself is infectious?

Yes _____ No _____

24. What changes have you noticed in your family since the incidence? _____

_____

_____

_____

_____

25. (a) Do you think those who have tried to kill themselves should be punished by Law?

Yes _____ No _____

(b) Why? _____

_____

_____

APPENDIX IV

QUESTIONS FOR KEY INFORMANTS

1. Age _____ 2. Sex: Male _____

   Female _____

3. Occupation _____

4. Education: Years at school _____

   Standard reached _____

5. Place of residence _____

   Years of stay _____

6. Religion _____

7. Have you ever heard of one trying or killing himself/herself Yes _____ No ____

8. If yes, (a) When did you hear of one killing himself? _____

   (b) Where? _____

   (c) What were the reasons for doing so?

   _____

   _____

   (d) What sex? _____

   (e) What means? _____

   _____

9. Do you think suicide used to be a problem in Kenya? Yes ____ No ____

   (b) Why? _____

   _____

10. Do you think suicide is on increase in Kenya?

Yes _____ No _____

(b) Why? _____

_____

11. Do you think suicide is a problem in your area? Yes _____ No _____

If yes, Why? _____

_____

_____

12. What in your opinion makes people kill themselves? _____

_____

_____

13. What in your opinion makes people try to kill themselves? _____

_____

_____

14. In your area what happens to a person who has killed himself? _____

_____

_____

(b) What used to happen to him long time ago?

_____

_____

15. In your area what happens to a person who has tried to kill himself? _____

_____

_____

(b) What used to happen to such a person?

_____

_____

_____

16. What happens to the relatives of a person who has killed himself in your area?

_____

_____

_____

(b) What used to happen to them?

_____

_____

_____

17. In your area what happens to the relatives of a person who has tried to kill himself?

_____

_____

(b) What used to happen to them?

_____

_____

18. What happens to the property of a person who has killed himself in the area?

_____

_____

_____

19. Is the person who has killed himself buried and mourned in the same way as a person who has died a natural death? Yes ____ No ____

(b) If no, why? _____

_____

_____

(c) If no, how is it done? _____

_____

_____

20. Do you think it is a sin to kill oneself?

Yes ____ No ____

(b) If yes, why? _____

_____

_____

21. Do you think suicide is contagious? Yes ___

No ____

(b) If yes, Why? _____

_____

(c) If yes, how can it be transmitted?

_____

_____

22. Do you think suicide is a disease?

Yes ____ No _____

(b) If yes, what type of disease? _____

_____

23. Do you think suicide can be treated?

Yes _____ No _____

(b) If yes, how was it done in your area?

_____

_____

(c) How is it done in your area now? _____

_____

_____

24. Do you think suicide can be prevented?

Yes _____ No _____

(b) If yes, how do you think it can be done?

_____

_____

25. What type of people do you think kill themselves? _____

_____

26. What types of people do you think try to kill themselves? _____

_____

_____

27. What methods did people use to kill themselves?

_____

_____

_____

28. What methods do they now use in your area to kill themselves? _____

_____

_____

29. What would you like to see being done to those people who have tried to kill themselves?

_____

_____

_____

30. What would you like to be done to the families of those who have killed or tried to kill themselves? _____

_____

_____

_____

31. Do you think that those who have tried to kill themselves should be punished?

Yes _____ No _____

(b) Why? _____

_____

_____

(c) If yes, how should they be punished?

_____

_____

_____

APPENDIX V

Dear Dr./Mr./Mrs./Miss .....

The Pope has just visited us in Kenya. In his speech he spoke of the family as a basic unit for any society and its development.

We are interested to find out some of the problems that families face in Kenya and how best the families can be helped to overcome them.

Your name and address has been picked as one of the people who can help us with the information we need.

In order to reach you and have a talk with you please fill in the following and send it back to us as soon as possible.

.....

1. Your name .....
2. Place of Residence in Nairobi:

   Location . .. .

   House Number .....

   Door Number .....

   Name of the Road near your home .....

   Box Number ....

   House Telephone Number .....

3. Place of work in Nairobi:

Name of Company/Organization.....

Box Number ... .

Office Telephone Number .....

Name of the Area .. ..

The nearest name of the Road .....

4. Would you please tell us the day of the week and time of the day that would be most convenient to meet you.

Day: ....

Time: Morning .....

Afternoon .....

Evening .....

Place: At work .....

At home .....

Either .....

P. Onyango (Mrs)

APPENDIX A:

Population by Sex, Five Year Age Group and Education. August, 1979

Sex	Age	No Education	Primary ST.1-4	Primary ST.5-7	Secondary Form 1-4	Secondary Form 5+	Not Stated
Males	0-4	100.0	-	-	-	-	-
	5-9	49.3	48.5	0.2	-	-	2.0
	10-14	12.2	58.0	27.5	1.3	-	1.0
	15-19	12.6	17.0	47.0	22.2	0.8	0.5
	20-24	17.7	11.1	34.1	32.9	3.2	1.0
	25-29	22.0	12.5	35.7	26.1	3.2	0.6
	30-34	25.8	13.8	36.6	20.3	2.9	0.6
	35-39	34.9	19.1	31.0	12.0	2.4	0.6
	40-44	42.2	21.7	25.7	7.9	1.7	0.8
	45-49	50.6	22.1	19.9	5.6	1.2	0.6
	50-54	59.9	22.3	12.9	3.3	0.9	0.7
	55+	74.8	16.6	6.2	1.2	0.5	0.7
	NS	61.6	12.4	11.8	4.2	0.5	9.6
	TOTAL	45	24.2	19.7	9.3	1.0	0.3
Females	0-4	100.0	-	-	-	-	-
	5-9	49.5	48.3	0.3	-	-	1.9
	10-14	15.4	53.4	28.8	1.5	-	0.9
	15-19	22.6	15.1	41.4	19.7	0.6	0.6
	20-24	37.9	12.7	28.3	18.3	1.1	1.6
	25-29	49.6	14.2	25.0	9.6	0.9	0.6
	30-34	62.2	14.2	17.8	4.3	0.7	0.7
	35-39	71.9	15.1	9.8	2.1	0.6	0.6
	40-44	78.5	12.8	6.2	1.3	0.4	0.8
	45-49	82.6	11.6	4.1	0.8	0.4	0.5
	50-54	87.1	8.9	2.4	0.5	0.3	0.8
	55+	93.0	4.5	1.1	0.3	0.3	0.8
	NS	75.4	10.2	5.8	1.9	0.1	6.7
	TOTAL	57.4	21.4	14.7	5.2	0.3	0.9

Source: Economic Survey, 1981:31 Central Bureau of Statistics, Ministry of Economic Planning & Developme

APPENDIX B:

Percentage of Population by Age, Sex and Educational Attainment

Sex	Age	No Education	Primary ST:1-4	Primary ST:5-8	Secondary Form 1-4:	Secondary Form V
Male	0-4	100 0	-	-	-	-
	5-9	86.2	13.8	-	-	-
	10-14	43.5	44.8	12.0	0.2	-
	15-19	31.7	20.7	39.4	8.1	0.1
	20-24	31.3	12.0	38.2	17 2	1.3
	25-29	49.9	15 5	31.3	9.7	1.7
	30-39	54 3	15 3	23.4	5.5	1 4
	40-49	70.0	9 9	15.6	3.4	1.1
	50-59	80.5	6 3	10 3	2.0	0.8
	60+	89.9	3.8	4 9	0 8	0 5
	TOTAL	66.4	14.8	14.6	3.7	0.5
Female	0-4	100.0	-	-	-	-
	5-9	87 5	12.5	-	-	-
	10-14	53 2	37 4	9.3	0 1	-
	15-19	50.3	16.4	28.6	4 6	0 1
	20-24	61.1	12.4	21.3	4.1	0.6
	25-29	76.4	12.5	9.8	1.8	0.5
	30-39	83.3	8.8	6.2	1.3	0.4
	40-49	90.6	4.0	4.2	0.8	0.4
	50-59	94.9	2 1	2.0	0 5	0.4
	60+	97.6	1 0	0 7	0.4	0.3
	TOTAL	79.5	11 5	7 6	1 2	0.2

Source: 1969 Census Report Vol IV: 82,
Central Bureau of Statistics,
Ministry of Finance & Planning

APPENDIX C:

Education according to Sex and Age in Rural Kenya

	19 Yrs. or less	20-39 Years	40-49 Years	50 Yrs	TOTAL
In School					
Male	67.5	12.0	0.1	0.0	38.5
Female	58 3	3 2	0.0	0.0	27.2
Std 4					
Male	2 3	15 1	24.1	13 1	9 2
Female	2.2	13 8	11.3	0.9	6.1
Std. 7 or 8					
Male	1.2	27.2	15 9	1.1	7.3
Female	0 1	3.3	0.3	0.0	0.1
Others					
Male	0.0	0 0	0.0	0.0	0.0
Female	0.1	0.0	0.1	0.0	0.1
Never attended					
Male	28.9	33.6	54.4	85.5	42.2
Female	37.4	64.8	85 5	85.3	62.1
Total					
Male	100.0	100.0	100.0	100.0	100.0
Female	100.0	100 0	100.0	100.0	100.0

Source: Integrated Rural Survey 1974-1975
Basic Report, March 1977:26
Central Bureau of Statistics (CBS)
Ministry of Finance & Planning.